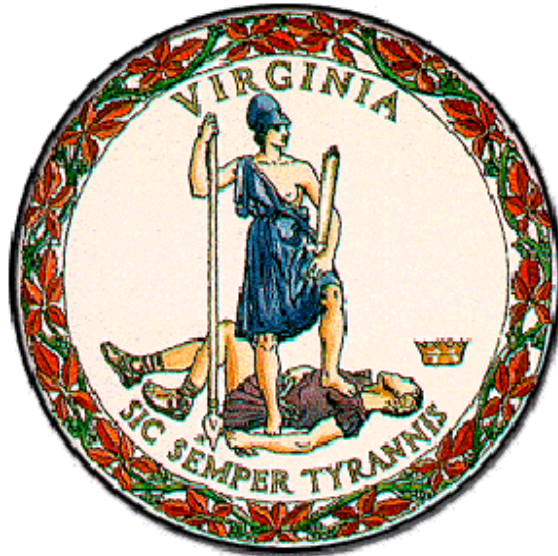# COMMONWEALTH OF VIRGINIA

Medicaid Enterprise System (MES)
Encounters Processing Solution (EPS)

Encounters Technical Manual
for
CCC Plus
Medallion 4.0
FFS Non-Emergency Medical Transportation

May 3, 2019
Document Version 2.1

Department of Medical Assistance Services (DMAS)

Document Version Control

Date	Document Version	Updated By	Description

07/09/18	2.0	DRH	Created one COV Encounters Technical Manual by combining the manuals listed below. Information covered under Section 6 has been relocated or removed as indicated under each listed manual.
			  1. CCC Plus Encounters Technical manual v1.7
			    Section 6.1 – removed
			    Section 6.2.1 – combined with section 5
			    Section 6.2.2 – combined with section 3.2.6
			    Section 6.2.3 – relocated to section 3.2.12
			    Section 6.2.4 – relocated to section 3.2.11
			    Section 6.3 - removed
			  2. Non-Emergency Medical Transportation Encounters Technical manual v1.7
			    Section 6.1 – removed
			    Section 6.2.1 – combined with section 5
			    Section 6.2.2 – combined with section 3.2.6
			  3. Medallion 4.0 Encounters Technical manual v1.0
			    Section 6.1 – removed
			    Section 6.2.1 – combined with section 5
			    Section 6.2.2 – combined with section 3.2.6
			    Section 6.2.3 – relocated to section 3.2.11
			    Section 6.2.4 – relocated to section 3.2.13

07/09/18	2.0	DRH	Section 5: This section was originally reserved for EPS Report documentation. EPS Reports are now documented in the COV EDI Procedure manual. Section 5 has been repurposed to cover information relating to EPS Business rules which was originally located in section 3.2.11.
07/09/18	2.0	DRH	Section 3.2.6: This section has been retitled to "National Provider Identifier (NPI) / Atypical Provider Identifier (API)". Section has been slightly rewritten to absorb info from section 6.2.2.
07/09/18	2.0	DRH	Updated all PS-F-106 references to PSF-113 (provider file).
07/09/18	2.0	DRH	Section 3.2.11.2: To identify institutional (837I) 340B drugs, each drug revenue line must contain modifier UD along with the procedure code and NDC only for bill types 13x and 83x. Reconstructed chart to clarify instructions for each transaction type.
07/09/18	2.0	DRH	Section 3.2.8.7: New section to provide instructions on reporting transportation services for monthly mass transit passes.
07/09/18	2.0	DRH	Section 3.2.8.8: New section to provide instructions on reporting transportation services by a Transportation Network Company (TNC) such as UBER, LYFT, or UZURV.
07/09/18	2.0	DRH	Section 4.3: There has been confusion with information presented in this section. A major rewrite of this section will be occur in the future by DMAS. For now, a few changes to the verbiage in sections 4.2.3 and 4.3.1 have been made to better clarify the use of RESEND/RESUBMISSION vs. Void/Replacement transactions.
04/18/19	2.1	DRH	Added page for DMAS Contact Information (immediately following Version Effective Dates).
04/18/19	2.1	DRH	Section 3.1.3 (v2.0): Relocated to section 4.1.1 (v2.1).
04/18/19	2.1	DRH	Section 3.2.3: Enhanced definition of denied pharmacy transactions.
04/18/19	2.1	DRH	Section 3.2.5: Removed reference to duplicate encounter transaction check as new section has been created for this topic (see below).
04/18/19	2.1	DRH	Section 3.2.8 (v2.1): New section - Duplicate Encounter Transactions

Date	Document Version	Updated By	Description
04/18/19	2.1	DRH	Section 3.2.8 (v2.0) / 3.2.9 (v2.1): 837P transaction must be used for submitting transportation services to EPS.
04/18/19	2.1	DRH	Section 3.2.8.1 (v2.0) / 3.2.9.1 (v2.1): Updated to reflect that DMAS will consider transportation taxonomy code set additions upon request. Removed taxonomy code list as codes may be found in the EPS Portal (Cache Code set TRANSPTAXONOMY).
04/18/19	2.1	DRH	Section 3.2.8.2 (v2.0) / 3.2.9.2 (v2.1): Added verbiage to indicate the exceptions for supplemental trip information (emergency and non-emergency ambulance). Updated "Usage" column in chart to reference new transportation data requirements grid in section 3.2.9.11 (v2.1).
04/18/19	2.1	DRH	Section 3.2.8.3 (v2.0) / 3.2.9.3 (v2.1): Updated section name; added verbiage to include requirements when using CMS 1500; updated requirement column in chart to synch-up with transportation data requirements grid in section 3.2.9.11 (v2.1). Added non-emergency ambulance as an exception for pick-up location data requirement.
04/18/19	2.1	DRH	Section 3.2.8.5 (v2.0) / 3.2.9.5 (v2.1): Added reference to new transportation data requirements grid in section 3.2.9.11 (v2.1).
04/18/19	2.1	DRH	Section 3.2.8.6 (v2.0) / 3.2.9.6 (v2.1): Added reference to new transportation data requirements grid in section 3.2.9.11 (v2.1).
04/18/19	2.1	DRH	Section 3.2.8.7 (v2.0) / 3.2.9.7 (v2.1): Section rewritten to add further detail on Mass Transit Passes.
04/18/19	2.1	DRH	Section 3.2.8.8 (v2.0) / 3.2.9.8 (v2.1): Added reference to new transportation data requirements grid in section 3.2.9.11 (v2.1).
04/18/19	2.1	DRH	Section 3.2.8.9.2 (v2.0) / 3.2.9.9.2 (v2.1): Added reference to new transportation data requirements grid in section 3.2.9.11 (v2.1).
04/18/19	2.1	DRH	Section 3.2.8.9.3 (v2.0) / 3.2.9.9.3 (v2.1): Added references to "EPS AMBUMODIFIERS Cache Code set".
04/18/19	2.1	DRH	Section 3.2.8.10 (v2.0) / 3.2.9.10 (v2.1): Simplified definition of deadhead mileage.
04/18/19	2.1	DRH	Section 3.2.9.11 (v2.1): New section - Transportation Data Requirements Grid
04/18/19	2.1	DRH	Section 3.2.9.12 (v2.1): New section - Transportation Cache Code sets
04/18/19	2.1	DRH	Section 3.2.9.1 (v2.0) / 3.2.10.1 (v2.1): Updated definition of "Date of Payment (DPYM)". Added statement that definitions are not applicable to Transportation Mass Transit Passes.
04/18/19	2.1	DRH	Section 3.2.12.2 (v2.0) / 3.2.13.2 (v2.1): Updated definition of "Date of Payment (DPYM)" as it relates to Consumer Directed transactions.
04/18/19	2.1	DRH	Section 4 (v2.0) / Section 4 & 5 (v2.1): Section has been split and rewritten for clarification and added detail. Section 4.1.3 (v2.1) now includes definitions for EPS Validation Status HOLD and EXCLUDE.
04/18/19	2.1	DRH	Section 5 (v2.0) / Section 6 (v2.1): Removed verbiage concerning EPS business rule details. Business rule details can be found on the EPS portal.

Version Effective Dates

Document Version	Effective Date
2.0	07/13/18
2.1	05/03/19

DMAS Contact Information

Topic	DMAS Contact

CCC Plus:
    General Encounter Support
    EPS Business Rules
    Encounter Data Quality Scorecard
    Encounter File Certifications
    EPS/Payment Cycle Reconciliation
    Encounter Technical Manual
    MES/EPS Companion Guides
    Trading Partner Testing
    EDI Compliance Check
	Primary Contact:
	    CCCPlusEncounters@dmas.virginia.gov
	Copy:
	    HCSEncounters@dmas.virginia.gov

Medallion 4:
    General Encounter Support
    EPS Business Rules
    Encounter Data Quality Scorecard
    Encounter File Certifications
    EPS/Payment Cycle Reconciliation
    Encounter Technical Manual
    MES/EPS Companion Guides
    Trading Partner Testing
    EDI Compliance Check
	Primary Contact:
	    HCSEncounters@dmas.virginia.gov
	Copy:
	    CCCPlusEncounters@dmas.virginia.gov

DMAS EDI Support:
    EDI Enrollment Forms/Registration Package
    Trading Partner Agreements
    MFT GoAnywhere Access (FTP) /Availability/Issues
    EDI File Submission
    EPS Response Files
    EPS Portal Access/Availability/Issues
	Primary Contact:
	    DMASEDISupport@dmas.virginia.gov
	Copy:
	    CCCPlusEncounters@dmas.virginia.gov
	    HCSEncounters@dmas.virginia.gov

Notes	
These mailboxes are to be used by contracted CCC Plus / Medallion 4.0 MCOs and their designees only.	

