California Medicaid

(Medi-Cal Dental Program)

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guides
Based on ASC X12 version 005010

March 2020
005010 v2.0

Disclosure Statement

The information in this document is subject to change in the event the Medi-Cal Dental Program revises its policies or HIPAA Transactions and/or Code Sets are updated or amended.

Preface

This Companion Guide to the v5010 Accredited Standards Committee (ASC) X12N Implementation Guides and associated errata adopted under the Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the California Medicaid Medi-Cal Dental Program. Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides.

This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

California Medicaid (Medi-Cal Dental) Companion Guide

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1. INTRODUCTION

1.1 Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This mandate requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.2 Intended Use

The instructions in this Companion Guide are not intended to be stand-alone requirements. The Medi-Cal Dental Program Companion Guide conforms to the requirements of associated ASC X12 Implementation Guides and is in conformance with ASC X12's "Fair Use" and copyright statements.

1.3 Scope

Electronic Data Interchange (EDI) addresses how providers, or their business associates, exchange Dental Claims, Claim Remittance Advice, and Claim Status Inquiry and Response transactions with the California Medicaid Dental Program (Medi-Cal Dental Program). The table below lists transactions supported by the Medi-Cal Dental Program.

Transaction	Version
276 Health Care Claim Status Request	005010X212
277 Health Care Claim Status Response	005010X212
835 Health Care Claim Payment/Advice	005010X221A1
837 Health Care Claim: Dental	005010X224A2
999 Acknowledgement for Health Care Insurance	005010X231A1
TA1 Interchange Acknowledgement	00501

1.4 Overview

Medi-Cal Dental EDI service is an optional method of data submission available to all participating Medi-Cal Dental providers. EDI is an easy, efficient, paperless system that transmits information to and from the dental practice computer and Medi-Cal Dental.

Providers using EDI may electronically transmit the following:

- Claims
- Treatment Authorization Requests (TARs)
- Notices of Authorization (NOAs)
- Claim Adjustments
- Claim/NOA Tracers

EDI trading partners (submitters) may elect to send all of the above documents electronically, or to send only claims and TARs. If submitters elect to send only claims and TARs, this choice does not preclude sending the other document types at a later date.

Optionally, submitters may elect to receive information electronically. Document types that can be received electronically include the NOA and Resubmission Turnaround Document (RTD), as well as Explanation of Benefits (EOB) data and Electronic Remittance Advice (ERA) data. With proper support in the Practice Management System, electronic EOB and ERA data allows submitters to systematically post claim payment information to their accounts.

To participate in EDI, the following are required:

- A computer system and appropriate software
- Enrollment in the Medi-Cal Dental EDI program
- Internet (HTTPS) connection capability
- Successful completion of EDI Testing and Certification

1.5 References

ASC X12 5010 Implementation Guides and HIPAA Code Sets: http://store.x12.org/store/

Medi-Cal Dental website: http://www.denti-cal.ca.gov

1.6 Additional Information

There is no charge from Medi-Cal Dental Program to use EDI. Practice management system vendors and billing intermediaries or clearinghouses charge for their services, and costs vary. Studies have shown that sending data electronically using EDI reduces paperwork and improves office efficiency, resulting in decreased administrative costs.

2. GETTING STARTED

To participate in EDI, a computer and Internet access is necessary, as well as specific application software for electronic data transmission to Medi-Cal Dental Program. If an electronic billing system is already in place, it may need an upgrade to submit data electronically. A practice management (or office management) system vendor can assist with a system upgrade or in selecting a system and software that best meet the requirements for electronically processing Medi-Cal Dental data. Contact Medi-Cal Dental Program for an EDI Enrollment form when a computer system and appropriate software have been installed. The electronic submission of data can begin once enrollment processing, and testing and certification are completed successfully.

2.1 Working with Medi-Cal Dental Program

Providers, billing intermediaries and clearinghouses interested in submitting or receiving electronic transactions with Medi-Cal Dental Program should contact Medi-Cal Dental Program EDI Support by emailing medi-caldentaledi@delta.org or by calling (916) 853-7373.

2.2 Trading Partner Registration

Trading Partner Registration is required to submit or receive EDI transactions with Medi-Cal Dental Program. To enroll in Medi-Cal Dental EDI Program, providers, billing intermediaries and clearinghouses must submit a completed Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement. In addition, providers must submit a:

- Completed Provider Service Office Electronic Data Interchange Option Selection Form, and
- ERA Enrollment Form (if 835 transaction data is desired)

The following links provide form access:

Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement:

https://www.denti-cal.ca.gov/DC_documents/providers/EDI_Application_Agreement.pdf

Provider Service Office Electronic Data Interchange Option Selection Form:

https://www.denti-cal.ca.gov/DC_documents/providers/Provider_Service_office_EDI_options_selection_form.pdf

Electronic Remittance Advice (ERA) Enrollment Form:

https://www.denti-cal.ca.gov/DC_documents/providers/ERA_enrollment_form.pdf

2.3 Certification and Testing Overview

To participate in EDI, a provider, billing intermediary or clearinghouse must demonstrate the ability to transmit compliant transactions in the ASC X12 837D format. This format is documented in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) – Health Care Claim: Dental (also referred to as the Implementation Guide).

Medi-Cal Dental Program trading partners must successfully complete a testing and certification process prior to participation in EDI. The testing and certification process verifies the trading partner's ability to:

- Establish communications through the internet
- Create and transmit documents in the proper format
- Receive reports

3. TESTING WITH MEDI-CAL DENTAL

All submitters are required to successfully complete a testing and certification process before authorization is granted to submit production data electronically. The certification process ensures the submitter has established communications with the EDI facility and is prepared to:

- Submit documents electronically,
- Receive reports and data from Medi-Cal Dental, and
- Act upon those reports when appropriate

In most cases, testing is conducted over the course of several test sessions. All trading partners must complete three general categories of testing:

1. Data communications
2. Data formatting
3. Receipt of reports and data

If trading partners intend to submit only first-time documents (i.e., claims and TARs), testing for data formatting is reduced in scope. If, at a later date, transmitting additional types of EDI documents is desired, additional testing is required.

3.1 Test Scheduling

Trading partners may contact Medi-Cal Dental Program EDI Support to schedule a mutually convenient time for data communications and data format testing. Subsequent testing will be scheduled as needed to ensure successful completion of each testing phase.

3.2 Data Communications Testing

Trading partners must demonstrate four data communications functions:

- Log on to the secure HTTPS website
- Upload files to the site
- Retrieve files from the site
- Log off

3.3 Data Format Testing

Data format testing is designed to verify the submitter's ability to create files using the most currently approved version of the ASC X12 transaction set. The transactions accepted by Medi-Cal Dental Program are the X12 837 and 276.

3.3.1 837 Transaction Data Format Testing

Certification is required for each type of 837 transaction the trading partner intends to send. This includes the following documents types:

- Claims
- Treatment Authorization Requests (TARs)
- Notices of Authorization (NOAs)
- Claim Adjustments

Trading partners are required to submit 15-20 HIPAA-compliant transactions, which include the following conditions:

1. Representation of all document types as applicable:
    a) Claim
    b) TAR
    c) NOA for Payment
    d) Claim Adjustment
2. Claim and/or TAR with X-rays and attachments. If a certified electronic attachment vendor is used, be sure to submit the PWK segment of Loop 2300, and identify the attachment is with the vendor.
3. Claim and/or NOA with multiple dates of service.
4. Claim and/or NOA with multiple rendering providers.
5. At least one transaction that includes a service description.
6. At least one transaction that includes a Share of Cost amount.
7. At least one transaction that includes an Other Health Coverage amount.
8. At least one transaction reflecting a non-employment-related accident.
9. At least one transaction reflecting an employment-related accident.
10. One or more transactions that include:
    a) Tooth code(s)
    b) Arch code(s)
    c) Quadrant code(s)
    d) Surface code(s)

Additionally, Medi-Cal Dental Program strongly encourages the submission of test transactions meeting the following conditions, if applicable:

11. When a single NPI is registered with Medi-Cal Dental Program for more than one service office, the NPI is considered non-subparted. If transactions for non-subparted NPIs will potentially be submitted, submit transactions for multiple service offices. Service office locations are identified using qualifier 'LU' in REF01 of Loop 2010BB.
12. If services will potentially be rendered to recipients residing in Skilled Nursing facilities (SNF) or Interim Care facilities (ICF), submit Service Facility Information in Loop 2310C.

The certification process generally requires multiple iterations of the following:

- The trading partner sends test 837 transactions.
- Medi-Cal Dental Program EDI Support critiques the 837 transactions, responding to the trading partner with any problems found with the transactions.
- The trading partner makes appropriate changes to the 837 transactions, correcting any problems, and sends the corrected 837 transactions to Medi-Cal Dental Program for evaluation.

3.3.2 276 Transaction Data Format Testing

Trading partners are required to submit at least fifteen (15) requests prior to being certified for the 276 transaction. At least one request must be a claim inquiry for multiple dates of service.

3.3.3 Certification

When the test transactions are error free, the trading partner is given approval to send production data. The first time the trading partner sends production data, the file should contain a limited number of transactions, mutually agreed upon by the trading partner and Medi-Cal Dental Program EDI Support. These transactions are closely monitored to ensure they are processed through the Medi-Cal Dental system successfully. If there are issues with the production transactions, it may be necessary to revisit the certification process and have the trading partner send more test transactions. An acceptance letter from Medi-Cal Dental Program EDI Support to the trading partner serves as official notice of participation in the EDI program.

3.4 Receipt of Reports and Data Testing

As part of the testing process, Medi-Cal Dental Program EDI Support makes sample reports, files and labels available for retrieval. The reports, files and labels contain only sample data and are not related to the data trading partners send in their test 837 and 276 transactions.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Medi-Cal Dental Program System Availability

Batch data transmission activity is supported 24 hours daily, Monday through Sunday, with the exception of 10 p.m. to 2 a.m. (Pacific Time), when system maintenance is performed. Documents received by 6 p.m. (Pacific Time), Monday through Saturday, holidays excluded, are entered into that evening's processing. More than one transmission type may be scheduled during a single communications session.

