California Department of Health Care Services

837 Professional Encounter Data Transaction

Health Care Claim/Encounter (837P)

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 2.7
September 2019

Document History (Version Control)

Version	Date	Author	Brief Description of Modifications
1.0	12/28/2012	Greg Dawson	Created
1.1	03/21/2013	Greg Dawson	Initial EDIP updates
1.2	04/05/2013	Greg Dawson	Further EDIP modifications
1.3	04/24/2013	Greg Dawson	Respond to submitted FAQ's
1.4	09/17/2013	Greg Dawson	Update ISA, file name, duplicates and void/replace descriptions
1.5	11/27/2014	Greg Dawson	Added ICD-10 and transaction limits. Removed DME as an element in duplication logic. Update Void and Replacement logic
1.6	01/17/2014	Greg Dawson	Updated void and replacement logic description and duplicate validation description. Remove Patient Status from 2300 NTE
1.7	02/28/2014	Greg Dawson	Update duplicate logic, and update accept/reject description
1.8	03/19/2014	Greg Dawson	Clarify usage of 2010BB and Provider Specialty
1.9	04/21/2014	Greg Dawson	Correct reference to LIN segment and use of organizational NPI's
2.0	07/02/2014	Greg Dawson	Include MSSP guidance, update file naming convention description
2.01	07/17/2014	Greg Dawson	Modify references to the XML Response file to Encounter Validation Response (EVR) file
2.1	09/18/2014	Greg Dawson	Update 2010CA, 2300 NTE, taxonomy usage

Version	Date	Author	Brief Description of Modifications
2.2	07/01/2015	Greg Dawson	Include 340B information, update NPI definition
2.3	04/05/2016	Greg Dawson	Update references to CN1 and paid amount balancing. Clarify use of 2010CA Patient Loop
2.31	07/06/2016	Greg Dawson	Update references for section 3.14
2.32	10/17/2017	Jeff Jennings	Updated Section 3.7 Response File Naming Convention
2.4	02/12/2018	Jeff Jennings	Added Sec. 3.24 EPSDT reporting guidance
2.5	04/13/2018	Bilochan Sainju	Added clarification that Denied Void and Denied Replacement Encounters cannot be acted on
2.51	05/22/2018	Wendy Ng	Updated as per EDQU suggestions • Updated formatting in section 3.22 • Clarified verbiage in section 3.22 regarding representative scenarios • Clarified verbiage in the Note column in Appendix B.4 • Clarified verbiage on the reason scenario in Appendix B.4 for Encounter ID 0091234 cannot be corrected
2.52	12/11/2018	Sravan Bojja	Updated as per EDQU suggestions Under section 3.8, Added logic regarding newborn reporting
2.6	7/22/2019	Jeff Jennings	Updated Section 3.6 to clarify rules on First Node of submitted File Name.
2.7	9/27/2019	Jeff Jennings	Added NDC requirement for PADs to Section 3.23

This template is Copyright © 2010 by The Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA), on behalf of the Accredited Standards Committee (ASC) X12. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided “as is” without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12.

2013 & 2018 © Companion Guide copyright by California Department of Health Care Services

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

1 TI Introduction 8

1.1 Overview of HIPAA Legislation 8
1.2 Compliance according to ASC X12 9
1.3 Intended Use 9

2 Included ASC X12 Implementation Guides 9

3 Instruction Tables 10

3.1 Transaction Submission 10
3.2 Available Transaction Responses 11
3.3 Transaction Components 11
3.4 File Contents 11
3.5 File and Transaction Acceptance/Rejection 12
3.6 Submitted Encounter File Naming Conventions 12
3.7 Response File Naming Conventions 14
3.8 Duplicate Encounters 15
3.9 MSSP Encounter Guidance 16
3.10 ISA/IEA 17
3.11 GS/GE 19
3.12 ST/SE 20
3.13 Member Identifiers 20
3.14 Provider Identifiers 20
3.15 Provider Specialty 22
3.16 National Coding Standards 23
3.17 ICD-10 Diagnosis Codes 23
3.18 Payment Information 23
3.19 Paid Amount Balancing 23
3.20 Medi-Cal Specific Information 24
3.21 Encounter Identification 24
3.22 Correcting a Submitted Encounter 24
3.23 Physician Administered Drugs – 340B 26
3.24 Early & Periodic Screening, Diagnosis and Treatment (EPSDT) 26
3.25 Header 28
3.26 Billing Provider Detail 28
3.27 Subscriber Detail 29
3.28 Payer Name 29
3.29 Patient Detail 30
3.30 Claim Level Detail 30
3.31 Service Line Detail 34