Table of Contents

1 Introduction and Purpose

This document provides information and guidance for external contractors submitting encounter claims data for Virginia Medicaid. The information in this document applies to all managed care organizations for the CCC Plus program, Medallion 4.0 program and to the Commonwealth's fee-for-service non-emergency transportation broker. Additional information and requirements are documented in the Virginia Medicaid Encounters Companion Guides and in the specific contracts for each program. EPS replaces the existing DMAS encounter processing system, providing a more modular, configurable, cost effective, and advanced solution for the Agency.

For purpose and clarity of this document, please refer to the definitions below:

- The term "Contractor" refers to any entity that contracts with DMAS, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance DMAS' capability for effective administration of the program.
- The term "Subcontractor" refers to an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with DMAS.
- The term "Payer" refers to an entity that adjudicates and/or provides payment of the claim to the provider. The Payer and the Contractor may be the same entity. Or, the Payer and the Subcontractor may be the same entity.
- The term "Contract" refers to a specific contract or managed care program, such as CCC Plus, Medallion 4.0, or fee-for-service Non-emergency Transportation Services.
- The term "MCO" refers to a Managed Care Organization.

The information in this manual is intended to be applicable to all encounters that are processed in the MES/EPS system.

2 Encounter Processing Solution (EPS) in the MES system - Overview

The Encounter Processing Solution (EPS) is a primary component of Virginia's vision for a new Medicaid Enterprise System (MES). The Virginia MES will be an integrated set of functional and operational processes that complies with the CMS Medicaid Information Technology Architecture (MITA) initiative. This initiative is intended to foster integrated business and IT transformation across the Medicaid enterprise (including all external vendors) to improve the administration of the Medicaid program. The key MES components that interface with the EPS are as follows:

- Member demographics, eligibility, and enrollment
- Provider demographics, taxonomy, and enrollment
- Reference data for validation and lookup
- Enterprise Data Warehouse Solution (EDWS) for data quality assessment and reporting
- Medicaid Pharmacy Benefit Manager (PBM) Contractor for collection of pharmacy rebates
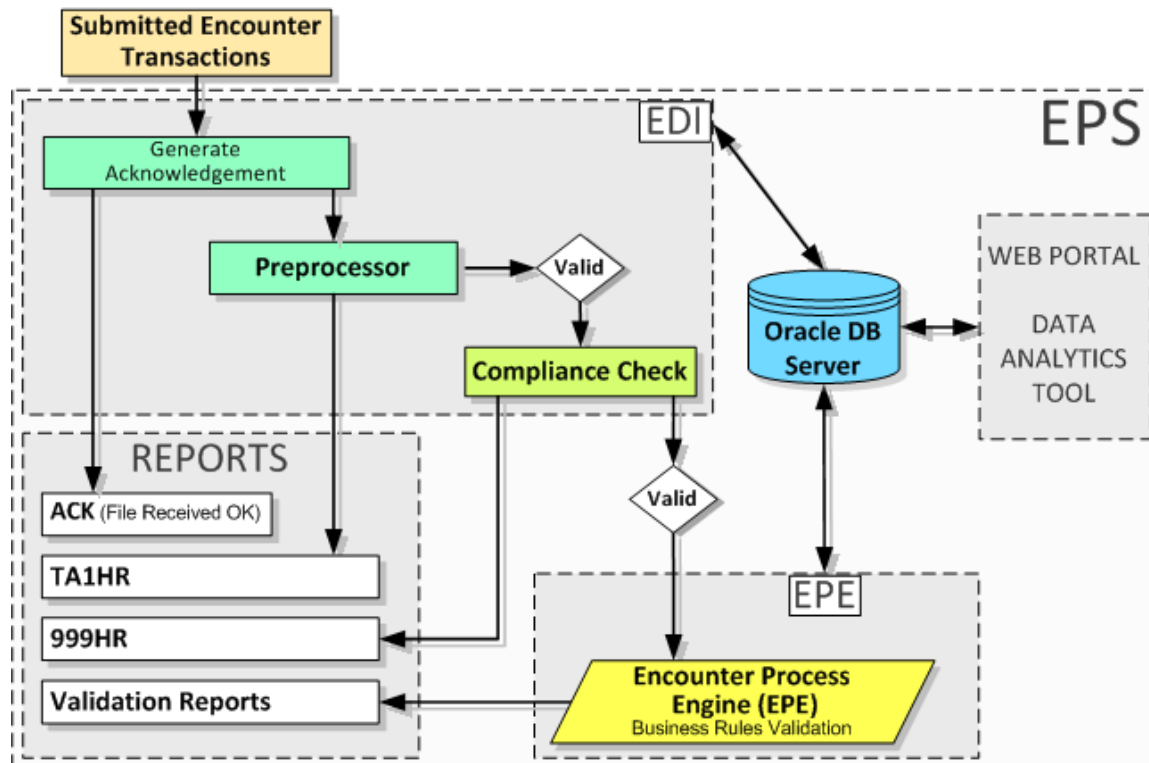
3   Encounter Requirements

This section covers EPS file and data requirements for all types of encounters.

3.1   Encounter Files

3.1.1   File Requirements

FILE REQUIREMENTS	REQUIREMENT DETAILS
Each encounter file must contain 5,000 transactions or less.	Transaction count is based on the following: 837 = CLM segment count NCPDP = G1 segment count
Subcontractor encounters must be submitted to DMAS by the Contractor.	Subcontractors may not submit encounter files directly to DMAS.
The Contractor must submit subcontractor encounters in separate files to DMAS. Each subcontractor file(s) should be mutually exclusive (i.e. separate file(s) for Pharmacy, separate file(s) for Vision, separate file(s) for Transportation, etc.).	Subcontractor encounters must not be included in the same file as the Contractor's encounter data or with another subcontractor's encounter data.
Only one EDI Interchange is allowed per 837 file.	EDI Interchange = All segments between and including the ISA segment and the IEA segment
File-naming convention for encounter files is unrestricted.	Files may be named in any manner. It is recommended that a standard file extension be used. (Example: .837, .TXT, .EDI, etc.)

EDI file delimiters are restricted.	For 837 files, the following delimiters must be used:
	    Data element separator = asterisk (*)
	    Component element separator = colon (:)
	    Repetition separator = caret (^)
	    Segment terminator = tilde (~)

3.1.2   File Submission Guidelines

Please see the *COV EDI Procedure Manual* for instructions on how to submit Encounter files.   Encounter files should follow the submission guidelines below.

FILE SUBMISSION GUIDELINES	GUIDELINE DETAILS
The number of files that may be posted for routine file submission is unlimited.	There is no limit to the number of files that may be submitted per day or week for routine file postings. (Routine = approximately one payment cycle plus corrections to encounters from the prior payment cycle).
File submission frequency is unlimited.	Files may be submitted daily. Corrections to encounter data may be submitted same-day as original posting. Corrections may be posted multiple times per day. Files may be submitted 24/7.
Large encounter backlogs must be discussed with DMAS prior to submission.	DMAS will work with the Contractor to create a backlog submission schedule for large backlogs.

3.1.3   Duplicate Encounter Files

The EDI Preprocessor will evaluate the preexistence of EDI files with same contents that were previously submitted using a hash value calculated using the SHA-256 algorithm. By comparing hash values, the preprocessor ensures that a duplicate file is not created. Duplicate encounter files are not allowed. The discovery of an exact duplicate will halt further processing and a TA1 response will be created. For X12 files, the ISA, GS, ST, BHT, SE, GE, and IEA segments are not included in the hash total.

EPS also checks for duplicates at the transaction level. See section 3.2.8.

3.1.4   Test File Submission

Future Development

3.1.5   Production File Submission

Future Development

3.2 Encounter Data

3.2.1 EDI Transactions

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered entities must use standard transaction sets when exchanging certain information. In accordance with the law, DMAS uses HIPAA transaction sets as the standard for Virginia Medicaid encounter data submission.

The ANSI X12 Technical Report Type 3 (TR3) and the National Council for Prescription Drug Programs (NCPDP) are the official standard for electronic submission of health care encounter data. Nothing in this documentation is intended to conflict or contradict the ANSI X12 TR3 or NCPDP Implementation Guide.

HIPAA adopted national code sets for use in all transaction sets. These code sets include most of the information currently codified in the UB92 and CMS 1500 paper claims and their electronic counterparts. DMAS will only allow valid procedure codes that are adopted for national use and will not accept local codes.

DMAS currently requires use of a variation of the Provider-to-Payer-to-Payer COB model of the 837 transaction sets, Version 5010, Addendum 2 for facility and professional services. For prescription drugs, the mandated transaction set is the NCPDP Batch Version D.0 Telecommunication Standard. As new versions of the transaction sets are adopted by HIPAA, DMAS will use the newer versions in accordance with HIPAA requirements.

For 837 transactions, the EPS will accept all claim frequency types with original, replacement, and void transactions being the most prevalent. For NCPDP transactions, the EPS will accept new billings (B1 transactions), and reversals (B2 transactions).

All EDI transactions should pass an EDI compliance check (SNIP Levels 1, 2, 3, 4) before the Contractor submits the encounter data to DMAS.

The matrix below, based on billing entity, should be used to determine which EDI transaction type is appropriate for the reporting the encounter.

