

California Medicaid (Medi-Cal Dental)

**HIPAA Transaction
Standard Companion Guide**

**Refers to the Implementation Guides
Based on ASC X12 version 005010**

Disclosure Statement

The information in this document is subject to change in the event the Medi-Cal Dental 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. 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.

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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 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 (Medi-Cal Dental). The table below lists transactions supported by the Medi-Cal Dental.

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.dental.dhcs.ca.gov>

1.6 Additional Information

There is no charge from Medi-Cal Dental 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. 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 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

Providers, billing intermediaries and clearinghouses interested in submitting or receiving electronic transactions with Medi-Cal Dental should contact Medi-Cal Dental EDI Support by emailing Med-CalDentalEDI@gainwelltechnologies.com or by calling (800) 423-0507.

2.2 Trading Partner Registration

Trading Partner Registration is required to submit or receive EDI transactions with Medi-Cal Dental. 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.dental.dhcs.ca.gov/MCD_documents/providers/EDI_Application_Agreement.pdf

Provider Service Office Electronic Data Interchange Option Selection Form:

https://www.dental.dhcs.ca.gov/MCD_documents/providers/Provider_Service_office_EDI_options_selection_form.pdf

Electronic Remittance Advice (ERA) Enrollment Form:

https://www.dental.dhcs.ca.gov/MCD_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 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 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 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 strongly encourages the submission of test transactions meeting the following conditions, if applicable:

11. When a single NPI is registered with Medi-Cal Dental 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 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 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 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 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 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 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.