4 TI Additional Information 36

Appendix A – Medi-Cal Data Definitions 37

A.1 HIC Number..37
A.2 MEDS ID 37
A.3 Service Facility Location County 38

Appendix B – Void and Replacement Scenarios 39

B.1 Void of an Accepted Encounter...39
B.2 Void of a Denied Encounter 40
B.3 Replacement of an Encounter 41
B.4 Encounters that can NOT be corrected...43

Transaction Instruction (TI)

1 TI Introduction

1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This 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
- Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).

- Change the meaning or intent of the standard's implementation specification(s).

1.2 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.3 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222A1	Health Care Claim: Professional (837)

3 Instruction Tables

These tables 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.

Only those elements that require specific explanation are included in these tables. The underlying TR3 document for this transaction is available at http://store.x12.org.

3.1 Transaction Submission

Encounter data files should be uploaded to a plan’s designated Secure File Transfer Protocol (SFTP) “submission” folder administered by DHCS Information Technology Services Division (ITSD). File submission will proceed automatically. A DHCS process will tag the file with a date and time stamp and then forward the submitted file to a secure internal server for file validation. When processed by DHCS the submitted file will be deleted from the submission folder.

DHCS requires that encounters be submitted in files dedicated to a specific Healthcare Plan Code (HCP). The specific HCP will be included in the submitted file name and the file ISA segment as described in succeeding sections. Encounters for beneficiaries not enrolled in this HCP but included on the submitted file will be denied.

The lag-time between a file being uploaded to the submission folder and initiation of file processing will be a maximum of five minutes. The date and time stamp will constitute the “Submission Date and Time” of the file.

A submitted encounter file will be either accepted or rejected.

3.2 Available Transaction Responses

Any responses to submitted encounter files will be posted to a plan’s designated SFTP “response” folder.

No TA1 response is available at this time.

Plans may choose to receive any of the following response files for each submitted encounter data file. At least one response type must be selected. Multiple types of files can also be selected:

- 999 –X12 standard transaction.
- 277 –X12 standard transaction.
- Encounter Validation Response (EVR) file – custom XML error report detailing each error including file position of each record found to be in error, error value and error message.

For the purposes of error resolution, DHCS would encourage plans to receive at least the EVR file at a minimum.

3.3 Transaction Components

Data element separator will be “*”

Segment terminator will be “~”

3.4 File Contents

A submitted encounter data file should only contain encounters for a single Health Plan Code (HCP).

Files should be comprised of only 837P (Professional) transactions. Up to 50 ST-SEs are allowed, each ST-SE can have up to 5,000 instances of the 2300 loop.

3.5 File and Transaction Acceptance/Rejection

A submitted file may be entirely rejected based on file name issues or invalid ISA and GS values. If a file is rejected due to these conditions the response will be an EVR file only as required information for a 999 is unlikely to be available.

A submitted file can contain multiple logical transactions defined by an ST-SE grouping. Each ST-SE is evaluated separately for adherence to the transaction standard and is either accepted or rejected. The responses to this situation are a 999, a 277 and the EVR file. For example, if a submitted file is comprised of three ST-SEs and one of the ST-SEs is rejected:

- A single 999 will be returned which will indicate partial acceptance and each of the three ST-SEs will be described.
- A single 277 will be returned that will only reflect the two ST-SEs that were accepted.
- A single EVR file that will describe errors for all three ST-SEs.

3.6 Submitted Encounter File Naming Conventions

Submitted encounter files must use the following naming convention:

XXXXX—X_HHH_837P_MCE_YYYYMMDD_NNNNN.dat

Where:

XXXXX-X is the first node of the file name and is the name of the health plan as specified by the plan and approved by DHCS.

HHH is the HCP code for the encounters being submitted.

837P_MCE is a constant designating the file as an 837 professional managed care encounter.

YYYYMMDD is the date of the submission.

NNNNN is a unique numeric transaction identifier used to differentiate between encounter data files submitted on the same day by the same health plan. This node is limited to 5 numeric characters.

Each node in the file name must be separated from the next node by an underscore, as shown in the example.