Billing Entity	Transaction
Inpatient Urgent Care Facility	837 Institutional
Outpatient Urgent Care Facility	837 Institutional
Inpatient Mental Health Facility	837 Institutional
Outpatient Mental Health Facility	837 Institutional
Federally Qualified Health Center	837 Professional
Long Term Care Facility	837 Institutional
Skilled Nursing Facility	837 Institutional
Home Health Provider	Either 837 Institutional or 837 Professional, depending on contract between the MCO and the provider.
Pharmacy Benefit Manager	NCPDP
Retail Pharmacy	NCPDP
Hospital Pharmacy	837 Institutional
Independent Laboratory	837 Professional
Hospital-based Laboratory	837 Institutional
Non-Emergency Medical Transportation	837 Professional
Emergency Transportation	837 Professional
Hospital-based Clinic	837 Institutional
Free-standing Clinic	837 Professional

Billing Entity	Transaction
Physicians	837 Professional
Other medical professionals	837 Professional
Dentist	837 Dental

3.2.2   Service Center and Subcontractor Identifiers

During the registration process, the Contractor will be assigned a Service Center ID. If the Contractor will be submitting subcontracted encounter data, Subcontractor IDs will also be assigned. The Subcontractor ID will default to "000" when the Contractor does not use a Subcontractor or when the Contractor is submitting non-subcontracted encounter data. These values will be used to identify subcontracted data and non-subcontracted data in the EPS.

SERVICE CENTER AND SUBCONTRACTOR ID					
Trans Type	Element Name	Loop	Segment	Element	Value
837	Security Information Qualifier		ISA	02	Use 4-character Service Center ID assigned by DMAS.

	Interchange Sender ID		ISA	06	If Contractor is submitting non-subcontracted encounter data, use:
					    Service Center ID + Subcontractor ID default "000"
					
					If Contractor is submitting subcontracted encounter data, use:
					    Service Center ID + Subcontractor ID

	Application Sender's Code		GS	02	
NCPDP	Transaction Header		ØØ-File Control	K1	

837 Example
Example 1: Non-subcontracted data

Sample data:
    Service Center = `CP14`
    Subcontractor ID default = `000`
 	
ISA/GS segments:
 	
`ISA*03*`**`CP14`**`    *00*          *ZZ*`**`CP14000`**`       *ZZ*VAMES EPS   *160805*0509*^*00501*000020498*1*P*:~`
`GS*HC*`**`CP14000`**`*VAMES EPS*20170522*0708*20498*X*005010X222A1~`

Example 2: Subcontracted data

Sample data:
    Service Center = `CP14`
     Subcontractor ID = `001`
 	
ISA/GS segments:
 	
`ISA*03*`**`CP14`**`    *00*          *ZZ*`**`CP14001`**`       *ZZ*VAMES EPS   *160805*0509*^*00501*000020498*1*P*:~`
`GS*HC*`**`CP14001`**`*VAMES EPS*20170522*0708*20498*X*005010X222A1~`

NCPDP Example
Example 1: Non-subcontracted data
Sample data:
Service Center = `CP14`
Subcontractor ID default = `000`
NCPDP Transaction Header:
`STX`00TCP14000   0066546201704060359P125148010900   `ETX`
Example 2: Subcontracted data
Sample data:
Service Center = `CP14`
Subcontractor ID = `001`
NCPDP Transaction Header:
`STX`00TCP14001   0066546201704060359P125148010900   `ETX`

3.2.3   Paid & Denied Encounters

The contractor is responsible for submitting paid and denied encounters to DMAS for all transaction types (837 and NCPDP). For NCPDP transactions, the contractor should submit denied encounters only for those claims that were denied for reasons other than missing information.

The EPS will use the PYMS Payment Status value that is populated by the Payer on the inbound encounter transaction (K3 segment) to determine if the encounter is paid or denied. See section 3.2.10.1 for further details.

3.2.4   Subcontractor Encounters

Subcontractor encounters must be submitted to DMAS by the Contractor. The subcontracting entity may not post encounter transactions directly to DMAS. All subcontractor encounters should be EDI compliance-checked through SNIP Levels 1, 2, 3, and 4 prior to submission.

3.2.5   Payer Claim Identifier

The EPS requires a unique Payer Claim ID for each encounter transaction (original, replacement, and void/reversal). It is the Contractor's responsibility to ensure that subcontractor encounter transactions also contain a unique Payer Claim Identifier and that there is no duplication between subcontracted Payer Claim IDs and the Contractor's Payer Claim IDs. Please see section 3.2.8 for details regarding the duplicate encounter transaction validation in EPS.

RESEND and RESUBMISSION transactions are an exception as these transactions must contain the Payer Claim ID of the transaction that is being corrected. See section 5 for further detail.

PAYER CLAIM IDENTIFIER						
Name	Trans Type	Loop	Segment	Element	Value	Requirements
Payer Claim ID	837P 837I 837D	2300	CLM	01	Payer Claim ID	Must be unique for original, replacement, and void transactions. Exception: RESEND & RESUBMISSION (See section 5)
	NCPDP		AM01	CX	99	Patient ID Qualifier
				CY	Payer Claim ID	Must be unique for B1 transactions (new billings). Exception: RESEND & RESUBMISSION (See section 5)

3.2.6   National Provider Identifier (NPI) / Atypical Provider Identifier (API)

The NPPES-registered NPI must be included when reporting provider information on the Encounter.   When reporting provider information on the encounter, NPI must be used. The only exception to this requirement is when reporting services provided by consumer-directed attendants (see section 3.2.13).

Please note that the PSF-113 provider file must contain an entry (including NPI) for each entity (MCO, DMAS NEMT broker, etc.) that submits encounters to DMAS.

3.2.7   Provider Taxonomy

A valid taxonomy code is required for each provider NPI that is present on the encounter at the loops shown below. The taxonomy code must be found on the EPS Cache Code set to be considered valid. In addition, the provider taxonomy code must be found in the PSF-113 Provider file and be associated with the provider.

Please see section 3.2.9.1 for special considerations regarding taxonomy for Transportation encounters.

PROVIDER TAXONOMY						
Trans Type	Doc/Line Level	Loop	Segment	Element	Value	Requirements
837P	Document	2000A	PRV	03	Taxonomy code	• Taxonomy code must be present for each provider NPI on the encounter. • Taxonomy code must be found on the EPS Cache Code set. • For transportation services, the taxonomy code must be associated with a "transportation" taxonomy code on the EPS Cache Code set. • Taxonomy code must be found on the PSF-113 Provider file and associated with the provider on the encounter.
		2310B				
	Line	2420A				
837I	Document	2000A				
		2310A				
837D	Document	2000A				
		2310A				
		2310B				
		2310D				
	Line	2420A				
		2420B				
NCPDP	NCPDP does not support taxonomy code					

3.2.8 Duplicate Encounter Transactions

Duplicate encounter transactions should not be submitted to EPS. To guard against this, EPS has business rules that will edit to ensure that only unique Payer Claim IDs are received. The logic below is used to identify duplicate encounter transactions in EPS.

For 837 and NCPDP transactions, EPS performs a duplicate encounter transaction check based on Payer Claim ID. If two transactions are received with the same Payer Claim ID, the second transaction will fail as a duplicate Payer Claim ID, regardless of the payment status, *since a unique Payer Claim ID is expected* on all 837 and NCPDP transactions. When the second transaction is processed, its status will be automatically set to INACTIVE. It will not appear on the EPS Failure Log report or be included in the Data Quality Scorecard "encounter completeness" measure.

NCPDP transactions are validated at an additional level for uniqueness. The second check is based on matching Servicing Provider NPI + DOS + Rx No. + NDC. *Encounters with a <u>denied</u> payment status are excluded from this matching logic.* If a second <u>paid</u> B1 transaction matching all four key fields is received and the first B1 transaction has not been reversed by a B2 transaction, it will fail as a duplicate. Its status will be automatically set to INACTIVE. It will not appear on the EPS Failure Log report or be included in the Data Quality Scorecard "encounter completeness" measure.

RESEND and RESUBMISSION transactions are excluded from duplicate encounter transaction editing as these transactions must contain the Payer Claim ID of the transaction that is being corrected. See section 5 for further detail.

EPS Duplicate Transaction Check Data Elements - Level 1				
TRANS TYPE	**NAME**	**LOOP**	**SEGMENT**	**ELEMENT / FIELD**
837P 837I 837D	Payer Claim ID	2300	CLM	01
NCPDP	Payer Claim ID		AM01	CY

EPS Duplicate Transaction Check Data Elements - Level 2			
TRANS TYPE	**NAME**	**SEGMENT**	**FIELD**
NCPDP	Servicing Provider NPI	Transaction Header	201-B1
	Date of Service (DOS)		401-D1
	Prescription No.	AM07	402-D2
	National Drug Code (NDC)		407-D7

3.2.9   Transportation Services

The 837P (professional) transaction must be used for submitting <u>all</u> transportation services. This includes emergency and non-emergency transportation services as there are no exceptions to this requirement. See section 3.2.1 for further documentation regarding EDI transactions.

3.2.9.1   Identifying Transportation Encounters in EPS

Each transportation encounter must contain a taxonomy code from the EPS Cache Code set TRANSPTAXONOMY at the BILLING provider level. The EPS will use the billing provider taxonomy code to identify the encounter as containing transportation services. Once identified as a "transportation" encounter, the transaction will be subject to all EPS transportation business rules/edits.

Only taxonomy codes in the EPS TRANSPTAXONOMY Cache Code set may be used for transportation providers. The Cache Code set can be viewed in the EPS Portal. DMAS will consider additions to the code set upon request.