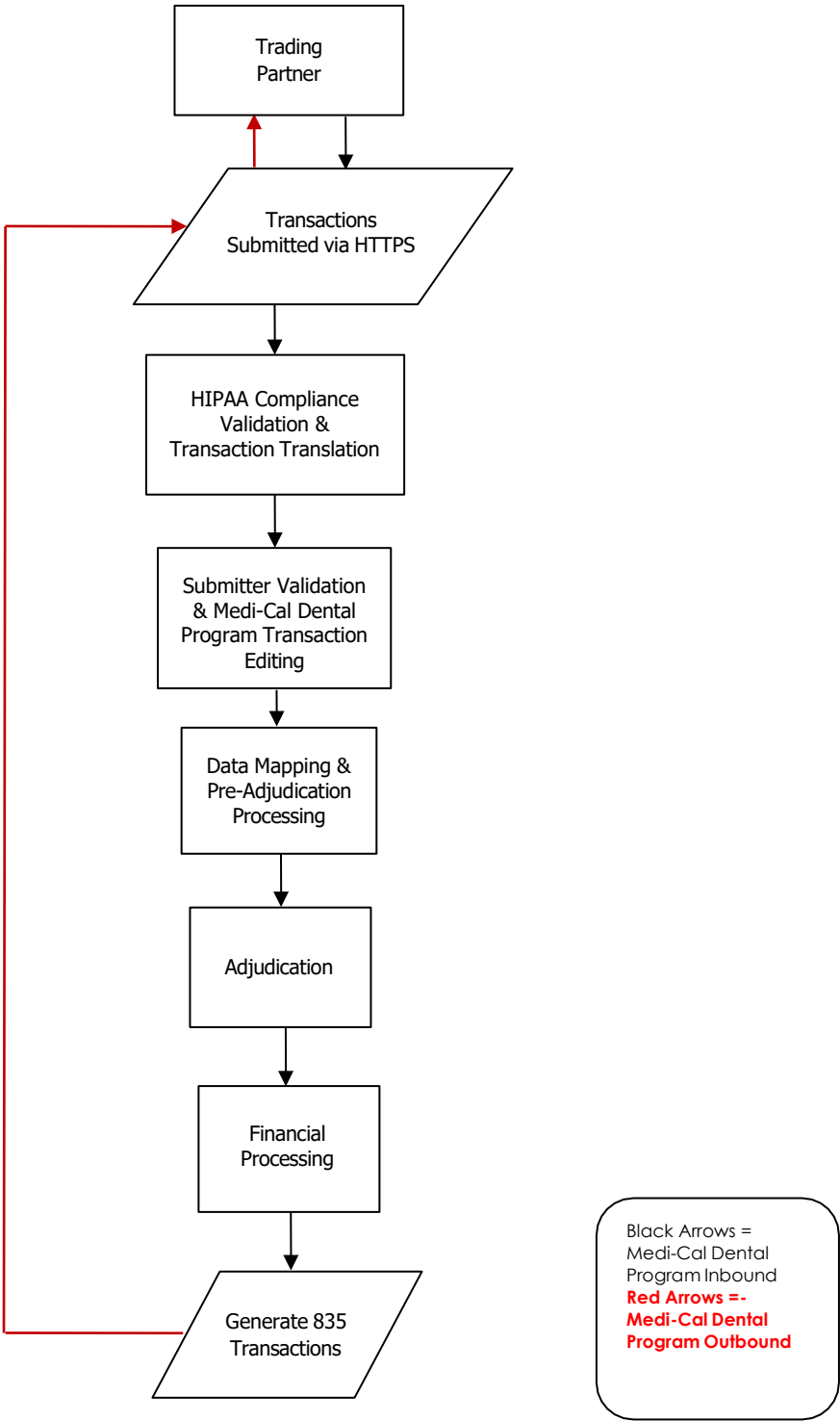


Figure 4-1 Batch Process for 837 and 835 Transactions

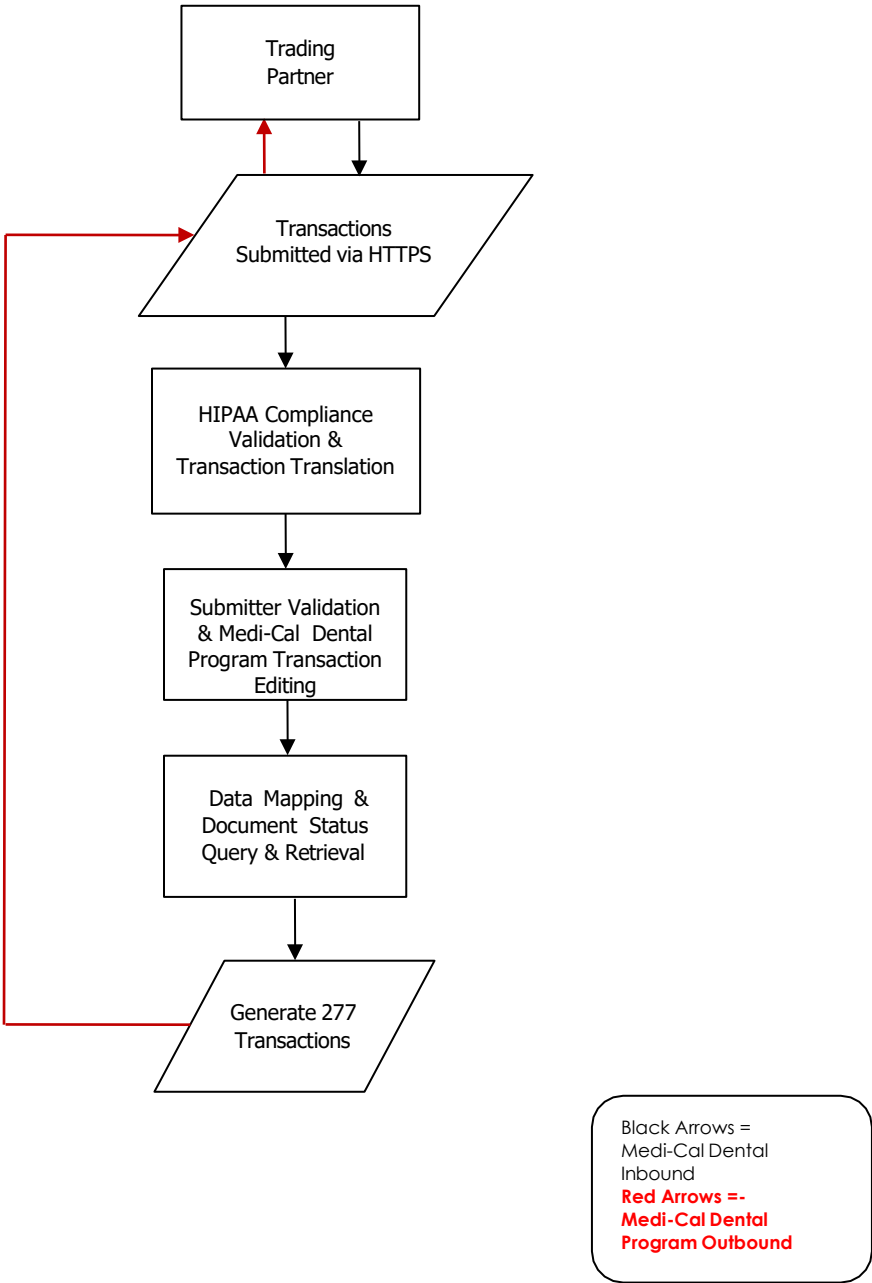


Figure 4-2 Batch Process for 276 and 277 Transactions

4.2 Transmission Administrative Procedures

Medi-Cal Dental supports a secure HTTPS website for the transmission of files to and from Medi-Cal Dental. 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.