The First Node value must contain no underscores or other special characters. Using a dash in the First Node is allowed. Plans may elect to use multiple different values for the First Node depending upon their business needs. Each value must be approved by DHCS and used consistently within the terms of that approval.

Valid examples:

MYHEALTHPLAN_678_837P_MCE_20120930_00001.dat

MY HEALTH PLAN_678_837P_MCE_20120930_00001.dat

MYHP-LTC_678_837P_MCE_20120930_00001.dat

MYHP-VENDOR1_678_837P_MCE_20120930_00001.dat

A file submitted with a duplicate file name will be rejected.

3.7 Response File Naming Conventions

Response files will mirror the submitted file name with an added designation, as follows:

XXXXX—X_HHH_837P_MCE_YYYYMMDD_NNNNN_RESP_FFF(NNN).EEE

Where:

RESP is a constant designating the file as a response file

FFF is either “999”, “277” or “RPT” designating what format of response file has been created. “RPT” indicates the response is an EVR file formatted as .xml

NNN is numeric value used when the response is an EVR file. The default number is 000. The first instance of an EVR file is numbered as “000”. This number is incremented when EVR generation is interrupted and restarted. If the EVR process is restarted for that file, the number increments by a single digit, to “001”, etc.

EEE is the file extension. The file extension will be either “dat” for 999 or 277 files, or “xml” for the EVR file.

Examples:

MYHEALTHPLAN_678_837P_MCE_20120930_00001_RESP_999.dat

MYHEALTHPLAN_678_837P_MCE_20120930_00001_RESP_RPT000.xml

The DHCS system will track the date and time that a response file was made available, this will be noted as the “Processed Date and Time” and will be used to track the time taken by a submitter to correct specific errors.

3.8 Duplicate Encounters

Encounters will be evaluated for duplicates at the service line level. If a service line is found to be a duplicate of a previously submitted service line, the entire encounter will be denied.

For the purposes of an 837 Professional service line, a duplicate would have the same following values as a previously submitted service line:

- Client Identification Number (CIN) – 2010BA NM109
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Rendering Provider – can be sourced from a variety of places – see section 3.14. The valued stored for purposes of duplicate validation will be the value derived for rendering provider at the service line level. This derived value may have been submitted at a higher level where no other identifier was submitted at either the claim or service line. This derived value may also be either a Medi-Cal Provider ID or State License number depending upon the presence of an NPI. If no NPI is submitted because the provider is atypical, a submitted secondary identifier will be used. The order of priority for secondary identifiers is Medi-Cal Provider ID first and State License Number second.
- Procedure Code – 2400 SV101-2
- Procedure Modifier(s) – 2400 SV101-3,4,5,6
- Drug Code – 2410 LIN03 - Drug code is used when it is present.

Conditional usage of Drug Code - When a submitted encounter is compared to previously submitted encounters and all other key fields match but one of the encounters has a drug code and the other does not – this situation is still identified as a duplicate. If all other key fields match and the drug codes are different, the situation is not a duplicate.

In order to appropriately represent encounters for the same service that can be performed multiple times in a day, usage of modifiers: 59, 76 and 77 will over-ride the duplicate validation logic, however, the use of these modifiers will be strictly monitored.

Services for babies with no CIN should be reported under the mother's CIN. To report the same service that was performed for the mother and the baby or babies, modifiers: 59, 76 and 77 will over-ride the duplicate validation logic, however, modifiers require procedure codes to use them.

3.9 MSSP Encounter Guidance

Multipurpose Senior Services Program (MSSP) Encounters must be submitted using the 837 Institutional transaction, NOT the 837 Professional. Please refer to the 837 Institutional Encounter guide for details.

3.10 ISA/IEA

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	
	ISA02	Authorization Information		10 blanks
	ISA03	Security Information Qualifier	00	
	ISA04	Security Information		10 blanks
	ISA05	Interchange ID Qualifier	ZZ	
	ISA06	Interchange Sender ID		Sender's Federal Tax ID (9 digits - no hyphens) + HCP (3 digits) + 3 spaces
	ISA07	Interchange ID Qualifier	ZZ	This ID qualifies the Receiver in ISA08
	ISA08	Interchange Receiver ID	CALIFORNIA-DHCS	
	ISA11	Repetition Separator	^	
	ISA13	Interchange Control Number		The Interchange Control Number, ISA13 - must be a positive unsigned number identical to the associated Interchange Trailer IEA02
	ISA14	Acknowledgement Requested	0	No TA1 response is available at this time
	ISA16	Component Element Separator	:	