TRANSPORTATION Identifying Transportation Encounters in EPS					
Trans Type	**Loop**	**Segment**	**Element**	**Value**	**Requirement**
837P	2000A	PRV	01	BI	• Billing provider taxonomy is required. • For an encounter to be identified as a "transportation" encounter, a transportation taxonomy code must be present at the BILLING provider level.
			02	PXC	
			03	Value from EPS Cache Code Set TRANSPTAXONOMY	

3.2.9.2 Trip Information

Encounters that contain transportation services other than emergency and non-emergency ambulance must contain supplemental trip information. The requirement for each trip information field is provided on the transportation data requirements grid in section 3.2.9.11.

On the 837P, the CR109 element is used to capture the additional data shown below. The trip data is reported by using a field label ("Field" column in chart below), a hyphen immediately following, and the field value. The field label must appear exactly as shown in the chart. Field/value pairs may be in any order. There must be at least one space to serve as a delimiter between the pairs. See 837P example below.

Trip number on the encounter record must be nine digits. If the payer's internal trip number is less than nine digits, the trip number on the encounter record must be right-justified and zero-filled to equal nine digits.

Element CR106 must be populated with zero as DMAS will use the mileage value in loop 2400, SV104 for data analysis.

<table>
<tr><td colspan="6" align="center">**TRANSPORTATION**
Trip Information</td></tr>
<tr><td>**Doc/Line Level**</td><td>**Trans Type**</td><td>**Loop**</td><td>**Seg**</td><td>**Elem**</td><td>**Description**</td></tr>
<tr><td rowspan="2">Document Level</td><td rowspan="2">837P</td><td rowspan="2">2300</td><td>CR1</td><td>06</td><td>Populate with a value of zero</td></tr>
<tr><td>CR1</td><td>09</td><td>

FIELD	DESCRIPTION	USAGE	FORMAT	SIZE	VALID VALUE
TRIPNUM	Trip Number*	See section 3.2.9.11	nnnnnnnnn	9	000000001-999999999

</td></tr>
<tr><td rowspan="2">Line Level</td><td rowspan="2">837P</td><td rowspan="2">2400</td><td rowspan="2">CR1</td><td rowspan="2">09</td><td>

FIELD	DESCRIPTION	USAGE	FORMAT	SIZE	VALID VALUE
PUTIME	Pick-up time	See section 3.2.9.11	HHMM	4	00-23[HH]00-59[MM]
DOTIME	Drop-off time	See section 3.2.9.11	HHMM	4	00-23[HH]00-59[MM]
PULOC	Pick-up location code	See section 3.2.9.11	XX	2	Value from PICKUPDROPOFFLOC Cache Code Set
DOLOC	Drop-off location code	See section 3.2.9.11	XX	2	Value from PICKUPDROPOFFLOC Cache Code Set
TRIPTYPE	Trip Type	See section 3.2.9.11	XX	2	TRIPTYPECODE
TRIPLEG	Trip Leg	See section 3.2.9.11	X	1	TRIPLEG

</td></tr>
<tr><td>

Notes:
- There should be at least one space between the pair values.
- Each pair must have one hyphen (-) between the field and value.
- The pair values may be in any order.
- *Trip number must be 9 digits. If less than 9 digits, must be right-justified and zero-filled.

</td></tr>
</table>

837P - Example	
Sample Data	Note: Sample data contains a provider internal trip number that is less than 9 digits. `TRIPNUM=000023  TRIPTYPE=I  TRIPLEG=A  PULOC=AD  PUTIME=1820  DOLOC=HO  DOTIME=1850`
CR1 segment example	`CR1****A*DH*0***TRIPNUM-000000023 TRIPTYPE-I TRIPLEG-A PULOC-AD PUTIME-1820 DOLOC-HO DOTIME-1850`

3.2.9.3 Pick-up/Drop-off Location Name and Address

The encounter must contain the pick-up location name and address for all transportation services except emergency ambulance services, third party liability/crossover claims, and paper claims submitted on the CMS-1500. The encounter must contain the drop-off location name and address for all transportation services. For claims submitted on the CMS-1500, the drop-off location should be recorded in Block 32 "Service Facility Location Information".

<table>
<tr><td colspan="8" align="center">TRANSPORTATION
Pick-up / Drop-off Location</td></tr>
<tr><th>Trans Type</th><th>Doc/Line Level</th><th>Loop</th><th>Segment</th><th>Element</th><th colspan="2">Value</th><th>Requirement</th></tr>
<tr><td rowspan="24">837P</td><td colspan="7" align="center">Pick-up Location</td></tr>
<tr><td rowspan="6">Document</td><td rowspan="6">2310E</td><td rowspan="2">NM1</td><td>01</td><td colspan="2">PW=Pick-up location</td><td rowspan="11">Mandatory for most transactions

Exceptions:
• Emergency ambulance services (EPS EMERAMBUPROCS Cache Code set)
• Third party liability/crossover claims
• Paper claims submitted directly to Plan on CMS-1500

Please see the transportation data requirements grid in section 3.2.9.11 for further information.</td></tr>
<tr><td>02</td><td colspan="2">2=Non-person entity</td></tr>
<tr><td>N3</td><td>01</td><td colspan="2">Address</td></tr>
<tr><td rowspan="3">N4</td><td>01</td><td colspan="2">City</td></tr>
<tr><td>02</td><td colspan="2">State</td></tr>
<tr><td>03</td><td colspan="2">Postal Code</td></tr>
<tr><td rowspan="6">Line</td><td rowspan="6">2420G</td><td rowspan="2">NM1</td><td>01</td><td colspan="2">PW=Pick-up location</td></tr>
<tr><td>02</td><td colspan="2">2=Non-person entity</td></tr>
<tr><td>N3</td><td>01</td><td colspan="2">Address</td></tr>
<tr><td rowspan="3">N4</td><td>01</td><td colspan="2">City</td></tr>
<tr><td>02</td><td colspan="2">State</td></tr>
<tr><td>03</td><td colspan="2">Postal Code</td></tr>
<tr><td colspan="7" align="center">Drop-off Location</td></tr>
<tr><td rowspan="6">Document</td><td rowspan="6">2310F</td><td rowspan="2">NM1</td><td>01</td><td colspan="2">45=Drop-off location</td><td rowspan="12">Mandatory for most transactions

Exceptions:
• When QL or SH modifier is present

Please see the transportation data requirements grid in section 3.2.9.11 for further information.</td></tr>
<tr><td>02</td><td colspan="2">2=Non-person entity</td></tr>
<tr><td>N3</td><td>01</td><td colspan="2">Address</td></tr>
<tr><td rowspan="3">N4</td><td>01</td><td colspan="2">City</td></tr>
<tr><td>02</td><td colspan="2">Statue</td></tr>
<tr><td>03</td><td colspan="2">Postal Code</td></tr>
<tr><td rowspan="6">Line</td><td rowspan="6">2420H</td><td rowspan="2">NM1</td><td>01</td><td colspan="2">45=Drop-off location</td></tr>
<tr><td>02</td><td colspan="2">2=Non-person entity</td></tr>
<tr><td>N3</td><td>01</td><td colspan="2">Address</td></tr>
<tr><td rowspan="3">N4</td><td>01</td><td colspan="2">City</td></tr>
<tr><td>02</td><td colspan="2">State</td></tr>
<tr><td>03</td><td colspan="2">Postal Code</td></tr>
</table>

3.2.9.4 Trip Legs

Each trip leg must be reported on the Service line (loop 2400, LX) of the encounter. Please note that pick-up and drop-off name and address location information is required at both the Header level (loops 2310E/2310F) and the Line level (loops 2420G/2420H). The Header level pick-up and drop-off location information should reflect the first leg of the trip reported on the first service line (LX*1), regardless of the number of trip legs. In summary, EPS requires pick-up and drop-off location information at the Header level and on every trip leg/service line. See section 3.2.9.3 for exceptions to reporting pick-up and drop-off location information on transportation encounters.

837P Example TRANSPORTATION – TRIP LEGS Single-Leg Trip

Example: One-leg trip ONLY
 	
Header Level (Home to Doctor)
`CR1*LB*140**A*DH*20***TRIPNUM-000000001~`
`HI*ABK:A228~`
`NM1*DN*1*YOKOIS*NANCY*U***XX*1780629865~`
`NM1*82*1*AGUIAR*MARIA*A***XX*1306908413~`
`PRV*PE*PXC*3416A0800X~`
`NM1*77*2*CHKDOUTPATIENT DEPARTMENT*****XX*1164501581~`
`N3*601 CHILDRENS LN~`
`N4*NORFOLK*VA*89502~`
`NM1*PW*2~`
`N3*123 ANYWHERE DR~`
`N4*NORFOLK*VA*89505~`
`NM1*45*2~`
`N3*601 CHILDRENS LN~`
`N4*NORFOLK*VA*89505~`
 	
Line Level (Home to Doctor)
`LX*1~`
`SV1*HC:T2003*50*UN*25***1~`
`CR1*LB*140**A*DH*0***PUTIME-0900 DOTIME-0934 TRIPTYPE-X TRIPLEG-1 PULOC-RE DOLOC-DO~`
`DTP*472*D8*20170321~`
`REF*6R*124109261~`
`K3*PYMS-P~`
`NM1*PW*2~`
`N3*123 ANYWHERE DR~`
`N4*NORFOLK*VA*89505~`
`NM1*45*2~`
`N3*601 CHILDRENS LN~`
`N4*NORFOLK*VA*89505~`
`SVD*CP13*25*HC:T2003**1~`
`CAS*CO*45*25~`
`DTP*573*D8*20170325~`