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 are placed, and the “Out” mailbox is where outgoing files from Medi-Cal Dental 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 does not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Medi-Cal Dental 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 are kept internal; Medi-Cal Dental 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 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 (800) 423-0507 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 EDI Support:

- (800) 423-0507 – request to be transferred to EDI Support
- Med-CalDentalEDI@gainwelltechnologies.com

5.2 EDI Technical Assistance

The practice management system vendor provides technical assistance with computer hardware or software. Medi-Cal Dental 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 EDI Support:

- (800) 423-0507 – request to be transferred to EDI Support
- Med-CalDentalEDI@gainwelltechnologies.com

5.3 Provider Service Number

Providers may contact the Medi-Cal Dental Provider Customer 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.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Provider_Forms/ProviderFormsMain

General Medi-Cal Dental information can be accessed online at:

<https://www.dental.dhcs.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'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 recommends the following delimiter values (Figure 6-1) be used when sending X12 data files to Medi-Cal Dental.

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 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'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 expects to receive the value listed in the codes column.
	ISA02	Authorization Information		Medi-Cal Dental expects to receive: DENTICAL
	ISA03	Security Information Qualifier	00	Medi-Cal Dental expects to receive the value listed in the codes column.
	ISA04	Security Information		Medi-Cal Dental expects to receive:

Loop ID	Reference	Name	Codes	Notes/Comments
				NONE
	ISA05	Interchange ID Qualifier	ZZ	Medi-Cal Dental expects to receive the value listed in the codes column.
	ISA06	Interchange Sender ID		Medi-Cal Dental expects to receive the Submitter's Denti-Cal Remote ID.
	ISA07	Interchange ID Qualifier	ZZ	Medi-Cal Dental expects to receive the value listed in the codes column.
	ISA08	Interchange Receiver ID		Medi-Cal Dental expects to receive: DENTICAL
	ISA14	Acknowledgement Requested	0	Medi-Cal Dental 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 expects to receive the Submitter's Denti-Cal Remote ID.
	GS03	Application Receiver's Code		Medi-Cal Dental expects to receive: DENTICAL

6.4 ST-SE

Medi-Cal Dental 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 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 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 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 system. The DCN is returned electronically on EDI reports.

Medi-Cal Dental 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 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 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 by affixing the Medi-Cal Dental -supplied EDI label to specially marked envelopes. The Medi-Cal Dental 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 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 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 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 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 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 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 for billing.

(CP-O-NOA-P)		NOTICE OF AUTHORIZATION		MM/DD/YY 23:45:12		PAGE 01 OF 01	
DCN: 000000000000 0		AUTHORIZATION PERIOD FROM MM/DD/YY TO MM/DD/YY					
RE-EVALUATION IS REQUESTED <input type="checkbox"/> (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: 000000000000			
X-RAYS ATTACHED <input type="checkbox"/> (X FOR YES) HOW MANY? <input type="checkbox"/>				ACCIDENT / INJURY <input type="checkbox"/> (X FOR YES)			
OTHER ATTACHMENTS <input type="checkbox"/> (X FOR YES)				EMPLOYMENT RELATED <input type="checkbox"/> (X FOR YES)			
OTHER DENTAL COVERAGE <input type="checkbox"/> (X FOR YES)				CHDP <input type="checkbox"/> (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
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 (000000000000) 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 for processing.

(CP-O-RTD-P)NOTICE OF RESUBMISSION01/09/12 23:45:04 PAGE 01 OF 01

BUSINESS NAME AND ADDRESSRTD ISSUE DATE: MM-DD-YY

SERVICE OFFICE/ FICTITIOUS NAME0000000000RTD DUE DATE: MM-DD-YY

PROVIDER NAME

ADDRESSDOCUMENT TYPE: CLAIM

CITYCA 00000-0000BEGINNING DOS: 01-02-12

PROVIDER DCN : 0000000000000000

PATIENT INFORMATION

LAST NAME	FIRST NAME	MEDICAL ID NBR	DENTAL REC	AMOUNT BILLED	DCN
LAST	FIRST	0000000000		364.00	000000000000 0

CLAIM

INFORMATION	FIELD	CLAIM SUBMITTED	PROCEDURE
BLOCK	NO.	LINE	INFORMATION
TOOTH-CODE			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. 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 OR NPI	PROVIDER DCN	RECIPIENT LAST	NAME FIRST	D T	SSN/CIN OR MEDS	BASE DCN	RSN CD	

0000000000	000000000000000000	LAST	FIRST	C	XXXXX0000		G	
0000000000	000000000000000000	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 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 OR NPI	BASE DCN	PROV DCN	RECIPENT LAST	NAME FIRST	SSN/CIN/ OR MEDS
0000000000	00000000000	0000000000	LAST	FIRST	000000000
MEDI CAL NBR: 000000000		SYS IND:	DOC TYPE: C	SUBMIT AMOUNT:	1500.00
0000000000	00000000000	00000000000	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 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.