4.1 Process Flowcharts

Figures 4-1 and 4-2 on the following pages illustrate the high-level processes for the 837 and 835 transactions, and the 276 and 277 transactions.

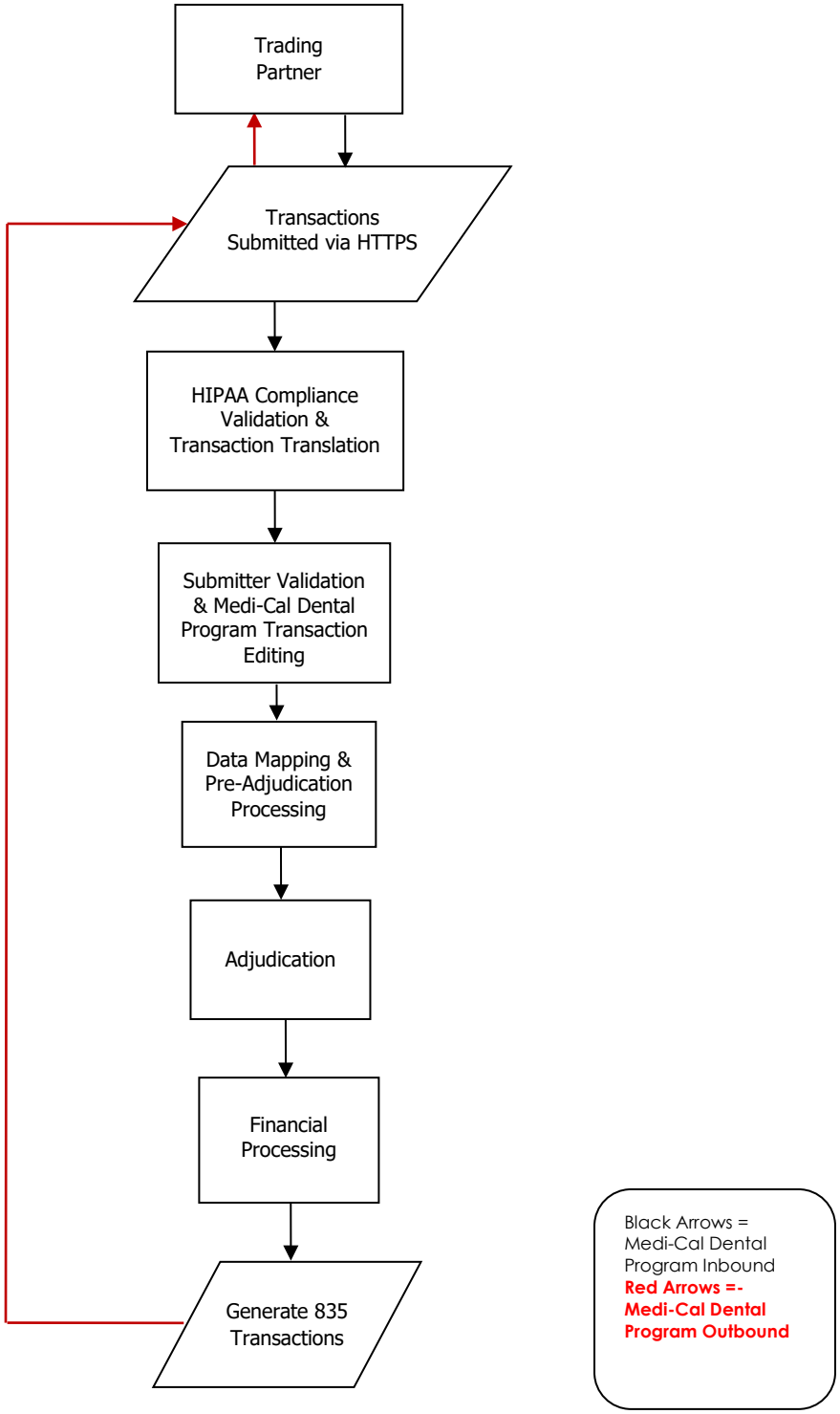

Figure 4-1 Batch Process for 837 and 835 Transactions

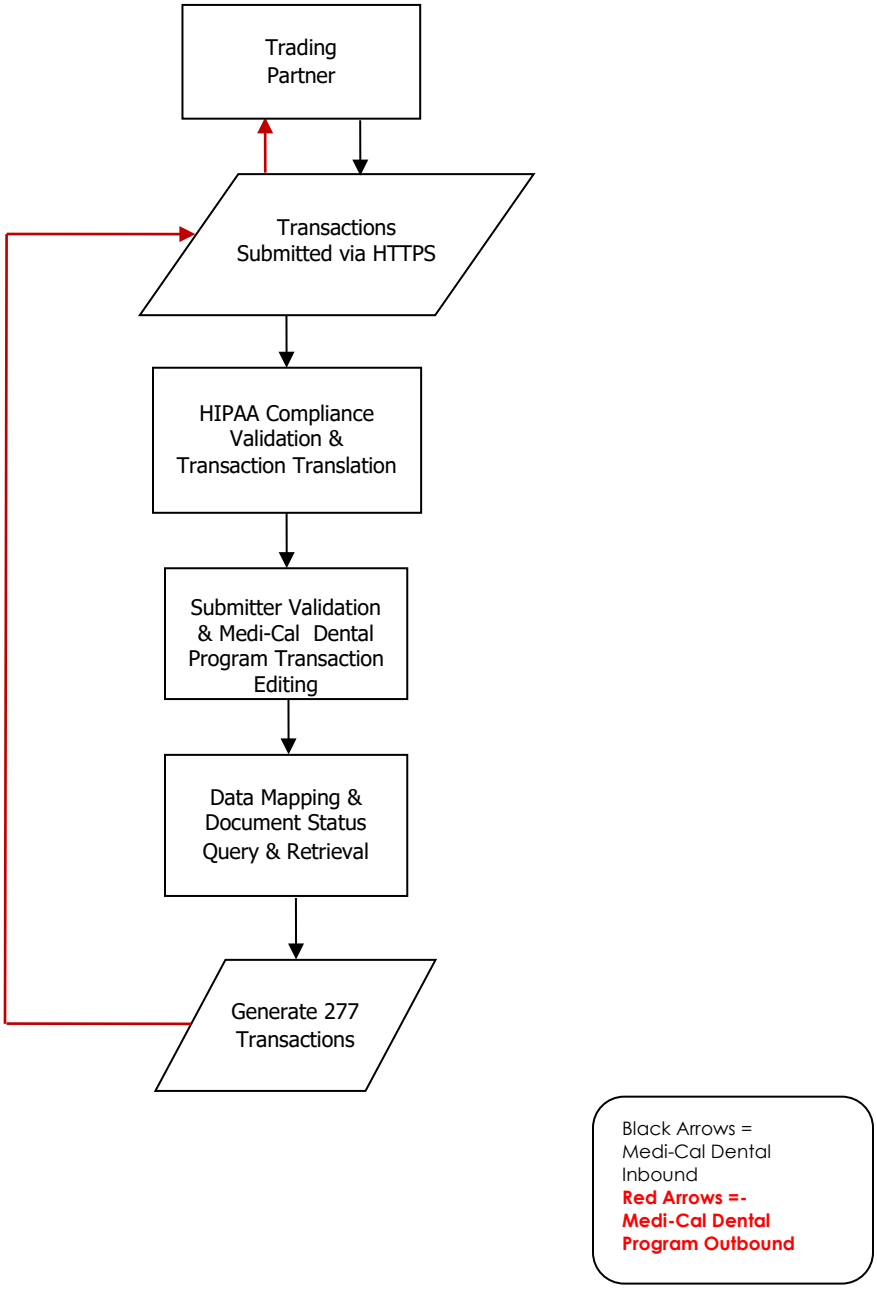

Figure 4-2 Batch Process for 276 and 277 Transactions

4.2 Transmission Administrative Procedures

Medi-Cal Dental Program supports a secure HTTPS website for the transmission of files to and from Medi-Cal Dental Program. Trading partners must have a computer with Internet Explorer (IE) version 9.0 or higher to securely transfer files to and from Medi-Cal Dental Program.

Trading partners are assigned a secure user ID and password that will grant access to established "In" and "Out" mailboxes. The "In" mailbox is where incoming files to Medi-Cal Dental Program are placed, and the "Out" mailbox is where outgoing files from Medi-Cal Dental Program are retrieved by the trading partner. Any file name is supported for incoming files, as all files in the "In" folder are extracted for processing. However, files cannot be zipped and must reflect a ".txt" extension.

4.3 Retransmission Procedure

Medi-Cal Dental Program does not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Medi-Cal Dental Program supports secure transmission of files through the internet via HTTPS using Secure Socket Layer (SSL) protocols. All EDI transaction files transferred to Medi-Cal Dental Program are kept internal; Medi-Cal Dental Program does not push these files out to external entities.

4.5 Passwords

A user ID and password are required for secure file transfer within the Medi-Cal Dental Program EDI system. As part of the testing and certification process, trading partners are assigned a permanent user ID and a temporary password. When logging in the first time, a user will be prompted to change their password. Passwords must be complex and contain characters from the following categories:

- Base 10 digits (0 – 9)
- Non-alphanumeric, such as: !@#$%^&*()_+|\'"[]><.,/?
- English uppercase or lowercase (A/a – Z/z)
- Must be a minimum of 8 characters
- No reuse of the last five passwords associated with account

Accounts will be locked after five (5) invalid password attempts. To reset your password, call (916) 853-7373 between 8 a.m. and 5 p.m., Monday through Friday (Pacific Time), and ask to be transferred to EDI Support.

NOTE: *Passwords expire and must be changed every one-hundred eighty (180) days*.