837P Example
TRANSPORTATION – TRIP LEGS
Multi-Leg Trip

Example: Two-leg trip

Header Level (Home to Doctor)
```
CR1*LB*140**A*DH*20***TRIPNUM-000000001~
HI*ABK:A228~
NM1*DN*1*YOKOIS*NANCY*U***XX*1780629865~
NM1*82*1*AGUIAR*MARIA*A***XX*1306908413~
PRV*PE*PXC*3416A0800X~
NM1*77*2*CHKDOUTPATIENT DEPARTMENT*****XX*1164501581~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89502~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
```

Line Level (Leg 1: Home to Doctor / Leg 2: Doctor to Home)
```
LX*1~
SV1*HC:T2003*50*UN*25***1~
CR1*LB*140**A*DH*0***PUTIME-0900 DOTIME-0934 TRIPTYPE-X TRIPLEG-1 PULOC-RE DOLOC-AD~
DTP*472*D8*20170321~
REF*6R*124109261~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
SVD*CP13*25*HC:T2003**1~
CAS*CO*45*25~
DTP*573*D8*20170325~
LX*2~
SV1*HC:T2003*50*UN*25***1~
CR1*LB*140**A*DH*0***PUTIME-1600 DOTIME-1634 TRIPTYPE-X TRIPLEG-2 PULOC-AD DOLOC-RE~
DTP*472*D8*20170321~
REF*6R*124109262~
K3*PYMS-P~
NM1*PW*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
SVD*CP13*25*HC:T2003**1~
CAS*CO*45*25~
DTP*573*D8*20170325~
```

3.2.9.5   Third-Party Liability (TPL) / Crossover Transportation Claims

As a best practice for TPL and crossover claims, please send the accurate trip information in the CR1 segment if it is available. If not available, trip information should be omitted and default values should not be used. In this situation, the EPS trip information rules will be relaxed.

Please see the transportation data requirements grid in section 3.2.9.11 for further information.

3.2.9.6   Transportation-Related Services & Special Cases

Transportation-related services such as gas reimbursement, hotel charges, meals, escort lodging, escort meals, parking fees, tolls, and transportation provided by family members, neighbors, case workers, transportation attendants, etc. should be reported on the encounter at the line level as shown in the example below. Please note that "transportation attendant" (proc code T2001) should not be confused with "attendant care services" (proc code S5125). It should also be noted that taxi cabs are not considered to be special cases. A list of transportation-related services and special case procedure codes may be found on the EPS web portal.

Please see the transportation data requirements grid in section 3.2.9.11 for further information.

TRANSPORTATION						
Transportation-related Services & Special Cases						
Trans Type	**Doc/Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Line	2420D	NM1	01	DQ	Mandatory at the Line Level
				02	1	
				03	Provider Last Name	
				04	Provider First Name	
			REF	01	LU	
				02	Trip Number	

837P - Example
Transportation-Related Services & Special Cases
Procedure Codes: A0090, A0110, A0120, A0140, A0160, A0170, A0180, A0190, A0200, A0210, T2001

Loop 2000B - Subscriber

```
SBR*S*18*******MC~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB FRSTNM*E***MI*999999999999~
N3*100 ANYSTREET LANE~
N4*AFTON*VA*229202834~
DMG*D8*19440817*F~
NM1*PR*2*VAMES EPS*****PI*DMAS MEDICAID~
```

Loop 2300 – Claim

```
CLM*709101003009*100***99:B:1*Y*A*Y*Y~
REF*D9*709101003009~
K3*DREC-20170920 DADJ-20170925 DPYM-20171006 PYMS-P~
K3*CN101-05~
CR1****A*DH*0***TRIPNUM-000100003~
HI*ABK:R99~
NM1*DQ*1*PROVIDER LSTNM*PROVIDER FRSTNM~
REF*LU*000100003~
```

> *Document Level -*
> *Provider Name (Hotel, Per Diem, Family member, etc.) - OPTIONAL*
> *Trip Number - OPTIONAL*

Loop 2310E – Ambulance Pick-up Location

> *Document Level - Pick-up Location - REQUIRED*

```
NM1*PW*2~
N3*238 PICKUP ADDRESS~
N4*AFTON*VA*229202834~
```

Loop 2310F – Ambulance Drop-off Location

> *Document Level - Drop-off Location - REQUIRED*

```
NM1*45*2*RONALD MCDONALD HOUSE~
N3*3727 14TH ST NE~
N4*WASHINGTON*DC*200173004~
SBR*P*18*******MC~
AMT*D*100~
OI***Y***Y~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB FRSTNM*E***MI*999999999999~
NM1*PR*2*DEPT OF MED ASSIST SVCS*****PI*NE01~
```

Loop 2420D – Supervising Provider Information

```
LX*1~
SV1*HC:A0180:RD*100*UN*1***1~
CR1****A*DH*0***TRIPTYPE-I TRIPLEG-A PULOC-RE PUTIME-1600 DOLOC-UN DOTIME-1700~
DTP*472*D8*20170910~
K3*PYMS-P~
K3*CN101-05~
NM1*DQ*1*PROV LSTNM*PROV FRSTNM~
REF*LU*000100003~
```

> *Line Level CR1 data OPTIONAL*

> *Line Level -*
> *Provider Name (Hotel, Per Diem, Family member, etc.) - REQUIRED*
> *Trip Number - REQUIRED*
> *(Must be same value as document level trip number - 2300, CR109 TRIPNUM)*

Loop 2420G – Ambulance Pick-up Location

> *Line Level - Pick-up Location - REQUIRED*

```
NM1*PW*2~
N3*238 PICKUP ADDRESS~
N4*AFTON*VA*229202834~
```

Loop 2420H – Ambulance Drop-off Location

> *Line Level - Drop-off Location - REQUIRED*

```
NM1*45*2*RONALD MCDONALD HOUSE~
N3*3727 14TH ST NE~
N4*WASHINGTON*DC*200173004~
SVD*NE01*100*HC:A0180:RD**1~
DTP*573*D8*20171006~
```

3.2.9.7   Mass Transit Passes

Mass transit passes, such as bus or subway passes, must be reported to DMAS via encounter transactions using CPT code A0110. Please follow the procedures for special cases in section 3.2.9.6. The supervising provider in loop 2420D may vary based on how the pass is purchased which is listed in the chart below.

Please see the following sections for methods of reporting monthly, daily, and single-use passes. DMAS must receive encounter transactions as they appear in the vendor's claims processing system. For DMAS reconciliation purposes, EPS encounter transaction counts must match vendor claim counts.

Please see the transportation data requirements grid in section 3.2.9.11 for further information.

TRANSPORTATION — Mass Transit Passes						
Trans Type	Document / Line Level	Loop	Segment	Element	Value	Requirements
837P	Document	2300	SV1	01-2	A0110	• CPT code A0110 must be used for mass transit passes
	Line	2400	NM1	01	DQ	• EDI qualifier to indicate Supervising Provider segment
				03	Last name	• If the member purchases the pass and is reimbursed, populate supervising provider last name with member last name • If the transportation vendor purchases the pass and sends it to the member, populate supervising provider last name with transit company name.
				04	First name	• If the member purchases the pass and is reimbursed, populate supervising provider first name with member first name

3.2.9.7.1   Mass Transit - Additional Dates & Payment Status

For Mass Transit Passes, the following definitions will be used for the required additional date and payment status information that is reported on the K3 segment. Please note that these definitions override the descriptions listed in Section 3.2.10.1.

Document Level
- Date of Receipt (DREC) = Date that the pass is sent to the member (mandatory)
- Date of Adjudication (DADJ) = Date of Service (mandatory)
- Date of Payment (DPYM) = Date of Service (mandatory)
- Payment Status (PYMS) = Payment status will always be paid (mandatory)

Line Level
- Payment Status (PYMS) = Payment status will always be paid (mandatory)

3.2.9.7.2   Mass Transit - Monthly Passes

Monthly mass transit passes may be reported via encounter transaction(s) in one of the two ways:

- Submit the first encounter transaction with the full price of the monthly pass <u>on the first date of service.</u> Subsequent encounter transactions should be submitted for each date of service with a $0 payment amount.

  Example: Monthly bus pass cost $35 with 10 dates of service.

  First encounter transaction will be submitted <u>on the first date of service</u> for the month with a payment amount of $35. Nine encounter transactions will follow for each date of service with a payment amount of $0.

  OR

- Submit an encounter transaction for each date of service, dividing the cost of the monthly pass by the number of date of service trips for the monthly pass timeframe.

  Example: Monthly transit pass cost $35 with 10 dates of service.

  Ten encounter transactions will be submitted. Each encounter transaction for each date of service will have a payment amount of $3.50.

3.2.9.7.3   Mass Transit - Daily or Single-use Passes

Daily or single-use passes may be reported in one encounter transaction with the cost of the single pass as the payment amount <u>on the date of service.</u>

3.2.9.8   Services provided by a Transportation Network Company (TNC)

The TNC company (e.g. Uber, Lyft, UZURV) should enroll to get an NPI number and Taxonomy Code. If the TNC does not have an NPI and Taxonomy code, the broker/internal transportation's NPI with Taxonomy code 172A00000X should be used. Do not use an API. Specify the Provider (payee) as "TNC– and the name of the TNC company" in Loops 2310D, NM103 and 2420D, NM103. (Examples: "TNC–UBER" or "TNC–Lyft".) Use CPT A0120 (*Non-emergency transportation: mini-bus or other transportation systems*). The required trip information in Loop 2400 should also be provided. Different TNCs should not be recorded on the same encounter transaction.