BILLING NPI:XXXXXXXXX

PATIENT MEDS ID:MEMBER NAME

PROV. DCN:

BASE DCN:XXXXXXXXXXXX

MEDI-CAL DENTAL USE ONLY

PROVIDER NAME/BUSINESS NAME

STREET ADDRESS

CITY, STATEZIP

DC-O18A

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 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	000000000000000000	00000000000	LAST	FIRST	000000000
MEDI CAL NBR: 0000000000000000		DOC TYPE: C	SUBMITTED FEE:	100.00	
0000000000	000000000000000000	00000000000	LAST	FIRST	XXXXX0000
MEDI CAL NBR: 0000000000000000		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	0000000000	0000-0000000000	LAST	FIRST	XRAY/ATTCH
PROV DCN: 0000000000000-0000 BASE DCN: 000000000000 DOC TYPE: T SUB AMT: 380.00							
0000000000	12/27/07	14	0000000000	0000-0000000000	LAST	FIRST/	ADDIT DOC
PROV DCN: 0000000000000-0000 BASE DCN: 000000000000 DOC TYPE: T SUB AMT: 990.00							
0000000000	12/27/07	14	XXXXX0000	0000-0000000000	LAST	FIRST	X/RAY/ATTCH
PROV DCN: 0000000000000-0000 BASE DCN: 000000000000 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.