5. CONTACT INFORMATION

5.1 EDI Customer Service

Contact information for Medi-Cal Dental Program EDI Support:

- (916) 853-7373 – request to be transferred to EDI Support
- medi-caldentaledi@delta.org

5.2 EDI Technical Assistance

The practice management system vendor provides technical assistance with computer hardware or software. Medi-Cal Dental Program EDI Support staff can assist providers and their vendors regarding questions about technical requirements. During the testing phase, EDI Support works with providers and vendors to resolve any problems identified during the testing and certification process. Once the testing phase is completed successfully, the EDI Support Help Desk provides continued assistance to office personnel or vendor representatives. EDI Support provides timely response to issues regarding EDI data transmissions.

Contact information for Medi-Cal Dental Program EDI Support:

- (916) 853-7373 – request to be transferred to EDI Support
- medi-caldentaledi@delta.org

5.3 Provider Service Number

Providers may contact the Medi-Cal Dental Program Provider Telephone Service Center concerning the payment of claims by calling (800) 423-0507 between 8 a.m. and 5 p.m. (Pacific Time), Monday through Friday.

5.4 Applicable Websites/Email

EDI specifications, including this companion guide, can be accessed online at:

https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/EDI/

General Medi-Cal Dental Program information can be accessed online at:
www.denti-cal.ca.gov

6. CONTROL SEGMENTS/ENVELOPES

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the X12 Standard Implementation Guides. Medi-Cal Dental Program's requirements for inbound data, when applicable, are detailed in this section.

6.1 Delimiters

As described in the X12 Implementation Guides, transaction delimiters are determined by the characters sent in specified, set positions of the ISA header segment. Although not required, Medi-Cal Dental Program recommends the following delimiter values (Figure 6-1) be used when sending X12 data files to Medi-Cal Dental Program.

Data Element Separator	Hexadecimal '1D', decimal 29
Component Element Separator	Hexadecimal '22', decimal 34
Segment Terminator	Hexadecimal '1C', decimal 28

Figure 6-1 Delimiters for X12 Data Files

Medi-Cal Dental Program requires a carriage return, line feed sequence (CRLF) at the end of each segment. On the PC platform, the value of CRLF is hexadecimal '0D0A'. CRLF should always follow the segment terminator. Depending on how the data file is created, it may or may not be necessary to manually add the CRLF at the end of each segment. Most off-the-shelf PC applications automatically create this sequence when generating ASCII files.

6.2 ISA-IEA

The ISA segment is a fixed record length segment that must be used in accordance with the X12 Standard Implementation Guides. The following table clarifies Medi-Cal Dental Program's requirements for inbound 837 and 276 transactions.

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Medi-Cal Dental Program expects to receive the value listed in the codes column.
	ISA02	Authorization Information		Medi-Cal Dental Program expects to receive: DENTICAL
	ISA03	Security Information Qualifier	00	Medi-Cal Dental Program expects to receive the value listed in the codes column.
	ISA04	Security Information		Medi-Cal Dental Program expects to receive:

Loop ID	Reference	Name	Codes	Notes/Comments
				NONE
	ISA05	Interchange ID Qualifier	ZZ	Medi-Cal Dental Program expects to receive the value listed in the codes column.
	ISA06	Interchange Sender ID		Medi-Cal Dental Program expects to receive the Submitter's Denti-Cal Remote ID.
	ISA07	Interchange ID Qualifier	ZZ	Medi-Cal Dental Program expects to receive the value listed in the codes column.
	ISA08	Interchange Receiver ID		Medi-Cal Dental Program expects to receive: DENTICAL
	ISA14	Acknowledgement Requested	0	Medi-Cal Dental Program expects to receive the value listed in the codes column. Transactions are acknowledged in the Medi-Cal Dental Program CP-O-976 and CP-O-959-P reports.

6.3 GS-GE

The following table clarifies Medi-Cal Dental Program's requirements of the GS segment for inbound 837 and 276 transactions.

Loop ID	Reference	Name	Codes	Notes/Comments
Header	GS	Functional Group Header		
	GS02	Application Sender's Code		Medi-Cal Dental Program expects to receive the Submitter's Denti-Cal Remote ID.
	GS03	Application Receiver's Code		Medi-Cal Dental Program expects to receive: DENTICAL

6.4 ST-SE

Medi-Cal Dental Program has no requirements outside the X12 Standard Transaction Implementation Guides for the ST/SE segments.

7. PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1 Resubmission Turnaround Document (RTD) Corrections

Corrections in response to an RTD (also referred to as a Notice of Resubmission) may only be submitted on hard copy. Hard copy corrections may be submitted on the standard Medi-Cal Dental Program RTD form, or by returning report CP-O-RTD-P with the appropriate information added. If the CP-O-RTD-P report is returned in response to an RTD, the submitter must first elect to receive Medi-Cal Dental Program reports electronically.

7.2 Notice of Authorization (NOA) Submissions

An NOA may be submitted on either hard or electronic copy. The NOA report (CP-O-NOA-P) may be used for billing in place of the current NOA form. See Appendix B for examples of the CP-O-RTD-P and CP-O-NOA-P reports.

NOTE: *If a TAR was originally submitted on paper, the corresponding NOA may not be submitted electronically*.

7.3 Document Control Numbers (DCNs)

All documents sent electronically or by hard copy, are tracked by Medi-Cal Dental Program using a unique identifier called a Document Control Number (DCN). The DCN is assigned the day the document is electronically stored in the Medi-Cal Dental Program system. The DCN is returned electronically on EDI reports.

Medi-Cal Dental Program trading partners also assign a unique identifier to each EDI document, but not to hard copy documents. The unique identifier assigned by trading partners is referred to as a Provider Document Control Number (PDCN). Returning EDI documents, such as NOAs and claim adjustments, must contain the originally assigned Medi-Cal Dental Program DCN and the original trading partner-assigned PDCN.

In the case of EDI adjustments, for which the original claim was hard copy, there is no original PDCN to submit because the PDCN is not supported for hard copy documents. In these cases, a new PDCN must be sent with each EDI adjustment, along with the original Medi-Cal Dental Program DCN.

7.4 Radiographs and Hardcopy Attachments for EDI Documents

Documents may be transmitted electronically even though they require radiographs (X-rays) and/or hard copy attachments. Documents that require additional documentation to complete processing appear on the Provider/Service Office X-Ray/Attachment Request report (CP-O-971-P). Hard copy documentation, such as radiographs, periodontal charting, or other kinds of attachments may be mailed to Medi-Cal Dental Program by affixing the Medi-Cal Dental Program-supplied EDI label to specially marked envelopes. The Medi-Cal Dental Program DCN must be indicated on the EDI label, as well as the provider's National Provider Identifier (NPI), name and address, and the member's name.

Medi-Cal Dental Program also accepts digitized images submitted through certified electronic attachment vendors. When submitting digitized attachments in conjunction with EDI documents, it is important to include a properly formatted attachment control number in the PWK segment (PWK06) of the 837 transaction. Refer to Section 10.1 of this guide for additional information.

7.5 Labels

Labels are produced for submitters to use in identifying the claims, TARs, Adjustments and NOAs associated with radiographs and attachments sent to Medi-Cal Dental Program through the mail. Providers receiving the labels affix them to radiograph envelopes or Attachment Header Sheets before mailing. The information returned as part of the Provider XRay/Attachment Labels report (CP-O-971-P2) file is formatted to fit EDI-designed labels.

7.6 Service Facility Phone Number

When TARs and claims are submitted for members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), Medi-Cal Dental Program requires the service facility name, address, and phone number be provided. The service facility name and address should be submitted in Loop 2310C and the service facility phone number should be submitted in the Claim Note (NTE) segment of Loop 2300.

8. ACKNOWLEDGEMENTS AND REPORTS

8.1 Acknowledgements

All transactions received by Medi-Cal Dental Program will be acknowledged. If an error is identified within the Interchange Control (ISA/IEA) or Functional Group (ST/SE) envelopes, a TA1 will be returned. Otherwise, the standard X12 999 (Implementation Acknowledgment for Health Care Insurance) transaction will be returned.

The 999 transaction informs trading partners if the submitted transaction file contained TR3 compliance errors. Transactions determined to be error free will be accepted (IK5*A and/or AK9*A); transactions with errors will be rejected (IK5*R and/or AK9*R). If rejected, a corresponding HTML Error Report will be provided to help identify the specific transaction error(s) causing the rejection. Both the 999 transaction and the HTML Error Report are available in the submitter's 'Out' mailbox within minutes of submitting the 837D transaction. An example of this HTML Error Report is available in the Report Inventory subsection of this manual. Rejected transactions should be evaluated, corrected and resubmitted for processing.

NOTE: After passing TR3 compliance validation and being accepted by Medi-Cal Dental Program for processing, additional EDI editing is performed on 837D transactions. As a result, it is possible for an accepted transaction to be subsequently rejected. When this occurs, rejections will be identified on the CP-O-959-P Provider/Service Office Document Rejections report, which will be available in the submitter's 'Out' mailbox the following business day. An example of the CP-O-959-P report is located in the Report Inventory subsection below. Rejected transactions should be evaluated, corrected and resubmitted for processing.

8.2 Report Inventory

Providers may choose to receive a number of reports electronically. In some cases, EDI reports replace hard copy reports; in other cases, they offer new information. This section provides a brief description and a sample format of available EDI reports.