Please see the transportation data requirements grid in section 3.2.9.11 for further information.

837P - Example
Services provided by a Transportation Network Company (TNC)
Examples: UBER, LYFT, UZURV

Loop 2000B - Subscriber
```
SBR*P*18*******MC~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB FRSTNM*E***MI*999999999999~
N3*100 ANYSTREET LANE~
N4*AFTON*VA*229202834~
DMG*D8*19640817*M~
NM1*PR*2*VAMES EPS*****PI*DMAS MEDICAID~
```

Loop 2300 – Claim
```
CLM*709101003015*100***99:B:1*Y*A*Y*Y~
REF*D9*909131003009~
K3*DREC-20180320 DADJ-20180322 DPYM-20180325 PYMS-P~
K3*CN101-09~
CR1****A*DH*0***TRIPNUM-000000105~
HI*ABK:R99~
```

Loop 2310D – Supervising Provider Information
```
NM1*DQ*1*TNC-UBER~         ←  Document Level -
REF*LU*000000105~               "TNC-" prefix + TNC company name  (REQUIRED)
SBR*P*18*******MC~
AMT*D*270~
OI***Y*P**Y~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB*SUBSCRIB FRSTNM***MI*999999999999~
NM1*PR*2*MCO NAME*****PI*MM449~
```

Loop 2400 – Service Line
```
LX*1~
SV1*HC:A0120:RD*100*UN*1***1~      ←  Must use CPT code "A0120"
CR1****A*DH*0***TRIPTYPE-I TRIPLEG-A PULOC-RE PUTIME-1600 DOLOC-UN DOTIME-1700~
DTP*472*D8*20180315~
K3*PYMS-P~
K3*CN101-04~                         Line Level -
NM1*DQ*1*TNC-UBER~         ←          "TNC-" prefix + TNC company name  (REQUIRED)
REF*LU*000000105~          ←  Required line level trip number must be present
```

3.2.9.9   Ambulance Services

3.2.9.9.1   Emergency and Non-Emergency Services must be reported separately

Non-emergency and emergency services must be reported on separate encounter records. These services must not be mixed on the same encounter transaction.

3.2.9.9.2   Emergency and Non-Emergency Ambulance Services - Service & Mileage Code Reporting

Encounters that contain the procedure codes listed below for Land, Stretcher Van, Air Fixed Wing, or Air Rotor Wing ambulance services must contain service code and coordinating mileage code information. One line will contain the service code information and the other line will contain the coordinating mileage code information. Two lines are mandatory for all ambulance claims (other services may be present on the encounter as well). Mileage code/service code lines must be back-to-back and can be reported in any order.

Please see the transportation data requirements grid in section 3.2.9.11 for further information.

TRANSPORTATION			
Ambulance Services - Service & Mileage Code Reporting			
Transportation	**Procedure Code**		
Mode	**Service Code**		**Mileage Code**
Land	A0225 A0428 A0433 A0426 A0429 A0434 A0427 A0432 A0999		A0425
Stretcher Van (non-emergency)	T2005		T2049
Air Fixed Wing	A0430		A0435
Air Rotor Wing	A0431		A0436

3.2.9.9.3   Emergency and Non-Emergency Ambulance Services – Place of Origin/Destination Modifiers (EPS AMBUMODIFERS Cache Code set)

An encounter that contains an ambulance service must contain a two-letter modifier that will identify the place of origin and destination of the ambulance trip. The first letter will describe the origin of the transport, and the second letter will describe the destination (Example: For a patient that is picked up at home and is transported to the hospital, the modifier to describe the origin and destination would be "RH"). The two-letter modifier used must be found on the EPS AMBUMODIFIERS Cache Code set. Do not use values from the EPS PICKUPDROPOFF Cache Code set.

TRANSPORTATION						
Ambulance Services – Place of Origin/Destination						
(EPS AMBUMODIFERS Cache Code Set)						
Trans Type	**Document/ Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Line	2400	SV1	01-3	Procedure Code Modifier	• Ambulance services must contain procedure code modifiers to identify place of origin and destination. • The procedure code modifiers must be on the EPS AMBUMODIFERS Cache Code set.

3.2.9.9.4   Non-Emergency Ambulance Services – Medicare Affirmed/Non-affirmed Number

Medicare affirmed/Non-affirmed numbers for ambulance services should be reported on the encounter when applicable.

<table>
<tr><td colspan="7" align="center">TRANSPORTATION
Ambulance Services - Crossover Claims</td></tr>
<tr><td>Trans Type</td><td>Document/ Line Level</td><td>Loop</td><td>Segment</td><td>Element</td><td>Value</td><td>Requirements</td></tr>
<tr><td rowspan="2">837P</td><td rowspan="2">Document</td><td rowspan="2">2330B</td><td rowspan="2">REF</td><td>01</td><td>G1
(Prior Authorization)</td><td>Mandatory when applicable</td></tr>
<tr><td>02</td><td>Affirmed /
Non-affirmed number</td><td>Mandatory when applicable</td></tr>
</table>

3.2.9.10 Best Practices for Reporting Deadhead Mileage When Paid as a Separate Line Item

Deadhead miles are miles driven by a transportation provider without a member on-board.

When the deadhead miles are paid as a separate line item, the "TP" modifier must be used along with the appropriate transportation CPT/mileage procedure code (e.g. S0215).

<table>
<tr><td align="center">837P Example
TRANSPORTATION
Deadhead Miles – When Paid as a Separate Line Item</td></tr>
</table>

Loop 2400 – Service Line

```
LX*1~
SV1*HC:A0100*20*UN*14***1~
CR1****A*DH*0***TRIPTYPE-I TRIPLEG-1 PULOC-RE PUTIME-0750 DOLOC-UN DOTIME-0825~
DTP*472*D8*20171101~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE BLVD~
N4*RICHMOND*VA*23222~
NM1*45*2~
N3*987 ANYSTREET RD~
N4*HENRICO*VA*23294~
SVD*CPXX*20*HC:A0100**14~
DTP*573*D8*20171115~
LX*2~
SV1*HC:S0215:TP*25*UN*99***1~          ← TP Modifier must be used when deadhead
DTP*472*D8*20171101~                       mileage is paid as a separate line item
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE BLVD~
N4*RICHMOND*VA*23222~
NM1*45*2~
N3*987 ANYSTREET RD~
N4*HENRICO*VA*23294~
SVD*CPXX*25*HC:S0215:TP**99~
DTP*573*D8*20171115~
```

3.2.9.11 Transportation Data Requirements Grid

O = Optional   R = Required   S = Situational

DATA DESCRIPTION	EMERGENCY AMBULANCE (Non-mileage codes in EMERAMBUPROCS) WITH NO COB	TRANSPORTATION-RELATED SERVICES/SPECIAL CASES (Codes in TRANSREIMBPROCS) BUS PASSES (A0110 only) TNC SERVICES (A0120 only)	ANY ENCOUNTER WITH COB	NON-EMERGENCY AMBULANCE (Non-mileage codes in AMBUPROCCODES that are not in EMERAMBUPROC)	NON-EMERGENCY (Codes in TRANSPROCCODES that are not in AMBUPROCCODES, TRANSREIMBPROCS or BYPASS_TRANS_OTHER_SERVICE_PROCS)	NEMT CLAIMS SUBMITTED DIRECTLY TO THE PLAN (Typically CMS-1500 Paper Claims) EXCLUDES SPECIAL CASES, EMERGENCY AMBULANCE & COB PLEASE REFER TO THOSE COLUMNS
Claim Source	Any	Any	Any	Vendor/Broker/Internal Scheduler Subcontractor ID **NOT IN** TRANSBYPASS_SUBCONTRACTORS	Vendor/Broker/Internal Scheduler Subcontractor ID **NOT IN** TRANSBYPASS_SUBCONTRACTORS	Plan Subcontractor ID **IN** TRANSBYPASS_SUBCONTRACTORS
AMBULANCE ORIGIN/ DESTINATION MODIFIER	R	NA	S-Required for ambulance encounters	R	NA	S-Required for ambulance encounters
DROP-OFF LOCATION NAME, ADDR, CITY, STATE, ZIP	S – Required unless modifier is QL or SH	R	R	S – Required unless modifier is QL or SH	R	S – Required unless ambulance modifier is QL or SH
DROP-OFF LOCATION CODE	O	O	O	S – Required unless modifier is QL or SH	R	O
DROP-OFF TIME	O	O	O	S – Required unless modifier is QL or SH	R	O
PICK-UP LOCATION NAME, ADDR, CITY, STATE, ZIP	O	R	O	R	R	O
PICK-UP LOCATION CODE	O	O	O	R	R	O
PICK-UP TIME	O	O	O	R	R	O
SERVICE MILEAGE CODE	S – Required unless modifier is QL or SH	O	S-Required for T2005 and ambulance encounters without QL or SH modifier	S – Required unless modifier is QL or SH	S - Required for T2005	S – Required for T2005 and ambulance encounters without QL or SH modifier
TRANSPORTATION ATTENDANT for SPECIAL CASES or PURCHASER for BUS PASSES or TNC COMPANY NAME for TNC SERVICES	NA	R	NA	NA	NA	NA
TRIP NUMBER	O	R	O	R	R	O
TRIPLEG	O	O	O	R	R	O
TRIPTYPE	O	O	O	R	R	O