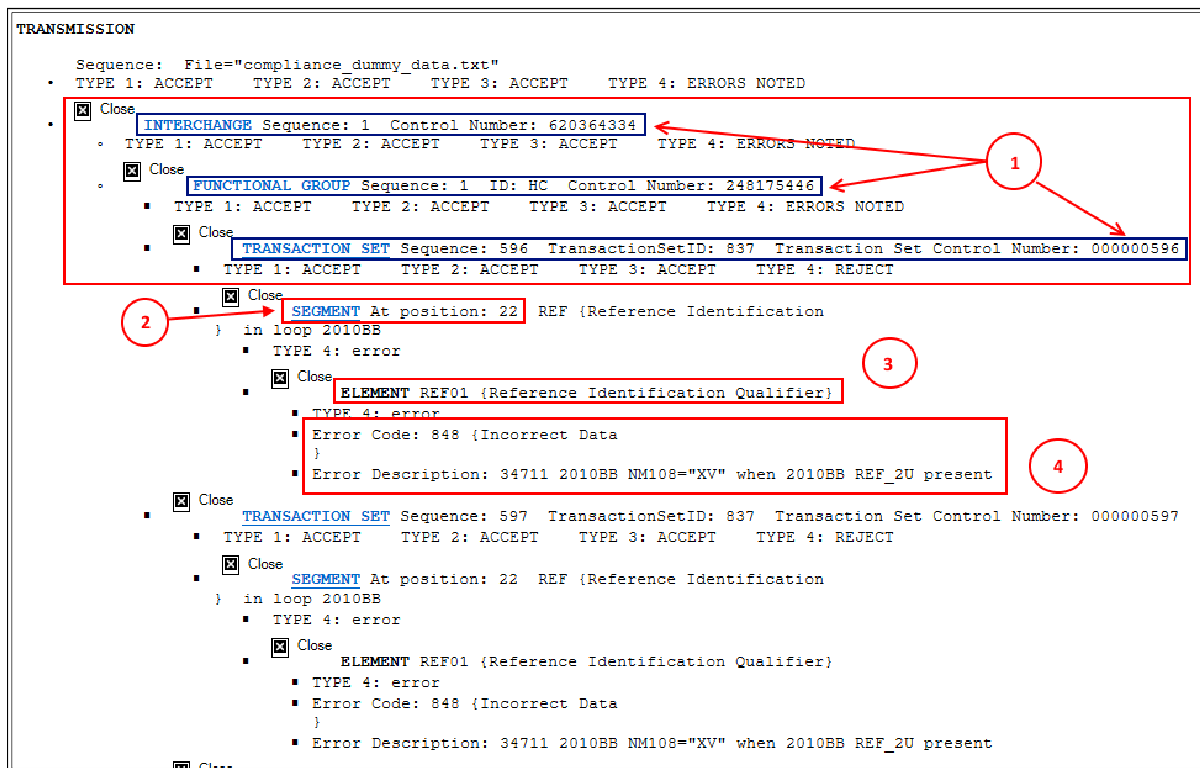


Figure 8-8 HTML Error Report

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.
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.
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.
- 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 Amount:** The amount allowed by Medi-Cal Dental 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, 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 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.
5. **Levy Deduction Amount:** The amount of the payment issued to the levy holder by Medi-Cal Dental, 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, 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	
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	MMDDYY
23	Check Date	X(6)	167-172	
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	
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	MMDDYY
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	
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	
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	MMDDYY
9	Check Date	X(6)	90-95	
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" MMDDYY
2	Accounts Receivable Control Number	X(5)	02-06	
3	Effective Date	X(6)	07-12	
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" MMDDYY
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	
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*DENTAL *00*NONE *ZZ*DENTAL *ZZ*remote-id *YYMMDD *HHMM*00303*trans control nbr*0*P/T**N _L
GS	GS	*TX*DENTAL*final destination provider ID and office number- *YYMMDD*HHMM*X*EDI VersionN _L
GS	ST	*864*DENTALN _L
GS	BMG	*ZZ*REPORTS FOR provider nameN _L
MIT	MIT	*RPTN _L
MIT		80 character report linesN _L
GS	SE	*count of segments from ST thru SE*DENTALN _L
GS	GE	*number of ST/SE sets*DENTALN _L
ENV	IEA	*Number of GS/GE sets*trans control numberN _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. The following are links to these documents:

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

https://www.dental.dhcs.ca.gov/MCD_documents/providers/prov_BI_app_agreement_and_covr_ltr.pdf

- Provider Service Office Electronic Data Interchange Option Selection Form:

https://www.dental.dhcs.ca.gov/MCD_documents/providers/Provider_Service_office_EDI_options_selection_form.pdf

- Electronic Remittance Advice (ERA) Enrollment Form:

https://www.dental.dhcs.ca.gov/MCD_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 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)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
66		BHT	Beginning of Hierarchical Transaction			
		BHT06	Claim or Encounter Identifier	CH		Medi-Cal Dental expects to receive the value listed in the codes column.
69	1000A	NM1	Submitter Name			
		NM109	Submitter Identifier			Medi-Cal Dental expects to receive the Submitter's Medi-Cal Dental Program Remote ID.
74	1000B	NM1	Receiver Name			
		NM103	Receiver Name			Medi-Cal Dental expects to receive: DENTAL
		NM109	Receiver Primary Identifier			Medi-Cal Dental expects to receive: 1822287119
78	2000A	PRV	Billing Provider Specialty Information			The Provider Specialty Information on file with the Medi-Cal Dental Program Provider Enrollment Unit is used as needed.
79	2000A	CUR	Foreign Currency Information			Medi-Cal Dental does not use the information sent in this segment. All amounts are processed in U.S. currency.
82	2010AA	NM1	Billing Provider Name			By failing to submit rendering provider information in either Loop 2310B or Loop 2420A, the provider is certifying the billing provider is the rendering provider, and the transaction is processed accordingly.
86	2010AA	N3	Billing Provider Address			The billing address on file with the Medi-Cal Dental Provider Enrollment Unit is used.
87	2010AA	N4	Billing Provider City, State, ZIP Code			The billing address on file with the Medi-Cal Dental Program Provider Enrollment Unit is used.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
89	2010AA	REF	Billing Provider Tax Identification			The Tax Identification Number on file with the Medi-Cal Dental Provider Enrollment Unit is used for income reporting on the 1099 forms.
91	2010AA	REF	Billing Provider UPIN/License Information			Medi-Cal Dental does not use this segment for provider identification.
96	2010AB	NM1	Pay-to Address Name			The pay-to information on file with the Medi-Cal Dental Provider Enrollment Unit is used to direct payment.
101	2010AC	NM1	Pay-to Plan Name			Medi-Cal Dental does not currently process subrogation payment requests.
114	2010BA	NM1	Subscriber Name			
		NM108	Identification Code Qualifier	MI		Medi-Cal Dental expects to receive the value listed in the codes column.
		NM109	Subscriber Primary Identifier			Medi-Cal Dental 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.
122	2010BA	REF	Subscriber Secondary Identification			Medi-Cal Dental strongly discourages the transmission of a secondary subscriber ID as the submission of an SSN causes a rejected transaction.
124	2010BB	NM1	Payer Name			
		NM103	Payer Name			Medi-Cal Dental expects to receive: DENTAL
		NM109	Payer Identifier			Medi-Cal Dental Program expects to receive: 94146
129	2010BB	REF	Payer Secondary Identification			Medi-Cal Dental does not use this segment for payer identification.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
131	2010BB	REF	Billing Provider Secondary Identification			
		REF01	Reference Identification Qualifier	LU		When a single NPI is registered with Medi-Cal Dental 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.
133	2000C	HL	Patient Hierarchical Level			Medi-Cal Dental recipients are identified by a unique identification number; therefore all patients/recipients are considered the subscriber and must be identified at the Subscriber Level.
137	2010CA	NM1	Patient Name			Medi-Cal Dental recipients are identified by a unique identification number; therefore all patients/recipients are considered the subscriber and must be identified at the Subscriber Level.
145	2300	CLM	Claim Information			
		CLM01	Patient Control Number		17	Medi-Cal Dental 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 expects to receive the values listed in the codes column.
		CLM11-1	Related Causes Code	OA EM AA		Medi-Cal Dental expects to receive the values listed in the codes column.
		CLM11-2	Related Causes Code	OA EM AA		Medi-Cal Dental expects to receive the values listed in the codes column.
		CLM12	Special Program Indicator			Medi-Cal Dental does not use the information sent in this element.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		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.
153	2300	DTP	Date – Appliance Placement			Medi-Cal Dental Program does not use the information sent in this segment.
154	2300	DTP	Date – Service Date			
		DTP02	Date Time Period Format Qualifier	D8		Medi-Cal Dental expects to receive the value listed in the codes column.
156	2300	DN1	Orthodontic Total Months of Treatment			Medi-Cal Dental does not use the information sent in this segment.
158	2300	DN2	Tooth Status			
		DN202	Tooth Status Code	M		Medi-Cal Dental expects to receive the value listed in the codes column.
159	2300	PWK	Claim Supplemental Information			
		PWK01	Attachment Report Type	RB OZ		Medi-Cal Dental expects to receive the values listed in the codes column.
		PWK02	Attachment Transmission Code	BM FT		<p>Medi-Cal Dental expects to receive the values listed in the codes column.</p> <p>Medi-Cal Dental accepts digitized images submitted through certified electronic attachment vendors. For a listing of certified vendors, refer to Section 3 of the <i>Medi-Cal Dental Program Provider Handbook</i>.</p> <p>When submitting digitized radiographs and attachments through a certified vendor, use Attachment Transmission Code 'FT' and submit the Attachment Control Number in PWK06.</p>