8.2.1 Notice of Authorization (CP-O-NOA-P)

Providers may opt to receive the electronic NOA in lieu of the hardcopy form. It presents Medi-Cal Dental Program authorization of services requested by the provider on a TAR. If a provider selects this option, the electronic NOA may be printed, completed, signed and returned to Medi-Cal Dental Program for billing.

```
(CP-O-NOA-P)       NOTICE OF AUTHORIZATION    MM/DD/YY 23:45:12   PAGE 01 OF 01
DCN: 00000000000 0   AUTHORIZATION PERIOD FROM MM/DD/YY TO MM/DD/YY

                                       RE-EVALUATION IS REQUESTED _ (X FOR YES)

PATIENT NAME(LAST,FIRST,MI)               SEX  BIRTHDATE  MEDI-CAL-ID NO
LAST           FIRST                       X   00/00/00   000000000
                              PATIENT DENTAL RECORD NO.  :
                              PROVIDER DOC CONTROL NUMBER: 0000000000000
X-RAYS ATTACHED _ (X FOR YES) HOW MANY?  __     ACCIDENT / INJURY   _ (X FOR YES)
OTHER ATTACHMENTS  _ (X FOR YES)               EMPLOYMENT RELATED _ (X FOR YES)
OTHER DENTAL COVERAGE  _ (X FOR YES)           CHDP               _ (X FOR YES)

BUSINESS NAME AND ADDRESS      0000000000
PROVIDER NAME                                    BIC ISSUE DATE:_________________

ADDRESS
                                                 EVC #:_____________________________
CITY              CA 00000-0000

TO SURF  LN DESCRIPTION-OF-SVC   DATE-PER QTY PROC   FEE    ALLOW  ADJ-C PROVID
14       01 ROOT CANAL, THREE    ________ 01 D3330  330.00  330.00  092  ______

   AS OF MM/DD/YY, THE REMAINING BENEFICIARY DENTAL CAP BALANCE IS
   $1,800.00. AUTHORIZATION DOES NOT GUARANTEE PAYMENT.




DATE PROSTHESIS ORDERED : ___________     TOTAL FEE CHARGED              330.00
PROSTHESIS LINE ITEM    : __ __ __ __     TOTAL ALLOWANCE                330.00
                                          PATIENT SHARE-OF-COST AMT.   ________
                                          OTHER COVERAGE AMT.          ________
COMMENTS:                                 DATE BILLED                  ________
PAYMENT REQUEST MUST HAVE RENDERING PROV ID
** PLEASE NOTE:  THIS BENEFICIARY MAY ONLY BE ELIGIBLE
UNDER A PHP, MCP, GMC, HMO OR DMC WHICH INCLUDES DENTAL.
PLEASE VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICES.

                                          X_____________________________  ________
                                                  SIGNATURE                DATE

NOTE: PLEASE REFER TO THIS NBR (00000000000) ON ALL YOUR COMMUNICATIONS, WITH
      DENTI-CAL, INCLUDING ELECTRONIC TRANSACTIONS CONCERNING THIS DOCUMENT.
```

Figure 8-1 CP-O-NOA-P

8.2.2 Notice of Resubmission (CP-O-RTD-P)

Providers may opt to receive this electronic report in lieu of hard copy RTDs. It identifies requests for missing or additional information and is printed, completed, signed and returned to Medi-Cal Dental Program for processing.

```
(CP-O-RTD-P)    NOTICE OF RESUBMISSION         01/09/12 23:45:04 PAGE  01 OF 01
BUSINESS NAME AND ADDRESS                            RTD ISSUE DATE: MM-DD-YY
SERVICE OFFICE/ FICTITIOUS NAME           0000000000    RTD DUE DATE: MM-DD-YY
PROVIDER NAME

ADDRESS                                        DOCUMENT TYPE: CLAIM
                                               BEGINNING DOS: 01-02-12
CITY              CA 00000-0000                PROVIDER DCN : 00000000000000
------------ PATIENT INFORMATION --------------------
                                                      AMOUNT
LAST NAME    FIRST NAME  MEDICAL ID NBR  DENTAL REC     BILLED      DCN
LAST         FIRST       000000000                     364.00   00000000000 0

                 CLAIM
INFORMATION      FIELD    CLAIM SUBMITTED             PROCEDURE
BLOCK            NO.      LINE  INFORMATION           CODE
TOOTH-CODE       26        02   08                    D2335
           ERROR CD:  32  DESC: SUBMIT CURRENT X-RAY(S) SHOWING APICES OF TOOTH
           CORRECT INFORMATION: ____________________________________________
TOOTH-CODE       26        02   08                    D2335
           ERROR CD:  31  DESC: SUBMIT CURRENT X-RAYS/PHOTOGRAPHS
           CORRECT INFORMATION: ____________________________________________


X_________________________________  ________
         SIGNATURE                   DATE

NOTE:    PLEASE CORRECT THE CLAIM/TAR/NOA AND  RESUBMIT A COPY OF THIS FORM THRU
THE MAIL.   MAIL ANY REQUIRED X-RAYS / ATTACHMENTS IN THE APPROPRIATELY  COLORED
ENVELOPE,  WRITING IN THE DOCUMENT CONTROL NUMBER  (DCN).  PLEASE INCLUDE THE
DENTI-CAL ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH DENTI-CAL.
```

Figure 8-2 CP-O-RTD-P

8.2.3 Provider/Service Office Document Rejections (CP-O-959-P)

This report lists EDI transactions that passed TR3 compliance validation but were subsequently rejected by Medi-Cal Dental Program. These documents must be corrected and retransmitted before they can be processed.

```
REPORT ID:     CP-O-959-P         DENTI-CAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                  PAGE:        1
PROGRAM ID:    DCB969BS  ... DOCUMENT REJECTIONS ........



 PROV/SVC      PROVIDER        RECIPIENT  NAME     D  SSN/CIN              RSN
 OR NPI          DCN           LAST       FIRST    T  OR MEDS    BASE DCN  CD
---------- ----------------- ------------ -------- - --------- ----------- ---
0000000000 00000000000000000 LAST         FIRST    C XXXXX0000              G
0000000000 00000000000000000 LAST         FIRST    C 000000000              G


        PROVIDER/SERVICE OFC TOTALS

      A - INVALID PROV/SVC OFC   :      0
      B - INVALID C/H            :      0
      C - INVALID PROV/CH        :      0
      D - BATCH REJECTED         :      0
      E - RECORD COUNTS MISMATCH :      0
      F - INVALID PROVIDER NAME  :      0
      G - DUPLICATE DOCUMENTS    :      0
      H - SECOND NOA ISSUED      :      0
      I - INVALID RETURN DCN     :      2
      J - SUB/PROV/SITE MISMATCH :      0
      K - CLM OVR 90 LINES - 4010:      0
      L - USE CIN OR BIC-NOT SSN :      0
      M - FILE VERSION NOT AUTH  :      0
      N - PDCN REQUIRED          :      0
      P - CLM OVR 50 LINES - 5010:      0

      TOTAL  REJECTIONS          :      2
```

Figure 8-3 CP-O-959-P

8.2.4 Provider Xray/Attachment Request (CP-O-971-P)

This report identifies TARs and claims that require radiographs and/or hard copy attachments for processing. By displaying the Medi-Cal Dental Program assigned DCN and the provider PDCN, the report enables providers to identify the TARs and claims requiring radiographs and/or hard copy attachments.

```
REPORT ID:     CP-O-971-P         DENTI-CAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                  PAGE:        1
PROGRAM ID:    DCB971BS    X-RAY/ATTACHMENT REQUEST


 PROV/SVC   BASE          PROV               RECIPENT     NAME         SSN/CIN/
  OR NPI    DCN           DCN                LAST         FIRST        OR MEDS
----------  -----------  -----------------  ------------ ----------  ---------
0000000000  00000000000  0000000000          LAST         FIRST       000000000
MEDI CAL NBR: 000000000      SYS IND:     DOC TYPE: C SUBMIT AMOUNT:  1500.00
0000000000  00000000000  000000000000        LAST         FIRST       XXXXX0000
MEDI CAL NBR: 000000000      SYS IND:     DOC TYPE: C SUBMIT AMOUNT:   285.00
0000000000  00000000000  0000000             LAST         FIRST       000000000
MEDI CAL NBR: 000000000      SYS IND:     DOC TYPE: T SUBMIT AMOUNT:   300.00

** TOTAL X-RAY/ATTACHMENT REQUESTS FOR PROV/SVC OFC.:      3
```

Figure 8-4 CP-O-971-P

8.2.5 Provider Xray/Attachment Labels (CP-O-971-P2)

Labels are produced for submitters to use in identifying the claims and TARs associated with the radiographs and attachments sent to Medi-Cal Dental Program through the mail. The data in these labels has been preformatted to match special labels designed for the EDI process. Providers receiving these labels must affix them to special EDI radiograph envelopes before mailing.

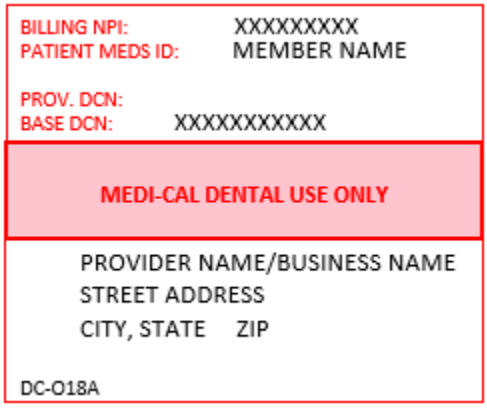

Figure 8-5 CP-O-971-P2

8.2.6 Provider/Service Office Daily EDI Documents Received Today (CP-O-973-P)

This report lists all accepted EDI documents received on the date displayed as “Period Ending:” prior to the daily cutoff time. It serves as a cross-reference between the Medi-Cal Dental Program DCN and the PDCN. The report is a confirmation of received claims, TARs, NOAs and Adjustments.

```
REPORT ID:     CP-O-973-P         DENTI-CAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                  PAGE:        1
PROGRAM ID:    DCB973BS DAILY EDI DOCUMENTS RECEIVED TODAY



PROV/SVC   PROVIDER          BASE        RECIPIENT    NAME       SSN/CIN/
 OR NPI    DCN               DCN         LAST         FIRST      OR MEDS
---------- ----------------- ----------- ------------ ---------- ---------
0000000000 00000000000000000 00000000000 LAST         FIRST      000000000
 MEDI CAL NBR: 00000000000000   DOC TYPE: C   SUBMITTED FEE:   100.00
0000000000 00000000000000000 00000000000 LAST         FIRST      XXXXX0000
 MEDI CAL NBR: 00000000000000   DOC TYPE: T   SUBMITTED FEE:   300.00

    TOTAL PROV/SVC OFC DOCUMENTS :     2
```