3.2.9.12 Transportation Cache Code Sets

Transportation Cache Code Set Name	Transportation Cache Code Set Description
AMBUMODIFERS	Origin and destination modifiers for ambulance encounters
AMBUPROCCODES	Service codes for emergency and non-emergency ambulance transportation
BYPASS_AMBUPROCCODES	Service codes that bypass the drop-off location address and drop-off time edits when a modifier in the PAT_DECEASED_MODS cache code set is present
BYPASS_TRANS_OTHER_SERVICE_PROCS	Non-transportation service codes (e.g., supplies, EKG) that may be present on a transportation encounter. The transportation edits do not set for these service codes.
EMERAMBUPROCS	Service and mileage codes for emergency ambulance transportation
MILEAGECODE	Mileage codes that require a specific transportation service code as indicated in the MILEAGE-SERVICE cache code set
MILEAGE-SERVICE	Required mileage and service code pairs. The mileage code must be submitted with the specified service code.
PAT_DECEASED_MODS	Ambulance modifiers that indicate a patient may not have been transported due to death.
PICKUPDROPOFFLOC	Pick-up and drop-off location codes
SERVICECODE	Service codes that require a specific mileage code as indicated in the SERVICE-MILEAGE cache code set
SERVICE-MILEAGE	Required service and mileage code pairs. The service code must be submitted with the specified mileage code.
TRANSBYPASS_SUBCONTRACTORS	The subcontractor ID that identifies encounters for non-emergency transportation claims that were submitted directly to the Plan. Some transportation edits are relaxed for paper claims that could not be submitted through the transportation broker/scheduling department.
TRANSBYPASSMODS	Modifiers to indicate deadhead miles. Some transportation edits are relaxed for deadhead mileage charges.
TRANSPROCCODES	CPT (service) codes that are accepted on a transportation encounter
TRANSPTAXONOMY	Taxonomy codes that indicate transportation providers
TRANSREIMBPROCS	Service codes for special case and transportation-related services such as gas reimbursement, hotel charges, meals, parking fees, tolls, bus passes and other transportation services.
TRIPLEG	Trip leg codes
TRIPTYPECODE	Trip type codes

3.2.10 Adjudication/Payment Information

3.2.10.1 Additional Dates & Payment Status

The Payer is required to provide additional dates and payment status information about the claim. The payment status will be required at the document and service line level. Please use the definitions below for encounters that originate from adjudication (original, replacement, void, etc.). For EPS corrections (RESEND or RESUBMISSION, see section 5 for further explanation), the date value should remain unchanged on the transaction unless the reason for the correction is to change/correct the date value.

For NCPDP transactions, the Date of Receipt, Date of Adjudication, and Date of Payment submitted in the 350-HN segment must be populated with the date for the time zone in which the transaction occurred. This requirement is to accommodate scenarios where there is a time zone difference between point-of-sale and adjudication.

The definitions below are applicable to all encounters except for services provided by Consumer-Directed Attendants (see section 3.2.13 for special instructions) and Transportation Mass Transit Passes (see section 3.2.9.7 for special instructions).

Document Level
- Date of Receipt (DREC) = Date that the Payer received the transaction from the provider (mandatory).
- Date of Adjudication (DADJ) = Date that the Payer adjudicated the transaction (mandatory).
- Date of Payment (DPYM) = Date that the Payer pays the claim (check date, remit date, or EFT date).
- Payment Status (PYMS) = Payment status will reflect whether the Payer's adjudication process considers the claim to be paid or denied (mandatory).

Line Level
- Payment Status (PYMS) = Payment status will reflect whether the Payer's adjudication process considers the service line to be paid or denied.

837 – Additional Payment Dates & Status					
Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Document Level	837P 837D 837I	2300	K3	01	**FIELD / DESCRIPTION / USAGE / FORMAT/VALUE** — DREC: Date of Receipt, Mandatory, CCYYMMDD; DADJ: Date of Adjudication, Mandatory, CCYYMMDD; DPYM: Date of Payment, Mandatory, CCYYMMDD; PYMS: Payment Status - Paid, Mandatory, P / Payment Status - Denied, D. **Note:** • There should be at least one space between the pair values • Each pair must have one hyphen(-) between the field and value • The pair values may be in any order
Line Level	837P 837D	2400	K3	01	**FIELD / DESCRIPTION / USAGE / FORMAT/VALUE** — PYMS: Payment Status - Paid, Mandatory, P / Payment Status - Denied, D
Line Level	837I	2400	NTE	02	**FIELD / DESCRIPTION / USAGE / FORMAT/VALUE** — PYMS: Payment Status - Paid, Mandatory, P / Payment Status - Denied, D

837 Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-x
K3 Segment	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P` `K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D`

NCPDP – Payment Date & Status					
Doc/Line Level	**Trans Type**	**Loop**	**Segment**	**Element**	**Description**
Document Level	NCPDP	AM	AM01	HN	<table><tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr><tr><td>DREC</td><td>Date of Receipt</td><td>Mandatory</td><td>CCYYMMDD</td></tr><tr><td>DADJ</td><td>Date of Adjudication</td><td>Mandatory</td><td>CCYYMMDD</td></tr><tr><td>DPYM</td><td>Date of Payment</td><td>Mandatory</td><td>CCYYMMDD</td></tr><tr><td>PYMS</td><td>Payment Status - Paid Payment Status - Denied</td><td>Mandatory</td><td>P D</td></tr></table>**Note:** • There should be at least one space between the pair values • Each pair must have one hyphen(-) between the field and value • The pair values may be in any order

NCPDP Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-x
HN Field	`HNDREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P` `HNDREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D`

3.2.10.2 Payment Amount & Date

The amount that the Payer paid the rendering provider must be reported on each encounter for a paid (non-denied) claim. The paid amount should reflect what the rendering provider was paid to provide services to the member and should not reflect a capitated or salaried reimbursement arrangement.

Denied claims should always have a payment amount of zero. Paid claims should contain a payment amount of zero or greater. Paid claims with a payment amount of zero should occur only under special circumstances. The "zero-paid" claim must not be considered a denied claim by the Payer. It must be considered an approved claim with a "zero-pay" paid amount.

Detailed (service line) adjudication/payment info should be reported when possible and as dictated by the Payer's billing system. Exceptions may include inpatient claims and price grouping such as EAPG.

The Payer must also include the date of the payment cycle in which the claim was paid or denied. This value is reported in the DTP segment with DTP01 = "573" and DTP03 containing the date value. Third-party payers should include a payment/denial date as well.

Loop 2320 (Other Subscriber Information) is used to report Payment/Adjudication information. Loop 2320 should be repeated for each payer that is involved in the payment of the claim (MCO entities are considered payers). Loop 2330B identifies the Payer and coordinating loop 2430 will contain the detailed adjudication/payment information. Please note the usage of the following elements:

- SBR01 (Payer Responsibility Sequence Number) indicates the order in which the claim is adjudicated when multiple payers are involved. Medicaid is always the payer of last resort.
- SBR09 (Filing Indicator Code) must be populated with the appropriate indicator to specify the carrier type. For example, Medicare Part B would use "MB". Medicaid (including MCOs) will use indicator "MC".
- Loop 2430, SVD01 (Other Payer Primary Identifier) must match the appropriate value in loop 2330B, NM109 (Other Payer Primary Identifier) for adjudication information to be complete.

837 – Adjudication/Payment Information
Trans Type	Loop	Segment	Element	Value	Description	Requirement

837P 837I	2320	SBR	01	Most common:
				  P=Primary
				  S=Secondary
				  T=Tertiary
				All TR3 values accepted
					Payer responsibility sequence number code; When multiple payers, Medicaid is always last.	Mandatory

			09	Most common:
				  MC=Medicaid/MCO
				  MA=Medicare A
				  MB=Medicare B
				  CI=Commercial Insurance
				All TR3 values accepted
					Claim Filing Indicator Code; Medicaid/MCO must use "MC".	Mandatory

		AMT	01	D	Payer Paid Amount	Mandatory
			02	Payment amount (COB)	COB Total Paid Amount	Mandatory when line amount not available
	2330B	NM1	09	Medicaid/MCO use Service Center Id	Other Payer Primary Identifier Must match 2430.SVD.01	Mandatory
	2430	SVD	01	Medicaid/MCO use Service Center Id	Other Payer Primary Identifier Must match 2320B.NM1.09	Mandatory
			02	Payment amount (line)	Line payment amount must be present when possible. Otherwise, COB total paid amount must be present (2320.AMT.02).	Mandatory when available
		DTP	01	573	Date Qualifier	Mandatory
			02	D8	Date – CCYYMMDD format	Mandatory
			03	Payment cycle date	Payment cycle in which the claim was paid or denied.	Mandatory

3.2.10.2.1   Single Payer

The example below shows an 837P encounter where only one payer was involved in the payment of the claim. 837I transactions will follow the same pattern.