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		PWK06	Identification Code			The Attachment Control Number for digitized radiographs and attachments MUST be submitted in the following format: Change Healthcare Users: CHC#999999999' DentalXChange Users: 'EHG#999999999' NEA Users: 'NEA#999999999' Vyne Users: 'DTX#999999999'
165	2300	REF	Predetermination Identification			Medi-Cal Dental does not use the information sent in this segment.
166	2300	REF	Service Authorization Exception Code			Medi-Cal Dental does not use the information sent in this segment.
168	2300	REF	Payer Claim Control Number			Submit this segment only when submitting an adjustment request (when CLM05-3 = '7'). Do not use this segment when submitting NOAs for payment. The REF – Prior Authorization segment (using Reference Identification Qualifier 'G1') should be transmitted when submitting an NOA for payment.
		REF02	Payer Claim Control Number			Submit the original Medi-Cal Dental DCN associated with the transaction to be reprocessed.
171	2300	REF	Prior Authorization			Submit this segment only when submitting an NOA for payment.
		REF02	Prior Authorization Number			Submit the original Medi-Cal Dental DCN associated with the approved TAR.
175	2300	REF	Claim Identifier for Transmission Intermediaries			Medi-Cal Dental does not capture the information sent in this segment.
180	2300	HI	Health Care Diagnosis Code			Medi-Cal Dental does not use the information sent in this segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2310A	PRV	Referring Provider Specialty Information			Medi-Cal Dental Program does not use the information sent in this segment for adjudication.
194	2310A	REF	Referring Provider Secondary Identification			Medi-Cal Dental Program does not use for provider identification.
196	2310B	NM1	Rendering Provider Name			Rendering Provider information submitted in this loop is applied to all dated service lines unless overridden by the presence of segment NM1 in Loop 2420A.
199	2310B	PRV	Rendering Provider Specialty Information			The Provider Specialty Information on file with the Medi-Cal Dental Program Provider Enrollment Unit is used as needed.
200	2310B	REF	Rendering Provider Secondary Identification			Medi-Cal Dental Program does not use for provider identification.
208	2310C	REF	Service Facility Location Secondary Identification			When the service(s) was rendered in the patient's home (the address reported as the patient address in the Subscriber or Patient loop), do not use the Service Facility Location loop. In that case, the place of service code in CLM05-1 indicates that the service occurred in the patient's home.
210	2310D	NM1	Assistant Surgeon Name			Medi-Cal Dental Program does not use the information sent in this Loop.
216	2310E	NM1	Supervising Provider Name			Medi-Cal Dental Program does not use the information sent in this Loop.
282	2400	SV3	Dental Service			
		SV304	Oral Cavity Designation Code			Medi-Cal Dental Program processes only one oral cavity code per service.
288	2400	TOO	Tooth Information			Although this segment may be repeated up to 32 times, Medi-Cal Dental Program processes only the first occurrence of the transmitted segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
291	2400	DTP	Date – Prior Placement			Medi-Cal Dental does not use the information sent in this segment.
292	2400	DTP	Date – Appliance Placement			Medi-Cal Dental does not use the information sent in this segment.
293	2400	DTP	Date – Replacement			Medi-Cal Dental does not use the information sent in this segment.
294	2400	DTP	Date – Treatment State			Medi-Cal Dental does not use the information sent in this segment.
295	2400	DTP	Date – Treatment Completion			Medi-Cal Dental does not use the information sent in this segment.
298	2400	REF	Service Predetermination Identification			Medi-Cal Dental does not use the information sent in this segment.
300	2400	REF	Prior Authorization			Medi-Cal Dental processes prior authorization information submitted in Loop 2300 only. Prior Authorization information sent in this loop is not used.
308	2400	AMT	Sales Tax Amount			Medi-Cal Dental does not use the information sent in this segment.
316	2420A	NM1	Rendering Provider Name			<p>Medi-Cal Dental 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.</p> <p>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.</p>