Figure 8-6 CP-O-973-P

8.2.7 Provider/Service Office Daily EDI Documents Waiting Return Information > 7 Days (CP-O-978-P)

This report lists all EDI documents awaiting radiographs and/or hard copy attachments or electronically generated RTDs for more than seven (7) days.

```
REPORT ID:     CP-O-978-P         DENTI-CAL                    RUN ON: MM/DD/YY
PERIOD ENDING: MM/DD/YY       PROVIDER/SVC OFC                  PAGE:        1
PROGRAM ID:    DCB978BS DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > 7 DAYS


PROV/SVC   ISSUE    DAYS SSN/CIN/  MEDI-CAL       RECIPIENT    NAME   TYPE OF
 OR NPI    DATE     SNCE OR MEDS   NUMBER         LAST         FIRST  REQUEST
---------- -------- ---- --------- -------------- ------------ ------ ----------
0000000000 12/26/07   15 000000000 0000-000000000 LAST         FIRST  XRAY/ATTCH
PROV DCN: 000000000000-0000 BASE DCN: 00000000000 DOC TYPE: T SUB AMT:   380.00
0000000000 12/27/07   14 000000000 0000-00000000  LAST         FIRST/ ADDIT DOC
PROV DCN: 000000000000-0000 BASE DCN: 00000000000 DOC TYPE: T SUB AMT:   990.00
0000000000 12/27/07   14 XXXXX0000 0000-000000000 LAST         FIRST  X/RAY/ATTCH
PROV DCN: 000000000000-0000 BASE DCN: 00000000000 DOC TYPE: C SUB AMT:   162.00

    TOTAL PROV/SVC OFC DOCUMENTS :     3
```

Figure 8-7 CP-O-978-P

8.2.8 HTML Error Report

Describes the reason transaction(s) were rejected for processing. This HTML Error Report will only be generated when transactions are identified as rejected in the ASC 999 acknowledgment transaction. Providers should use this report to identify and correct submission errors. Once errors have been corrected, the transaction will need to be resubmitted for processing.

It is strongly suggested that the HTML Error Report file be opened using a browser like *Internet Explorer*, *Chrome* or *Firefox*. Opening it in a text editor like *Notepad* makes the file harder to read, as it contains scripting code as well as HTML control elements/tags.

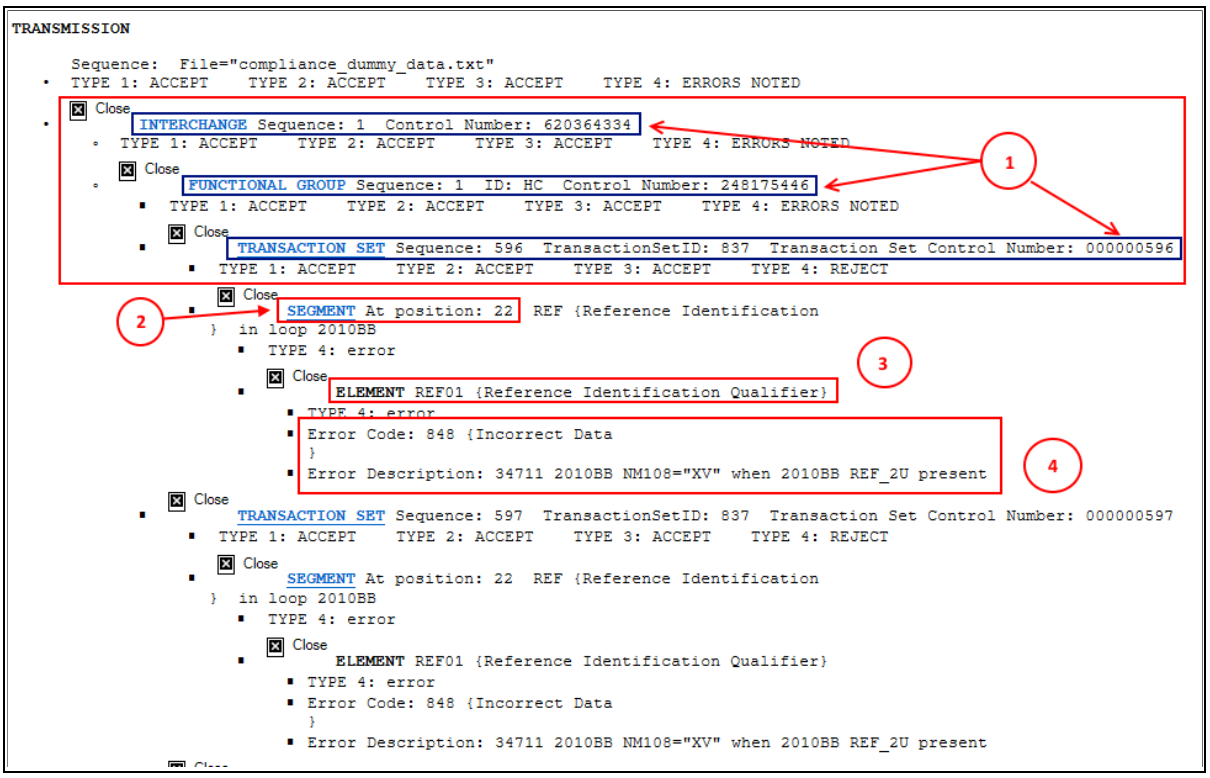

Figure 8-8 HTML Error Report

In order to identify the compliance issues in the file, the following process should be followed:

1. Identify the transaction set where the error was identified. This is done using the ISA Control Number, GS Control Number and ST Control Number as shown above.
2. Identify the position of the segment within the transaction set.
3. This step involves locating the element within the segment that has the issue.
4. Finally, the error itself is described via an Error Code and Error Description.

8.3 Supplemental EOB Data

In addition to the 835 transaction, providers may choose to receive Explanation of Benefits (EOB) information in a supplemental data format. The data is enveloped using the standard X12 envelope structure and is presented in upper case format. This option is made available for providers planning to perform automated reconciliation of receivables within their practice management systems.

Data available in the Supplemental EOB Data File includes adjudicated claims, accounts receivable and payable transactions, levy information and check cycle summary information. The following illustrates the Supplemental EOB Data File format, including a data element level definition of the individual record fields.

The Supplemental EOB Data File is comprised of six record types:

1. Claim Header Record
2. Claim Service Line Detail Record
3. Accounts Payable Detail Record
4. Levy Detail Record
5. Accounts Receivable Detail Record
6. Check Cycle Summary Record

Each record type is distinguished by the value in the first position of each record. All records within the file are the same length, with blanks used to pad each record to a fixed length.

The Claim Header Record shows claim level EOB information on a single claim. The Claim Service Line (CSL) Detail Record identifies EOB information relative to a specific service line. There is one CSL Detail Record per claim service line.

The Check Cycle Summary Record provides summary level information regarding claims payments, adjustments and non-claims transactions.

The other record types identify non-claims specific information pertaining to the provider's account, and they may or may not be present in an individual EOB Data File.

EDI providers may opt to discontinue receiving paper EOBs if they are transmitting the 835 transaction and/or Supplemental EOB file in Detail format. Choosing not to receive paper EOBs does not affect the receipt of payment nor provider checks, which are mailed separately from EOBs.

8.3.1 Supplemental EOB Data Field Definitions by Record Type

The following subsections present the definition of each field by record type. Fields are sequenced in the order they occur within the record.

Claim Header Record

1. **Record Type**: Code, value "1", indicating the record is a Claim Header Record.
2. **Adjustment Indicator**: Identifies whether or not the information is for an adjustment. A value of "Y" indicates the data is for an adjustment.
3. **Before/After Indicator**: Identifies whether, for an adjustment, the information is for the original document or the adjustment. A value of "B" (before) indicates the data is for the original document. A value of "A" (after) indicates that the data pertains to the adjustment. A blank indicates that the information is not for an adjustment.
4. **Adjustment Correction Code**: The reason for an adjustment. Refer to the *Medi-Cal Dental Program Provider Handbook, Section 7 – Readjudication Codes*, for values.
5. **Document Control Number (DCN):** The number assigned to each claim by Medi-Cal Dental Program.
6. **Provider Document Control Number (PDCN)**: The provider's practice management system's internal number that uniquely identifies the document sent to Medi-Cal Dental Program.
7. **Patient Last Name**: The member's last name.
8. **Patient First Name**: The member's first name.
9. **Medi-Cal ID Number**: The member's Client Index Number (CIN), Pseudo ID or masked Social Security Number (SSN).
10. **Date of Birth**: The member's birth date.
11. **Medi-Cal ID Number**: The member's CIN, Pseudo ID or masked SSN.
12. **Claim Policy Code**: Code that represents the reason for a claim level denial.
13. **Amount Billed**: The amount billed for the document.
14. **Share-of-Cost Amount**: The amount the patient paid toward a Share-of-Cost (SOC) obligation.
15. **Other Coverage Amount**: The amount paid by another carrier.
16. **Co-payment**: The amount of co-payment collected for the claim.
17. **Medicare Paid Amount**: The amount paid by Medicare for the claim.
18. **Allowed Amount**: The total amount allowed by Medi-Cal Dental for all services on the claim.
19. **Amount Paid**: The total amount paid on a claim by Medi-Cal Dental after deductions.
20. **Medi-Cal Dental Check Number**: The number of the check issued with the EOB.
21. **Direct Deposit Indicator**: Indicates whether a payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check; a value of "N" indicates the check was not a direct deposit.