Loop ID	Reference	Name	Codes	Notes/Comments
IEA		Interchange Control Trailer		
	IEA02	Interchange Control Number		Must match the value in ISA13

3.11 GS/GE

Loop ID	Reference	Name	Codes	Notes/Comments
GS		Functional Group Header		
	GS01	Functional Identifier Code	HC	
	GS02	Application Sender's Code		Sender’s Federal Tax ID - "
	GS03	Application Receiver's Code	CALIFORNIA-DHCS	
	GS06	Group Control Number		This must match the value in GE02
	GS08	Version / Release / Industry Identifier Code	005010X222A1	
GS		Functional Group Header		
	GE02	Group Control Number		This must match the value in GS06

3.12 ST/SE

Loop ID	Reference	Name	Codes	Notes/Comments
ST		Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	
	ST02	Transaction Set Control Number		This value must match the value in SE02
	ST03	Implementation Convention Reference	005010X222A1	
SE		Transaction Set Trailer		
	SE01	Number of Included Segments		Transaction Segment Count
	SE02	Transaction Set Control Number		This value must match the value in ST02

3.13 Member Identifiers

Each member must be identified in the Subscriber loop (2010BA), the Patient loop (2010CA) must not be sent. The Medi-Cal Client Identification Number (CIN) must be used in 2010BA NM1*IL NM109, with NM108 = “MI”.

3.14 Provider Identifiers

Medi-Cal Managed Care requires the submission of the National Provider Identifier (NPI) on all submitted encounters, with the sole exception being for atypical providers.

On the 837P, there are six main values where a provider identifier may be supplied:

	Billing Provider Level	
Billing Provider	**2010AA – NM1*85** Required	
	Claim Level	**Service Level**
Rendering	**2310B – NM1*82** Required if different than the Billing Provider	**2420A – NM1*82** Required if different than that at the claim level, or required when the rendering provider is blank at the claim level, but the rendering provider on the service level is different than the billing provider.
Supervising	**2310D – NM1*DQ** Required when the Rendering Provider is supervised by a physician.	**2420D – NM1*DQ** Required when the Rendering Provider is supervised by a physician, and the value on the service line is different than at the claim level.
Service Facility	**2310C – NM1*77** Required if different than the Billing Provider	**2420C – NM1*77** Required if different than the value entered at the claim level or the billing provider.

Referring	**2310A – NM1*DN or NM1*P3** Required if the claim involves a referral.	**2420F – NM1* DN or NM1*P3** Required if the service line involves a referral and the referring provider is different than at the claim level.
Ordering	N/A	**2420E – NM1*DK** Required if the service or supply was ordered by a provider who is different than the rendering provider for the service line.

Only the Billing Provider NPI and the Service Facility location can be an organizational NPI, the rest must be individual NPIs.

In addition to the NPI, encounter data submitters are requested to provide both the State License Number (REF*0B) and the Medi-Cal Provider Number (REF*G2) as applicable. Multiple instances of the Secondary Provider Information segment are permissible.

Atypical providers should be identified by leaving NM108 and NM109 unpopulated and entering whatever identification numbers are appropriate in the secondary identifier segment. Do NOT use social security number as an identifier.

3.15 Provider Specialty

Submitters are encouraged to provide provider specialty (taxonomy) information for each applicable provider identifier.

3.16 National Coding Standards

Submitters must adhere to national coding standards for procedure, modifier and diagnostic codes. Local codes will not be accepted.

3.17 ICD-10 Diagnosis Codes

Submitters must adhere to the ICD-10 compliance date, any encounters submitted for a date of service on or after October 1st 2015 must use ICD-10 diagnosis codes otherwise the encounter will be denied.

3.18 Payment Information

Submitters are required to provide actual payment information using the established structure in the 837P.

The type of arrangement used to pay the encounter must be described in the CN1 segment in the 2300 loop – CN101 Contract Type Code. When the encounter has been paid on a fee-for-service basis, CN102 should be populated with the amount paid. DHCS requires that 2300 CN1 be provided, and requests the 2400 CN1 segment to be included.

Any payments made to other health insurance carriers must be included in the relevant coordination of benefits segments.