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
319	2420A	PRV	Rendering Provider Specialty Information			The Provider Specialty Information on file with Medi-Cal Dental Program Provider Enrollment Unit is used as needed.
320	2420A	REF	Rendering Provider Secondary Identification			Medi-Cal Dental does not use for provider identification.
333	2420D	NM1	Service Facility Location Name			Medi-Cal Dental 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 expects to receive: DENTAL
		NM108	Identification Code Qualifier	PI		Medi-Cal Dental expects to receive the value listed in the codes column.
		NM109	Payer Identifier			Medi-Cal Dental expects to receive: 94146
		NM109	Information Receiver Identification Number			Medi-Cal Dental expects to receive the Submitter's Medi-Cal Dental Program Remote ID.
		NM108	Identification Code Qualifier	XX		Medi-Cal Dental expects to receive the value listed in the codes column.
		NM108	Identification Code Qualifier	MI		Medi-Cal Dental expects to receive the value listed in the codes column.
		NM109	Subscriber Identifier			Medi-Cal Dental 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	

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
66	2200D	AMT	Claim Submitted Charges			Medi-Cal Dental does not use the information sent in this segment.
67	2200D	DTP	Claim Service Date			Medi-Cal Dental only uses dates of service submitted in this Loop. Medi-Cal Dental Program does not use dates of service submitted in Loop 2210D.
		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.
69	2210D	SVC	Service Line Information			Medi-Cal Dental does not use information sent in this Loop. Information submitted in Loop 2200D is used to determine claim status. Data submitted in Loop 2210D is not used.
75	2200E	HL	Dependent Level			Medi-Cal Dental 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 populates this data element with the code value shown in the codes column.
		NM109	Payer Identifier			Medi-Cal Dental populates this data element with the value: DENTAL
		NM109	Information Receiver Identification Number			Medi-Cal Dental populates this data element with the Receiver's Medi-Cal Dental Program Remote ID.
		NM108	Identification Code Qualifier	XX		Medi-Cal Dental populates this data element with the code value shown in the codes column.
		NM108	Identification Code Qualifier	MI		Medi-Cal Dental populates this data element with the code value shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
138	2200D	STC	Claim Level Status Information			Medi-Cal Dental reports on the status of all documents that meet the submitted trace criteria, which may result in multiple responses to a single request. When a single NPI is registered with Medi-Cal Dental Program for more than one service office (and thus the NPI is considered non-sub parted), Medi-Cal Dental Program will generate a status response for each service office.
		STC01-1	Health Care Claim Status Category Code	D0 P1 F1 F2 E0		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		STC01-2	Status Code	0 1		Medi-Cal Dental populates this data element with the code values shown in the codes column.
155	2200D	DTP	Claim Service Date			
		DTP03	Claim Service Period			Medi-Cal Dental populates this data element with the first and last date of service for each document that matches the submitted trace criteria.
157	2220D	SVC	Service Line Information			Medi-Cal Dental reports document status at the claim level with Loop 2200D.
173	2000E	HL	Dependent Level			Medi-Cal Dental 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)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
69		BPR	Financial Information			
		BPR01	Transaction Handling Code	I		Medi-Cal Dental populates this data element with the code value shown in the codes column.
		BPR03	Credit or Debit Flag Code	C		Medi-Cal Dental populates this data element with the code value shown in the codes column.
		BPR04	Payment Method Code	CHK		Medi-Cal Dental populates this data element with the code value shown in the codes column.
77		TRN	Reassociation Trace Number			
		TRN03				Medi-Cal Dental 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.
82		REF	Receiver Identification			This segment is only included in transactions submitted to clearinghouses registered with Medi-Cal Dental.
		REF02	Receiver Identification			Medi-Cal Dental populates this data element with the Medi-Cal Dental Program assigned clearinghouse registration number.
87	1000A	N1	Payer Identification			
		N102	Payer Name			Medi-Cal Dental populates this data element with the value: DENTAL