22. **Provider Number:** The billing provider's National Provider Identifier (NPI).
23. **Check Date**: The date the EOB was issued.
24. **Filler**: Trailing blanks added to a record to make its length consistent with other records.

Claim Service Line Detail Record

1. **Record Type**: Code, value "2", indicating the record is a CSL Detail Record.
2. **Adjustment Indicator**: Identifies whether or not the information is for an adjustment. A value of "Y" indicates the data is for an adjustment. A value of "N" indicates the information is not related to an adjustment.
3. **Before/After Indicator**: Identifies whether, for an adjustment, the information is for the original document or the adjustment. A value of "B" (before), indicates the data is for the original document. A value of "A" (after) indicates that the data pertains to the adjustment. A blank value indicates the information is not adjustment-related.
4. **Adjustment Correction Code**: The reason for an adjustment. Refer to the *Medi-Cal Dental Program Provider Handbook, Section 7 Readjudication Codes*, for values.
5. **Document Control Number (DCN)**: The number Medi-Cal Dental assigns to each claim.
6. **Provider Document Control Number (PDCN)**: The provider's practice management system's internal number that uniquely identifies the document sent to Medi-Cal Dental Program.
7. **Patient Last Name**: The member's last name.
8. **Patient First Name**: The member's first name.
9. **Medi-Cal ID Number**: The member's CIN, Pseudo ID or masked social security number.
10. **Date of Birth**: The patient's birth date.
11. **Medi-Cal ID Number**: The member's CIN, Pseudo ID or masked social security number.
12. **Status**: Identifies the status of each claim line. A value of "P" identifies a paid line; a value of "D" identifies a denied line; a value of "A" identifies a previously processed line.
13. **Amount Billed**: The amount billed for each claim line.
14. **Share-of-Cost Amount**: The portion of the patient's share-of-cost payment that was deducted from the claim line allowed amount.
15. **Other Coverage Amount**: The portion of the other coverage payment that was deducted from the claim line allowed amount.
16. **Medicare Paid Amount**: The portion of the Medicare paid amount that was deducted from the claim line allowed amount.
17. **Allowed Amoun**t: The amount allowed by Medi-Cal Dental Program for the claim service line.
18. **Co-payment**: The portion of the co-payment that was deducted from the claim line allowed amount.
19. **Amount Paid**: The amount paid on the claim line after deductions.
20. **Medi-Cal Dental Program Check Number**: The number of the check issued with the EOB.

21. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of “Y” identifies a direct deposit check, a value of “N” indicates the check was not a direct deposit.
22. **Provider Number**: The billing provider's NPI.
23. **Tooth Code**: The tooth number, letter arch or quadrant on which the procedure was performed.
24. **Tooth Surface**: The surface(s) affected by the procedure.
25. **Procedure Code**: The code listed on a claim line that identifies the service performed. This code may be different from the procedure code submitted on the claim or TAR because a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim may have modified the procedure code.
26. **Procedure Quantity**: The number of occurrences of the procedure.
27. **Date of Service**: The date the service was performed.
28. **Adjudication R/S Code (Replace/Substitute Indicator)**: Code indicating whether one or more procedures were replaced with a substituted code. A value of “R” indicates the procedure was replaced. A value of “S” identifies the substituted procedure. A blank value indicates no replacement or substitution occurred for this procedure.
29. **Adjudication Reason Code**: The code that explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied.
30. **Check Date**: The date the EOB was issued.
31. **Claim Policy Code**: The reason for denial.
32. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Accounts Payable Detail Record

1. **Record Type**: Code, value “3”, indicating the record is an Accounts Payable Detail record.
2. **Accounts Payable Control Number**: The number assigned by Medi-Cal Dental Program, which identifies the Accounts Payable (A/P) transaction.
3. **Reason Code**: The code, which identifies the reason for the payable. A value of “1” identifies a Surveillance and Utilization Review Subsystem (S/URS) adjustment; “2” is for a standard Accounts Receivable (A/R); “3” is for an interim payment; “4” is for a recoupment penalty; “5” is for a recoupment of an overpayment.
4. **Description**: The description associated with the A/P reason code.
5. **Accounts Payable Amount**: The dollar amount of the individual accounts payable transaction.
6. **Check Number**: The number of the check issued with the EOB.
7. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of “Y” identifies a direct deposit check, a value of “N” indicates the check was not a direct deposit.
8. **Provider Number**: The billing provider's NPI.

9. **Check Date**: The date the EOB was issued.
10. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Levy Detail Record

1. **Record Type**: Code, value “4”, indicating the record is a Levy Detail record.
2. **Levy Holder Number**: The number issued by Medi-Cal Dental Program to the levy holder upon receipt of a levy request.
3. **Levy Holder Name**: The name of the levy holder.
4. **Levy Holder Check Number**: The number of the check issued to the levy holder by Medi-Cal Dental Program.
5. **Levy Deduction Amount**: The amount of the payment issued to the levy holder by Medi-Cal Dental Program, shown as a negative amount.
6. **Medi-Cal Dental Program Check Number**: The number of the check issued with the EOB.
7. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of “Y” identifies a direct deposit check, a value of “N” indicates the check was not a direct deposit.
8. **Provider Number**: The billing provider's NPI.
9. **Check Date**: The date the EOB was issued.
10. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Accounts Receivable Detail Record

1. **Record Type**: Code, value “5”, indicating the record is an Accounts Receivable Detail record.
2. **Accounts Receivable Control Number**: The number assigned by Medi-Cal Dental Program, which identifies the A/R transaction.
3. **Effective Date**: For standard A/R transactions (Reason Code “2”), the effective date of the A/R.
4. **Reason Code**: The code identifying the reason for the receivable. A value of “1” identifies a S/URS adjustment; “2” is for a standard A/R; “3” is for an interim payment; “4” is for a recoupment penalty; “5” is for a recoupment of an overpayment.
5. **Description**: The description associated with the A/R reason code.
6. **Opening Balance**: The A/R amount of the provider's account at the beginning of the check write.
7. **Applied Amount**: The dollar amount of the individual A/R transaction.
8. **New Balance**: The accounts receivable amount remaining after the A/R transaction has been applied.
9. **S/URS Recoupment Number**: The reference number associated with S/URS adjustment A/R (Reason Code “1”) transactions.

10. **Client Check Number**: The number of the check issued with the EOB.
11. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of “Y” identifies a direct deposit check, a value of “N” indicates the check was not a direct deposit.
12. **Provider Number**: The billing provider's NPI.
13. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Check Cycle Summary Record

1. **Record Type**: Code, value “6”, indicating the record is a Check Cycle Summary record.
2. **Total Paid Amount**: The total amount paid on other than adjustments.
3. **Total Adjusted Amount**: The net amount paid on all adjustments.
4. **Total Payable Amount**: The total amount of all accounts payable transactions.
5. **Total Levy Amount**: The total amount of all levies transactions.
6. **Total A/R Amount**: The total amount of all accounts receivable transactions.
7. **Total Co-payment**: The total co-payment collected on the claims.
8. **Total Check Amount**: The amount of the check that is for the EOB.
9. **Medi-Cal Dental Program Check Number**: The number of the check issued for the EOB.
10. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider’s account. A value of “Y” identifies a direct deposit check, a value of “N” indicates the check was not a direct deposit.
11. **Provider Number**: The billing provider’s NPI.
12. **Check Date**: The date the EOB was issued.
13. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

8.3.2 Supplemental EOB Record Formats

This section presents the format of each EOB record type. Fields are positional within each record and the starting and ending position of each field is defined in the tables below under "Position". The "Picture" refers to the data type and length of the data element and is expressed in COBOL terminology. Fields with a picture beginning in "X" are alphanumeric fields, those beginning with "9" and ending in ". 99" are money fields and all other fields beginning with "9" are numeric fields. For alphanumeric and numeric fields, the number within the parentheses identifies the field length. For money fields, the number within the parentheses indicates the number of dollar positions, while the "99" following the "." indicates two decimal places for the cents figure. Numeric and money fields include leading zeroes while alphanumeric fields include trailing blanks. A positive or negative sign precedes the first position of each money field.

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "1"
2	Adjustment Indicator	X(1)	02-02	
3	Before/After Indicator	X(1)	03-03	
4	Adjustment Correction Code	X(2)	04-05	
5	Document Control Number (DCN)	X(11)	06-16	
6	Provider Document Control Number (PDCN)	X(17)	17-33	
7	Patient Last Name	X(12)	34-45	
8	Patient First Name	X(10)	46-55	
9	Medi-Cal ID Number	X(9)	56-64	
10	Date of Birth	X(6)	65-70	MMDDYY
11	Medi-Cal ID Number	X(14)	71-84	
12	Policy Code	X(2)	85-86	
13	Amount Billed	-9(5).99	87-95	
14	Share-of-Cost Amount	-9(4).99	96-103	
15	Other Coverage Amount	-9(5).99	104-112	
16	Co-payment	-9(3).99	113-119	
17	Medicare Paid Amount	-9(5).99	120-128	
18	Allowed Amount	-9(5).99	129-137	
19	Paid Amount	-9(5).99	138-146	
20	Denti-Cal Check Number	9(9)	147-155	
21	Direct Deposit Indicator	X(1)	156-156	
22	National Provider Identifier	X(10)	157-166	
23	Check Date	X(6)	167-172	MMDDYY
24	Filler	X(28)	173-200	