3.19 Paid Amount Balancing

Balancing of paid amounts reported in CN102, AMT*D and SVD02 will occur whenever 2300 CN101 equals 02, 03, 04, or 06. In this situation, CN102 must equal AMT*D for a prior payer with SBR09 = “MC”. Additionally, AMT*D must equal the sum of all applicable SVD02 amounts for the same payer.

When CN101 equals “01” (DRG) a corresponding DRG code must also be present.

3.20 Medi-Cal Specific Information

There are a number of Medi-Cal specific data elements that have been historically provided on proprietary encounter data submissions. These data elements do not have corresponding positions on the 837P layout. Since Medi-Cal still needs these data elements in order to accurately process submitted encounters, they have been positioned in the NTE segment.

3.21 Encounter Identification

In accordance with X12 837 Professional data specification rules, unless the encounter is a void or replacement, CLM01 must be unique, a submitted encounter that has the same value in CLM01 as a previously submitted encounter will be denied. To aid in encounter identification, plans must use the HCP number of the plan that the beneficiary was enrolled in at the time of the encounter as the first three characters of CLM01.

During DHCS processing, each encounter will be assigned a unique identification number. This number will be provided back to the submitter in both the 277 and the EVR file. When attempting to correct a previously submitted encounter, plans must use this Encounter-ID as defined below.

3.22 Correcting a Submitted Encounter

Submitted encounters will be either accepted or denied by DHCS. When DHCS denies a submitted encounter the reasons for the denial will be reported on the available EVR file.

Submitted encounters can be subsequently corrected by either a void or a replacement action.

When a submitter needs to correct an encounter, the following data must be provided:

- The submitter of the correcting encounter must be the same as the submitter of the encounter being corrected.
- CLM01 must equal the value of CLM01 on the encounter being replaced or voided.
- The Encounter-ID (from either 277 or EVR) of the encounter to be corrected must be placed in the Payer Claim Control Number REF segment in the 2300 loop (REF*F8).
- A value of either “7” (replacement) or “8” (void) must be placed in the Claim Frequency Code in CLM05-03.

Representative scenarios for both void and replacement are included in Appendix B.

There are a number of situations which cannot be corrected through this process.

- Denied Void and Denied Replacement encounters cannot be acted on.
- If an encounter is voided, and then a subsequent replacement or void request is received this subsequent encounter will be denied. This denied encounter record is not correctable and will remain in a denied status, however, the “encounter” has been correctly voided.
- If the original submission of an encounter is not referenced as an original (CLM05-3 = “1”) – it will be denied. This specific denied encounter record is not correctable. The originally submitted encounter remains in a voided status.

Representative scenarios for non-correctable situations are also included in Appendix B.

Use of the term “denied” in this narrative does NOT refer to a claim or an encounter that was denied by a plan prior to submission to DHCS as an

encounter. DHCS requests that previously denied claims NOT be submitted as encounters.

3.23 Physician Administered Drugs – 340B

Service lines that have a 340B physician administered drug should include the "UD" modifier in one of the four available modifier positions (2400 SV101-3, 4, 5 or 6).

Please note: service lines that have a 340B physician administered drug must include the NDC for that drug in 2410 LIN03.

3.24 Early & Periodic Screening, Diagnosis and Treatment (EPSDT)

When submitting encounters for EPSDT services, follow the instructions in the Implementation Guide for the 837P:

- In the 2300 loop (claim level), use the CRC segment ("Conditions Indicator") to indicate whether an EPSDT referral was given for diagnostic or corrective treatment.
- The CRC segment should indicate the referral only, not the actual diagnostic or corrective treatment. The CRC referenced diagnostic or corrective treatment should be included on a separate encounter submission.
- In the 2400 loop (service level), use a "Y" in field SV111 ("Yes/No Condition Response Code") if there was EPSDT involvement in that service.

Encounters for EPSDT Diagnostic or corrective treatments will be submitted differently:

- Identify EPSDT diagnostic or corrective treatments by utilizing the **EP** modifier with the appropriate CPT code(s) for services rendered.