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
89	1000A	N3	Payer Address			
		N301	Payer Address Line			Medi-Cal Dental Program populates this data element with: P.O. BOX 15609
90	1000A	N4	Payer City, State, ZIP Code			
		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
97	1000A	PER	Payer Technical Contact Information			
		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: MEDI-CAL DENTAL 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: 8004230507
		PER05	Communication Number Qualifier	TE		Medi-Cal Dental Program populates this data element with the code value shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		PER06	Payer Technical Contact Communication Number			Medi-Cal Dental populates this data element with: 8004230507
102	1000B	N1	Payee Identification			
		N103	Identification Code Qualifier	FI XX		Medi-Cal Dental populates this data element with the code values shown in the codes column.
107	1000B	REF	Payee Additional Identification	PQ TJ		Medi-Cal Dental populates this data element with the code values shown in the codes column.
123	2100	CLP	Claim Payment Information			
		CLP01	Patient Control Number		17	
		CLP02	Claim Status Code	1 22		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		CLP06	Claim Filing Indicator	MC		Medi-Cal Dental populates this data element with the code value shown in the codes column.
		CLP09	Claim Frequency Code	1 7		Medi-Cal Dental populates this data element with the code values shown in the codes column.
129	2100	CAS	Claim Adjustment			Medi-Cal Dental claim adjustment amounts are sent at the CAS segment at the service level in Loop 2110.
137	2100	NM1	Patient Name			
		NM108	Identification Code Qualifier	MR		Medi-Cal Dental populates this data element with the code value shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
146	2100	NM1	Service Provider Name			If multiple rendering providers are associated with a document, Medi-Cal Dental will send information associated with the first rendering provider processed on the document. For rendering provider information specific to each submitted service, use the rendering provider information (REF segment) in Loop 2110.
		NM108	Identification Code Qualifier	MC XX		Medi-Cal Dental 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 populates this data element with the code value shown in the codes column.
		SVC06-1	Product/Service ID Qualifier	AD		Medi-Cal Dental populates this data element with the code value shown in the codes column.
195	2110	DTM	Service Date			
		DTM01	Date Time Qualifier	472		Medi-Cal Dental populates this data element with the code value shown in the codes column.
196	2110	CAS	Service Adjustment			
		CAS01	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		CAS05	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		CAS08	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		CAS11	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		CAS14	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		CAS17	Claim Adjustment Group Code	CO OA PR		Medi-Cal Dental populates this data element with the code values shown in the codes column.
204	2110	REF	Service Identification			Medi-Cal Dental does not send this segment.
207	2110	REF	Rendering Provider Information			
		REF01	Reference Identification Qualifier	1D HPI		Medi-Cal Dental populates this data element with the code values shown in the codes column.
217		PLB	Provider Adjustment			
		PLB02	Fiscal Period Date			Medi-Cal Dental 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 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 populates this data element with the code values shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		PLB09-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		PLB11-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental populates this data element with the code values shown in the codes column.
		PLB13-1	Adjustment Reason Code	51 CS IS L3 LE WO		Medi-Cal Dental populates this data element with the code values shown in the codes column.

11. APPENDIX

11.1 Implementation Checklist

Medi-Cal Dental recommends entities use the following information as a guide to becoming a Medi-Cal Dental 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.
- Contact Medi-Cal Dental Program EDI Support with any questions or concerns regarding Medi-Cal Dental requirements.
- Register as an EDI Trading Partner.
- Complete transaction testing and certification.
- Begin submitting EDI transactions to Medi-Cal Dental.

11.2 Business Scenarios

Medi-Cal Dental 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 website:

https://www.dental.dhcs.ca.gov/MCD_documents/providers/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 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.	
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: <ul style="list-style-type: none"> • Provide updated links to referenced documents, • Inform trading partners of Medi-Cal Dental's requirement for a CRLF at the end of each segment, and • Provide the new Medi-Cal Dental 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.	

Version Number	Date	Reason for Revision	Notes/Comments
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	2020 Cyclical Terminology updates required under DOIL 19-003	
3.0	March 2021	2021 Cyclical URLs updated throughout	
4.0	March 2022	2022 Cyclical Updated dates, text, and formatting	
5.0	March 2023	2023 Cyclical Page 55, Section 10.4; updated table Page 60, Section 11.3; updated link	
5.1	July 2023	DHCS requested updates Page 20, Section 7.1; Added Daily File Submission Limitations section Page 46, Section 10.1; Table updated. Replaced "Tesia/Renaissance" with "Vyne"	
6.0	February 2024	2024 Cyclical No updates required	