Figure 8-9 Claim Header Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant “2”
2	Adjustment Indicator	X(1)	02-02	
3	Before/After Indicator	X(1)	03-03	
4	Adjustment Correction Code	X(2)	04-05	
5	Document Control Number (DCN	X(11)	06-16	
6	Provider Document Control Number (PDCN)	X(17)	17-33	
7	Patient Last Name	X(12)	34-45	
8	Patient First Name	X(10)	46-55	
9	Patient Medi-Cal ID Number	X(9)	56-64	
10	Patient Date of Birth	X(6)	65-70	MMDDYY
11	Patient Medi-Cal ID Number	X(14)	71-84	
12	Status	X(1)	85-85	
13	Amount Billed	-9(5).99	86-94	
14	Share of Cost Amount	-9(4).99	95-102	
15	Other Coverage Amount	-9(5).99	103-111	
16	Medicare Paid Amount	-9(5).99	112-120	
17	Allowed Amount	-9(5).99	121-129	
18	Co-payment	-9(3).99	130-136	
19	Paid Amount	-9(5).99	137-145	
20	Denti-Cal Check Number	9(9)	146-154	
21	Direct Deposit Indicator	X(1)	155-155	
22	National Provider Number	X(10)	156-165	
23	Tooth Code	X(2)	166-167	
24	Tooth Surface	X(5)	168-172	
25	Procedure Code	X(5)	173-177	
26	Procedure Quantity	9(2)	178-179	
27	Date of Service	X(6)	180-185	
28	Adjudication R/S Code	X(1)	186-186	
29	Reason Code	X(4)	187-190	
30	Check Date	X(6)	191-196	MMDDYY
31	Claim Policy Code	X(2)	197-198	
32	Filler	X(02)	199-200	

Figure 8-10 Claim Service Line Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant “3”
2	Accounts Payable Control Number	X(7)	02-08	
3	Reason Code	X(1)	09-09	
4	Description	X(40)	10-49	
5	Accounts Payable Amount	-9(7).99	50-60	
6	Denti-Cal Check Number	9(9)	61-69	
7	Direct Deposit Indicator	X(1)	70-70	
8	National Provider Identifier	X(10)	71-80	
9	Check Date	X(6)	81-86	MMDDYY
10	Filler	X(114)	87-200	

Figure 8-11 Accounts Payable Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant “4”
2	Levy Holder Number	X(9)	02-10	
3	Levy Holder Name	X(40)	11-50	
4	Levy Holder Check Number	9(9)	51-59	
5	Levy Deduction Amount	-9(6).99	60-69	
6	Denti-Cal Check Number	9(9)	70-78	
7	Direct Deposit Indicator	X(1)	79-79	
8	National Provider Identifier	X(10)	80-89	
9	Check Date	X(6)	90-95	MMDDYY
10	Filler	X(105)	96-200	

Figure 8-12 Levy Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant “5”
2	Accounts Receivable Control Number	X(5)	02-06	
3	Effective Date	X(6)	07-12	MMDDYY
4	Reason Code	X(1)	13-13	
5	Description	X(40)	14-53	
6	Opening Balance	-9(7).99	54-64	
7	Applied Amount	-9(7).99	65-75	
8	New Balance	-9(7).99	76-86	
9	S/URS Recoupment Number	X(3)	87-89	
10	Client Check Number	9(10)	90-99	
11	Direct Deposit Indicator	X(1)	100-100	
12	National Provider Identifier	X(10)	101-110	
13	Filler	X(90)	111-200	

Figure 8-13 Accounts Receivable Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant “6”
2	Total Paid Amount	-9(6).99	02-11	
3	Total Adjusted Amount	-9(6).99	12-21	
4	Total Payable Amount	-9(7).99	22-32	
5	Total Levy Amount	-9(6).99	33-42	
6	Total A/R Amount	-9(7).99	43-53	
7	Total Co-payment Amount	-9(6).99	54-63	
8	Total Check Amount	-9(7).99	64-74	
9	Denti-Cal Check Number	9(9)	75-83	
10	Direct Deposit Indicator	X(1)	84-84	
11	National Provider Identifier	X(10)	85-94	
12	Check Date	X(6)	95-100	MMDDYY
13	Filler	X(100)	101-200	

Figure 8-14 Check Cycle Summary Record

8.4 Electronic Report Retrieval

EDI reports and data files may be retrieved from the "Out" mailbox after their creation. Reports, Supplemental EOBs, Labels, 835 Transactions, 999 Acknowledgements, HTML Error Reports, and TA1 Acknowledgements are created each within their own separate file. Format for the outgoing filenames are illustrated below.

NOTE: Outbound reports and files are retained in the "Out" mailbox for fifteen (15) days. After fifteen (15) days, the information is purged; please be sure to extract information in a timely manner.

reportMMDDYYHHMM.txt	=	Reports
eobMMDDYYHHMM.txt	=	Supplemental EOBs
labelMMDDYYHHMM.txt	=	Labels
835MMDDYYHHMM.txt	=	835 Transactions
999MMDDYYHHMMSSSSS.txt	=	999 Acknowledgements
HTMLERRMMDDYYHHMMSSSSS.html	=	HTML Error Reports
TA1MMDDYYHHMMSSSSS.txt	=	TA1 Acknowledgements

Where: MMDDYY = Month, Day, Year file was created

HHMMSSSSS = Hour, Minute, Seconds (when applicable) file was placed in mailbox

(Note: Time is always reflected in Eastern Time)

If file is zipped, the file extension will be ".zip"

Figure 8-15 File Naming Standards

8.5 Report and Data Enveloping

Reports and supplemental EOB data are enveloped using the standard X12 enveloping structure. This enveloping structure, and its relation to the returned information, is displayed below. The GS/GE envelope is repeated for each provider or service office.

Loop	Segment	Data Elements
ENV	ISA	*00*DENTICAL *00*NONE *ZZ*DENTICAL *ZZ*remote-id *YYMMDD *HHMM*00303*trans control nbr*0*P/T*"$^{N}_{L}$
GS	GS	*TX*DENTICAL*final destination provider ID and office number-*YYMMDD*HHMM*X*EDI Version$^{N}_{L}$
GS	ST	*864*DENTICAL$^{N}_{L}$
GS	BMG	*ZZ*REPORTS FOR provider name$^{N}_{L}$
MIT	MIT	*RPT$^{N}_{L}$
MIT		80 character report lines$^{N}_{L}$
GS	SE	*count of segments from ST thru SE*DENTICAL$^{N}_{L}$
GS	GE	*number of ST/SE sets*DENTICAL$^{N}_{L}$
ENV	IEA	*Number of GS/GE sets*trans control number$^{N}_{L}$

Figure 8-16 Standard X12 Enveloping Structure

9. TRADING PARTNER AGREEMENTS

A Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement (Trading Partner Agreement), a Provider Service Office Electronic Data Interchange Option Selection Form and Electronic Remittance Advice (ERA) Enrollment Form must be submitted and processed before transactions may be sent to or received from Medi-Cal Dental Program. The following are links to these documents:

- Telecommunications Provider and Biller Application/Agreement:
    - https://www.denti-cal.ca.gov/DC_documents/providers/EDI_Application_Agreement.pdf
- Provider Service Office Electronic Data Interchange Option Selection Form
    - https://www.denti-cal.ca.gov/DC_documents/providers/Provider_Service_office_EDI_options_selection_form.pdf
- Electronic Remittance Advice (ERA) Enrollment Form
    - https://www.denti-cal.ca.gov/DC_documents/providers/ERA_enrollment_form.pdf

10. TRANSACTION-SPECIFIC INFORMATION

This section must be used in conjunction with the associated ASC X12 Implementation Guide. The following tables reflect the specific requirements Medi-Cal Dental Program has, over and above, the information contained in the X12 Standard Implementation Guides.

The tables in this section contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

NOTE: *The use of uppercase alpha characters is strongly recommended to ensure data lookup compatibility.*

10.1 005010X224A2 Health Care Claim: Dental (837D)

		BHT06	Claim or Encounter Identifier	CH		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		NM109	Submitter Identifier			Medi-Cal Dental Program expects to receive the Submitter's Medi-Cal Dental Program Remote ID.
		NM103	Receiver Name			Medi-Cal Dental Program expects to receive: DENTICAL
		NM109	Receiver Primary Identifier			Medi-Cal Dental Program expects to receive: 1822287119
						The billing address on file with the Medi-Cal Dental Program Provider Enrollment Unit is used.

		NM108	Identification Code Qualifier	MI		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		NM109	Subscriber Primary Identifier			Medi-Cal Dental Program processing requires the ID be submitted as it appears on the Medi-Cal identification card; always use uppercase alpha characters. Do not submit an SSN, as the transaction will be rejected.
		NM103	Payer Name			Medi-Cal Dental Program expects to receive: DENTICAL
		NM109	Payer Identifier			Medi-Cal Dental Program expects to receive: 94146
						Medi-Cal Dental Program does not use this segment for payer identification.

		REF01	Reference Identification Qualifier	LU		When a single NPI is registered with Medi-Cal Dental Program for more than one Service Office (in which case the NPI is considered non-sub parted), Medi-Cal Dental Program expects to receive the value shown in the codes column.
		CLM01	Patient Control Number		17	Medi-Cal Dental Program processes only the first 17-characters; ensure the first 17-characters of this field represents a unique value.
		CLM05-3	Claim Frequency Code	1 7		Medi-Cal Dental Program expects to receive the values listed in the codes column.
		CLM11-1	Related Causes Code	OA EM AA		Medi-Cal Dental Program expects to receive the values listed in the codes column.
		CLM11-2	Related Causes Code	OA EM AA		Medi-Cal Dental Program expects to receive the values listed in the codes column.
		CLM12	Special Program Indicator			Medi-Cal Dental Program does not use the information sent in this element.