3.25 Header

Loop ID	Reference	Name	Codes	Notes/Comments
1000B	NM1	Receiver Name		
	NM101	Entity Identifier Code	40	
	NM103	Receiver Name	CALIFORNIA-DHCS	
	NM109	Identification Code	610442	

3.26 Billing Provider Detail

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	PRV	Billing Provider Specialty		Requested
	PRV01	Provider Code	BI	
2010AA	NM1	Billing Provider Name		Required
	NM101	Entity Identifier Code	85	
	NM109	Billing Provider Identifier		Use the NPI of the entity who submitted the claim or encounter to the reporting managed care plan–this will be validated against the NPPES file. Atypical billing providers should leave NM108 and NM109 blank and enter a secondary identifier
	REF	Billing UPIN/License Information		
	REF01	Reference Identification Qualifier	0B, 1G	Use “0B” for State License, “1G” for Provider UPIN

3.27 Subscriber Detail

Medi-Cal views each beneficiary as an individual subscriber.

Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM1	Subscriber Name		Required
	NM108	Identifier Code Qualifier	MI	
	NM109	Subscriber Primary Identifier		Medi-Cal CIN – this will be validated against the DHCS MEDS file to ensure that the beneficiary was eligible for Medi-Cal on the date of service of the encounter. Required format: "NNNNNNNNA" Eight numbers and a letter as the final character

3.28 Payer Name

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	NM1	Payer Name		
	NM101	Entity Identifier Code	PR	
	NM103	Payer Name	CALIFORNIA-DHCS	
	NM108	Identifier Code Qualifier	PI	
	NM109	Identification Code	610442	

3.29 Patient Detail

Submissions that include a Patient loop (2010CA) will cause discrepancies in the total number of encounters recorded per transaction and no Encounter ID will be returned for Encounters submitted within a 2010CA loop.

Loop ID	Reference	Name	Codes	Notes/Comments
2010CA		Patient Name		Since Medi-Cal views each patient as the subscriber, information in the Patient loop will not be accessed. Plans are required to not send this loop

3.30 Claim Level Detail

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM	Claim Information		
	CLM01	Claim Control Number		Must be a unique number when Claim Frequency Code = ‘1’. The first three characters must be the HCP number of the plan the beneficiary was enrolled in at the time of the encounter
	CLM05-3	Claim Frequency Code		Use “1” for an original encounter submission; Use “7” for a replacement submission; Use “8” for a void submission
	CN1	Contract Information		Required - Supply information as to how the encounter was paid for

Loop ID	Reference	Name	Codes	Notes/Comments
	CN102	Contract Amount (for capitated encounters), or Paid Amount		This is the amount paid by the plan as a part of their contract with Medi-Cal. This amount would equal the AMT*D amount for a payer designated with an SBR09 value of “MC”. Required when CN101 = 01, 02, 03, 04, and 06. Enter the amount paid for this encounter. This value may be zero
	CN104	Reference Identification		Enter the HCP Number of the plan this beneficiary is enrolled in
	REF	Payer Claim Control Number		Used only if 2300 CLM CLM05-3 indicates that this encounter is a replacement or a void of a previous encounter
	REF01	Reference Identification Qualifier	F8	
	REF02	Payer Claim Control Number		The Encounter-ID of the encounter that is being replaced or voided
	NTE	Claim Note		Required
	NTE01	Note Reference Code	ADD	
	NTE02	Description		Enter the following Medi-Cal specific data separated by a semi-colon” HIC Number; MEDS-ID; Service Facility Location County; Required See Appendix A for definitions

Loop ID	Reference	Name	Codes	Notes/Comments
2310A	NM1	Referring Provider Name		Required if the encounter involves a referral. This loop can be provided twice
	NM101	Entity Identifier Code	DN,P3	Referring Provider
	NM109	Referring Provider Identifier		NPI – this will be validated against the NPPES file.
	REF	Referring Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number
2310B	NM1	Rendering Provider Name		Required if the rendering provider is different than the billing provider
	NM101	Entity Identifier Code	82	Rendering Provider
	NM109	Rendering Provider Identifier		NPI – this will be validated against the NPPES file
	PRV	Rendering Provider Specialty Information		Requested
	REF	Rendering Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number, use “LU” for location number
2310C	NM1	Service Facility Name		Required when the location is different than the billing provider

Loop ID	Reference	Name	Codes	Notes/Comments
	NM101	Entity Identifier Code	77	Service Location
	NM109	Service Facility Primary Identifier		NPI – this will be validated against the NPPES file
	REF	Service Facility Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, G2, LU	Use “0B” for State License Number, use “G2” for the Medi-Cal Provider Number, use “LU” for location number
2310D	NM1	Supervising Provider Name		Required when the rendering provider is supervised by a physician
	NM101	Entity Identifier Code	DQ	Supervising Physician
	NM109	Supervising Provider Identifier		NPI – this will be validated against the NPPES file
	REF	Supervising Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number, use “LU” for location number