		CLM19	Predetermination of Benefits Code			Medi-Cal Dental Program does not use the information sent in this element.
		CLM20	Delay Reason Code			Medi-Cal Dental Program does not use the information sent in this element.
		DTP02	Date Time Period Format Qualifier	D8		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		DN202	Tooth Status Code	M		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		PWK01	Attachment Report Type	RB OZ		Medi-Cal Dental Program expects to receive the values listed in the codes column.
		PWK02	Attachment Transmission Code	BM FT		Medi-Cal Dental Program expects to receive the values listed in the codes column. Medi-Cal Dental Program accepts digitized images submitted through certified electronic attachment vendors. For a listing of certified vendors, refer to Section 3 of the *Medi-Cal Dental Program Provider Handbook*. When submitting digitized radiographs and attachments through a certified vendor, use Attachment Transmission Code 'FT' and submit the Attachment Control Number in PWK06.
		PWK06	Identification Code			The Attachment Control Number for digitized radiographs and

						attachments MUST be submitted in the following format: Change Healthcare Users: CHC#99999999' DentalXChange Users: 'EHG#99999999' NEA Users: 'NEA#99999999' Tesia/Renaissance Users: 'DTX#99999999'
		REF02	Payer Claim Control Number			Submit the original Medi-Cal Dental Program DCN associated with the transaction to be reprocessed.
		REF02	Prior Authorization Number			Submit the original Medi-Cal Dental Program DCN associated with the approved TAR.
						Medi-Cal Dental Program does not use the information sent in this segment for adjudication.

		SV304	Oral Cavity Designation Code			Medi-Cal Dental Program processes only one oral cavity code per service.
						Medi-Cal Dental Program does not use the information sent in this segment.

						Medi-Cal Dental Program strongly encourages submission of rendering provider information in Loop 2420A. If rendering provider data is not present in Loop 2420A, data sent in Loop 2310B is applied to all dated service lines. By failing to submit rendering provider information in either Loop 2420A or 2310B, the provider is certifying the billing provider is the rendering provider; therefore, the transaction is processed accordingly.

						Medi-Cal Dental Program processes Service Facility Location information submitted in Loop 2310C only. Service Facility Location information sent in this Loop is not used.

10.2 005010X212 Health Care Claim Status Request (276)

		NM103	Payer Name			Medi-Cal Dental Program expects to receive: DENTICAL
		NM108	Identification Code Qualifier	PI		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		NM109	Payer Identifier			Medi-Cal Dental Program expects to receive: 94146
		NM109	Information Receiver Identification Number			Medi-Cal Dental Program expects to receive the Submitter's Medi-Cal Dental Program Remote ID.
		NM108	Identification Code Qualifier	XX		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		NM108	Identification Code Qualifier	MI		Medi-Cal Dental Program expects to receive the value listed in the codes column.
		NM109	Subscriber Identifier			Medi-Cal Dental Program processing requires the ID be submitted as it appears on the Medi-Cal identification card. Always use uppercase alpha characters. Do not submit an SSN as transaction will be rejected.
		REF02	Patient Control Number		17	

		DTP02	Date Time Period Format Qualifier			Submit ‘D8’ when inquiring on claims or NOAs that include a single date of service. Submit ‘RD8’ when inquiring on claims or NOAs that include multiple dates of service.
						Medi-Cal Dental Program recipients are identified by a unique identification number; therefore, all patients/recipients are considered the subscriber and must be identified in the Subscriber Loop (2000D).

10.3 005010X212 Health Care Claim Status Response (277) Transaction

Medi-Cal Dental claims are processed as a whole document; as a result, the response transmitted in the 277 transaction represents the status of the entire claim – with no claim line status being reported. When a 276 inquiry request is processed and a document match is found, the 277 response will include the DCN, a status category code and a status code. If the claim was processed, it will include a payment date, Medi-Cal Dental check number and payment amount.

		NM108	Identification Code Qualifier	PI		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		NM109	Payer Identifier			Medi-Cal Dental Program populates this data element with the value: DENTICAL
		NM109	Information Receiver Identification Number			Medi-Cal Dental Program populates this data element with the Receiver's Medi-Cal Dental Program Remote ID.
		NM108	Identification Code Qualifier	XX		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		NM108	Identification Code Qualifier	MI		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.

		STC01-1	Health Care Claim Status Category Code	D0 P1 F1 F2 E0		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		STC01-2	Status Code	0 1		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		DTP03	Claim Service Period			Medi-Cal Dental Program populates this data element with the first and last date of service for each document that matches the submitted trace criteria.
						Medi-Cal Dental Program recipients are identified by a unique identification number; therefore, all patients/recipients are considered the subscriber and are reported in the Subscriber Loop (2000D).

10.4 005010X221A1 Health Care Claim Payment/Advice (835)

		BPR01	Transaction Handling Code	I		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		BPR03	Credit or Debit Flag Code	C		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		BPR04	Payment Method Code	CHK		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		TRN03				Medi-Cal Dental Program populates this data element with the value: 1822287119
79		CUR	Foreign Currency Information			This segment is not sent. All Medi-Cal Dental Program payments are made in U.S. dollars.
		REF02	Receiver Identification			Medi-Cal Dental Program populates this data element with the Medi-Cal Dental Program assigned clearinghouse registration number.
		N102	Payer Name			Medi-Cal Dental Program populates this data element with the value: DENTICAL

		N301	Payer Address Line			Medi-Cal Dental Program populates this data element with: P.O. BOX 15609
		N401	Payer City Name			Medi-Cal Dental Program populates this data element with: SACRAMENTO
		N402	Payer State Code			Medi-Cal Dental Program populates this data element with: CA
		N403	Payer Postal Zone or ZIP Code			Medi-Cal Dental Program populates this data element with: 958520609
		PER01	Contact Function Code	BL		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		PER02	Payer Technical Contact Name			Medi-Cal Dental Program populates this data element with: DENTI-CAL EDI SUPPORT GROUP
		PER03	Communication Number Qualifier	EM		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		PER04	Payer Contact Communication Number			Medi-Cal Dental Program populates this data element with: DENTI-CALEDI@DELTA.ORG
		PER05	Communication Number Qualifier	TE		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.

		PER06	Payer Technical Contact Communication Number			Medi-Cal Dental Program populates this data element with: 9168537373
		N103	Identification Code Qualifier	FI XX		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CLP01	Patient Control Number		17	
		CLP02	Claim Status Code	1 22		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CLP06	Claim Filing Indicator	MC		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		CLP09	Claim Frequency Code	1 7		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		NM108	Identification Code Qualifier	MR		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
						If multiple rendering providers are associated with a document, Medi-Cal Dental Program will send information associated with the first

		NM108	Identification Code Qualifier	MC XX		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
186	2110	SVC	Service Payment Information			
		SVC01-1	Product/Service ID Qualifier	AD		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		SVC06-1	Product/Service ID Qualifier	AD		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		DTM01	Date Time Qualifier	472		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.
		CAS01	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CAS05	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CAS08	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CAS11	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.

		CAS14	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		CAS17	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		REF01	Reference Identification Qualifier	1D HPI		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		PLB02	Fiscal Period Date			Medi-Cal Dental Program populates this element with December 31 of the current year, (e.g., 20121231).
		PLB05-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		PLB07-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		PLB09-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.
		PLB11-1	Adjustment Reason Code	51 CS		Medi-Cal Dental Program populates this data element

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
				IS L3 LE WO		with the code values shown in the codes column.
		PLB13-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental Program populates this data element with the code values shown in the codes column.

11. APPENDIX

11.1 Implementation Checklist

Medi-Cal Dental Program recommends entities use the following information as a guide to becoming a Medi-Cal Dental Program submitter and preparing to:

- Read and review this Guide.
- Obtain ASC X12 Implementation Guide(s) for the transaction(s) to be traded with Medi-Cal Dental Program.
- Contact Medi-Cal Dental Program EDI Support with any questions or concerns regarding Medi-Cal Dental Program requirements.
- Register as an EDI Trading Partner.
- Complete transaction testing and certification.
- Begin submitting EDI transactions to Medi-Cal Dental Program.

11.2 Business Scenarios

Medi-Cal Dental Program has no business scenarios to document at this time.

11.3 Frequently Asked Questions

Helpful processing tips related to EDI submission can be found in the EDI How-To Guide available on the Medi-Cal Dental Program website:

https://www.denti-cal.ca.gov/DC_documents/providers/Denti-Cal_EDI_How_To_Guide.pdf

11.4 EDI User Guide

The EDI User Guide will be available per request to the Trading Partners.

- EDI Service User Guide – SFTP
- EDI Service User Guide – Web Portal

11.5 Version History

Version Number	Date	Reason for Revision	Notes/Comments
1.0	December 28, 2012	Initial release.	Companion Guide was reformatted to comply with Operating Rules.
1.1	May 17, 2013	Updates made to comply with ASC X12 Intellectual Property policies.	
1.2	September 6, 2013	Update CP-O-959-P Report with new rejection code N.	

Version Number	Date	Reason for Revision	Notes/Comments
1.3	March 26, 2014	Eliminate Dial-up Asynchronous Communications.	
1.4	April 22, 2014	Update to include Electronic Remittance Advice (ERA) Enrollment Form information.	
1.5	August 6, 2014	Updated 837D Transaction to clarify Denti-Cal use of TOO Segment.	
1.6	February 13, 2015	Update CP-O-959-P Report with revised rejection code K and new rejection code P. Delete rejection code O.	
1.7	April 8, 2015	Include information that providers may discontinue receipt of paper EOBs.	
1.8	June 4, 2015	Update Data Format Testing section, which includes certain doc types for testing.	
1.9	March 24, 2016	Minor revisions to pages 26, 31, 33.	
1.10	March 9, 2017	Update to 835 transaction code, page 59.	
1.11	November 2017	Updates to incorporate new EDI compliance processing, 999 transaction and HTML Error Report.	
1.12	February 2018	Minor revisions to: • Provide updated links to referenced documents, • Inform trading partners of Medi-Cal Dental Program's requirement for a CRLF at the end of each segment, and • Provide the new Medi-Cal Dental Program Receiver Primary Identifier for use in 837D and 835 transactions.	
1.13	November 2018	Retrofit changes due to MCD 1612 Page 45 Update to PWK06 Identification Code for DentalXChange users.	
1.14	April 2019	Retrofit changes due to MCD 18075 Page 45 update to PWK06 Identification Code for Change Healthcare users.	
2.0	March 2020	Cyclical Updates	Includes terminology changes required under DOIL 19-003