3.31 Service Line Detail

Loop ID	Reference	Name	Codes	Notes/Comments
2400	CN1	Contract Information		Supply information as to how the encounter was paid for
2400	REF	Line Item Control Number		
	REF02	Line Item Control Number		Must be a unique number
2410	REF	Prescription or Compound Drug Association Number		Required when a prescription number is available
2420A	NM1	Rendering Provider Name		Required if the rendering provider is different than that at the claim level, or required when the rendering provider is blank at the claim level, but the rendering provider on the service level is different than the billing provider
	NM101	Entity Identifier Code	82	Rendering Provider
	NM109	Rendering Provider Identifier		NPI – this will be validated against the NPPES file
	PRV	Rendering Provider Specialty Information		Requested
	REF	Rendering Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number, use “LU” for location number

Loop ID	Reference	Name	Codes	Notes/Comments
2420C	NM1	Service Facility Name		Required when the location is different than at the Claim level or the billing provider
	NM101	Entity Identifier Code	77	Service Location
	NM109	Service Facility Primary Identifier		NPI – this will be validated against the NPPES file
	REF	Service Facility Secondary Identification		Multiple instance of this segment are allowed
	REF01	Reference Identification Qualifier	G2, LU	Use “G2” for the Medi-Cal Provider Number, use “LU” for location number
2420D	NM1	Supervising Provider Name		Required when the rendering provider is supervised by a physician, and the value on the service line is different than at the claim level
	NM101	Entity Identifier Code	DQ	Supervising Physician
	NM109	Supervising Provider Identifier		NPI – this will be validated against the NPPES file
	REF	Supervising Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number, use “LU” for location number
2420E	NM1	Ordering Provider Name		Required when the service was ordered by a provider who is different than the rendering provider for this service line
	NM101	Entity Identifier Code	DK	Ordering Physician

Loop ID	Reference	Name	Codes	Notes/Comments
	NM109	Ordering Provider Identifier		NPI – this will be validated against the NPPES file
	REF	Ordering Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number
2420F	NM1	Referring Provider Name		Required if the service involves a referral, and the referring provider is different than that at the claim level. Loop can be provided twice
	NM101	Entity Identifier Code	DN,P3	Referring Provider, Primary Care Provider
	NM109	Referring Provider Identifier		NPI – this will be validated against the NPPES file
	REF	Referring Provider Secondary Identification		Multiple instances of this segment are expected
	REF01	Reference Identification Qualifier	0B, 1G, G2	Use “0B” for State License Number, “1G” for Provider UPIN, use “G2” for the Medi-Cal Provider Number

4 TI Additional Information

None at this time.

Appendix A – Medi-Cal Data Definitions

A.1 HIC Number

Beneficiary HIC (Health Insurance Claim) number identifies Medi-Cal recipient's Medicare coverage identification number.

The HIC number is a twelve byte alphanumeric field.

A.2 MEDS ID

A supplemental beneficiary identification number sometimes used as a key within MEDS.

The MEDS ID is a nine byte alphanumeric field.

A.3 Service Facility Location County

This field identifies the California county within which the service facility is located.

This is a two-byte numeric, and is defined by the following table:

CODE	COUNTY	CODE	COUNTY
01	Alameda	31	Placer
02	Alpine	32	Plumas
03	Amador	33	Riverside
04	Butte	34	Sacramento
05	Calaveras	35	San Benito
06	Colusa	36	San Bernardino
07	Contra Costa	37	San Diego
08	Del Norte	38	San Francisco
09	El Dorado	39	San Joaquin
10	Fresno	40	San Luis Obispo
11	Glenn	41	San Mateo
12	Humboldt	42	Santa Barbara
13	Imperial	43	Santa Clara
14	Inyo	44	Santa Cruz
15	Kern	45	Shasta
16	Kings	46	Sierra
17	Lake	47	Siskiyou
18	Lassen	48	Solano
19	Los Angeles	49	Sonoma
20	Madera	50	Stanislaus
21	Marin	51	Sutter
22	Mariposa	52	Tehama
23	Mendocino	53	Trinity
24	Merced	54	Tulare
25	Modoc	55	Tuolumne
26	Mono	56	Ventura
27	Monterey	57	Yolo
28	Napa	58	Yuba
29	Nevada	99	Out of State
30	Orange		

Appendix B – Void and Replacement Scenarios

B.1 Void of an Accepted Encounter

The value in CLM01 is used as a short representation – appropriate format requirements are described earlier in this document.

This scenario shows the related fields used to void a previously submitted encounter that was accepted. The first table shows the original encounter submission after processing:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
03/01	A1234	1	n/a	0091234	Accepted	

A void is submitted. The following table shows both encounters after processing of the void on 03/26 has completed:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
03/26	A1234	1	n/a	0091234	Voided	Original encounter has been voided
03/26	A1234	8	0091234	0091245	Void Processed	

An attempt to replace this encounter once it has been voided would result in a denial, as follows:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
	A1234	1	n/a	0091234	Voided	No change
	A1234	8	0091234	0091245	Void Processed	No change
03/27	A1234	7	0091234	0091256	Denied	Once an encounter has been voided no further action can be taken

B.2 Void of a Denied Encounter

This scenario shows the related fields used to void a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
04/01	B2234	1	n/a	0081234	Denied	Rendering NPI was invalid

The submitted void was incorrectly formatted. The following table shows both encounters after processing of a void on 04/26 has been completed:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
	B2234	1	n/a	0081234	Denied	Unchanged
04/26	B2235	8	0081234	0081245	Denied	Invalid reference in CLM01

Another void is submitted on 04/27.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
	B2234	1	n/a	0081234	Voided	Voided on 4/27
	B2235	8	0081234	0081245	Denied	Invalid reference in CLM01
04/27	B2234	8	0081234	0081256	Void Processed	

B.3 Replacement of an Encounter

This scenario shows the related fields used to replace a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
05/01	C3234	1	n/a	0071234	Denied	Rendering NPI was invalid

A replacement transaction is submitted but is also denied for a different reason. The following table shows both encounters after processing of the replacement has been completed:

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
	C2234	1	n/a	0071234	Denied	Unchanged
05/16	C2234	7	0071234	0071245	Denied	Service Facility NPI was invalid

Another replacement is submitted on 05/27.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
05/27	C2234	1	n/a	0071234	Replaced	Original encounter was replaced
	C2234	7	0071234	0071245	Denied	Unchanged
05/27	C2234	7	0071234	0071256	Accepted	

In the previous table take special note of the fact that since there was no accepted encounter in the history of this submission, the value supplied in REF*F8 was the Encounter-ID for **<u>the earliest denied encounter.</u>**

Another replacement is submitted on 05/29.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
	C2234	1	n/a	0071234	Replaced	Unchanged
	C2234	7	0071234	0071245	Denied	Unchanged
05/29	C2234	7	0071234	0071256	Replaced	
05/29	C2234	7	0071256	0071267	Accepted	

In the previous table take special note of the fact that the value supplied in REF*F8 was the Encounter-ID for **the latest accepted encounter** “0071256 **NOT** the Encounter-ID for the original submission “0071234”.

B.4 Encounters that can NOT be corrected

This scenario shows an encounter that has been successfully voided.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
03/01	D2234	1	n/a	0081234	Voided	
03/15	D2234	8	0081234	0081245	Void Processed	Original encounter was voided

A subsequent replacement is submitted. This is denied.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
03/01	D2234	1	n/a	0081234	Voided	
03/15	D2234	8	0081234	0081245	Void Processed	Original encounter (0081234) was voided
03/18	D2234	7	0081234	0081267	Denied	Once an encounter has been voided, no further action can be taken
03/20	D2234	7	0081267	0081288	Denied	No action can be taken on denied Replacement
03/25	D2234	8	0081267	0081299	Denied	No action can be taken on denied Void

Denied Replacement Encounter with encounter ID 0081267 cannot be corrected.

Denied Void and Denied Replacement encounters cannot be acted on.

This scenario shows an encounter that has been submitted and denied, because although it is an original submission to DHCS it is not coded as an original encounter – CLM05-3 should be equal to '1' and REF8F8 should be blank on original submissions.

Date	CLM01	CLM05-3	REF8F8	DHCS Encounter ID	Internal DHCS Status	Note
03/01	E2234	7	0099345	0091234	Denied	Not an original encounter

Encounter ID 0091234 cannot be corrected.