PAYMENT INFORMATION 837P Example Single Payer	
Example 1: **Single Payer with Payment > 0**	**Example 2:** **Single Payer with Payment = 0** **(Non-denied "zero-paid" claim)**

`SBR*P*18*******MC~` ← *MC=Medicaid Primary*
`AMT*D*130~`
`OI***Y***Y~`
`NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~`
`N3*1329 ANYSTREET DR~`
`N4*ANYCITY*VA*229024939~`
`NM1*PR*2*PAYER NAME*****PI*CP01~`
`LX*1~`
`SV1*HC:99232*150*UN*1*21**1****Y~`
`DTP*472*D8*20170315~`
`SVD*CP01*130*HC:99232**1~` ← *Medicaid detailed payment info*
`CAS*CO*45*20~`
`DTP*573*D8*20170405~`
	`SBR*P*18*******MC~` ← *MC=Medicaid Primary*
	`AMT*D*0~`
	`OI***Y***Y~`
	`NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~`
	`N3*1329 ANYSTREET DR~`
	`N4*ANYCITY*VA*229024939~`
	`NM1*PR*2*PAYER NAME*****PI*CP01~`
	`LX*1~`
	`SV1*HC:99232*150*UN*1*21**1****Y~`
	`DTP*472*D8*20170315~`
	`SVD*CP01*0*HC:99232**1~` ← *Medicaid detailed payment info*
	`CAS*CO*45*150~`
	`DTP*573*D8*20170405~`

3.2.10.2.2   Third-party Liability (TPL)

If there is third-party liability (TPL) involved in the payment of the claim, the Contractor is required to submit the TPL adjudication/payment information in addition to his own payment information. This includes crossover or commercial claims submitted to the Medicaid plan/MCO where there is no Medicaid/MCO payment required or TPL in which there was a "zero payment". TPL may originate from other payers such as Medicare and Commercial carriers. When more than one third-party payment is involved, each third-party payer adjudication information must be reported separately via loop 2320. See example below.

PAYMENT INFORMATION
837P Example
TPL – Commercial Insurance

Example 1: Two Payers Commercial Payment = 0 and Medicaid Payment > 0	Example 2: Two Payers Commercial Payment > 0 and Medicaid Payment = 0

Example 1:

```
SBR*P*18*******CI~          ← Commercial Insurance Primary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MC~          ← Medicaid Secondary
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*0*HC:99232**1~   ← Commercial detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*166*HC:99232**1~      ← Medicaid detailed payment info
CAS*CO*45*24~
DTP*573*D8*20170411~
```

Example 2:

```
SBR*P*18*******CI~          ← Commercial Insurance Primary
AMT*D*50~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MC~          ← Medicaid Secondary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*70*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*50*HC:99232**1~   ← Commercial detailed payment info
CAS*CO*45*20~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~        ← Medicaid detailed payment info
CAS*CO*45*70~
DTP*573*D8*20170411~
```

Example 3: Three Payers Commercial Payment > 0, Medicare Payment > 0, and Medicaid Payment > 0

```
SBR*P*18*******CI~          ← Commercial Insurance Primary
AMT*D*100~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MB~          ← Medicare Secondary
AMT*D*43~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*M553~
SBR*T*18*******MC~          ← Medicaid Tertiary
AMT*D*95~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*365*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*100*HC:99232**1~  ← Commercial detailed payment info
CAS*CO*45*265~
DTP*573*D8*20170401~
SVD*M553*43*HC:99232**1~       ← Medicare detailed payment info
CAS*CO*45*322~
DTP*573*D8*20170410~
SVD*CP01*95*HC:99232**1~       ← Medicaid detailed payment info
CAS*CO*45*270~
DTP*573*D8*20170421~
```

3.2.10.2.3   Medicare

If there is Medicare payment involved with the claim, the Contractor is required to submit the Medicare adjudication/payment information in addition to his own payment information. This includes Medicare crossover claims submitted to the Medicaid plan/MCO for which there is no Medicaid/MCO payment required. Also included are claims in which there was a "zero payment" by Medicare. In addition, any claims for which the Medicaid plan/MCO was responsible for the Medicare covered services as a MA or D-SNP plan. The plans will calculate and separately record the Medicare and Medicaid liability for claim payment it makes to a provider as both the Medicare (MA or DSNP) and Medicaid payer. For 837 transactions, Medicare adjudication/payment information is reported in the same manner as TPL using loops 2320, 2330B, and 2430. Several 837P examples below show Medicare payment. 837I transactions will follow the same pattern.

ADJUDICATION/PAYMENT INFORMATION 837P Example Medicare

Example 1: Medicare Payment = 0 and Medicaid Payment > 0	Example 2: Medicare Payment > 0 and Medicaid Payment = 0

Example 1:

```
SBR*P*18*******MB~          ← MB=Medicare B Primary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~          ← MC=Medicaid Secondary
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*0*HC:99232**1~     ← Medicare B detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*166*HC:99232**1~    ← Medicaid detailed payment info
CAS*CO*45*24~
DTP*573*D8*20170411~
```

Example 2:

```
SBR*P*18*******MB~          ← MB=Medicare B Primary
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~          ← MC=Medicaid Secondary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*166*HC:99232**1~   ← Medicare B detailed payment info
CAS*CO*45*24~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~      ← Medicaid detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170411~
```

Example 3: Medicare Payment = 0 and Medicaid Payment = 0	Example 4: Medicare Payment > 0 and Medicaid Payment > 0

Example 3:

```
SBR*P*18*******MB~          ← MB=Medicare B Primary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~          ← MC=Medicaid Secondary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*0*HC:99232**1~     ← Medicare B detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~      ← Medicaid detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170411~
```

Example 4:

```
SBR*P*18*******MB~          ← MB=Medicare B Primary
AMT*D*125~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~          ← MC=Medicaid Secondary
AMT*D*45~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*125*HC:99232**1~   ← Medicare B detailed payment info
CAS*CO*45*65~
DTP*573*D8*20170405~
SVD*CP01*45*HC:99232**1~     ← Medicaid detailed payment info
CAS*CO*45*145~
DTP*573*D8*20170411~
```

3.2.11 Supplemental Contract Information

The EPS EDI compliance-check will not allow the CN1 segment on 837 transaction sets. If an encounter is submitted with this segment present at the document or line level, the EDI compliance check will set an error. In place of the CN1 segment, contractual information must be reported in the K3 segment. All encounters should identify how the claim was paid using values from the CN1 segment, but sent in the document level K3 segment. NOTE: Show the payment arrangement between the Payer and the provider, not the arrangement between DMAS and the Contractor.

<table>
<tr><th colspan="6">837 – Contract Information</th></tr>
<tr><th>Doc/Line Level</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr>
<td>Document Level</td>
<td>837P 837D 837I</td>
<td>2300</td>
<td>K3</td>
<td>01</td>
<td rowspan="2">

FIELD	DESCRIPTION	USAGE	SIZE	FORMAT/VALUE
CN101	Contract Type Code	Mandatory	2	99
CN102	Contract Amount	Optional	10	9999999.99
CN103	Contract Percent	Optional	3	999
CN104	Contract Code	Optional	3	XXX
CN105	Discount Percent	Optional	3	999
CN106	Version ID	Optional	4	XXX

Notes:
- The K3 segment containing CN1 data is mandatory.
- There should be at least one space between the pair values
- Each pair must have one hyphen (-) between the field and value
- The pair values may be in any order
- There is no CN1 segment in line level for 837I
</td>
</tr>
<tr>
<td>Line Level</td>
<td>837P 837D</td>
<td>2400</td>
<td>K3</td>
<td>01</td>
</tr>
</table>

<table>
<tr><th colspan="2">837 Example</th></tr>
<tr>
<td>Sample Format</td>
<td><code>CN101-99 CN102-9999999.99 CN103-999 CN104-xxx CN105-999 CN106-xxxx</code></td>
</tr>
<tr>
<td>K3 Segment with CN1 data requirements</td>
<td>

```
K3*CN101-01 CN102-50.23 CN103-34 CN104-AB1 CN105-57 CN106-V01
K3*CN101-01 CN102-50.23 CN103-34
K3*CN101-01 CN102-50.23 CN103-34 CN104-AB2
K3*CN101-01 CN102-50.23 CN104-AB1 CN105-57 CN106-V01
```
</td>
</tr>
</table>

3.2.12 Drug Services

3.2.12.1 Drug Rebates

DMAS is required by the Affordable Care Act to collect pharmacy rebates for drugs provided to Medicaid members in an outpatient setting who are enrolled in a managed care arrangement. For successful rebate collection, pharmacy/drug encounters must contain certain required fields, e.g., NDC, MCO payment date, MCO payment amount. Drugs may be submitted as pharmacy or medical for the following transaction types: Pharmacy (NCPDP), Professional (837P), and Institutional (837I).

The following data elements must be populated on the EDI transaction to DMAS for successful rebate collection from the manufacturer.

Data Element	EDI Reference		
	NCPDP Field	837P Loop.Segment.Element	837I (outpatient only) Loop.Segment.Element
MCO payment amount	431-DV	2430.SVD.02	Claim level: 2320.AMT.01=D 2320.AMT.02 OR Service level: 2430.SVD.02
MCO payment cycle date	443-E8	2430.DTP.01=573 2430.DTP.03	Claim level: 2330B.DTP01=573 2330B.DTP03 OR Service level: 2430.DTP.01=573 2430.DTP.03
Medicaid member ID	302-C2	2010BA.NM1.09	2010BA.NM1.09
NDC	407-D7	2410.LIN.02=N4 2410.LIN.03	2410.LIN.02=N4 2410.LIN.03
Drug unit of measure (837 only)	N/A	2410.CTP.05-1	2410.CTP.05-1
Drug unit/quantity	442-E7	2410.CTP.04	2410.CTP.04

3.2.12.2 340B Drugs

340B drugs are not eligible for rebate. The Contractor must have a process in place to identify 340B drugs so that the drug may be excluded from rebate collection. The technical requirements for 340B drug identification are shown below.

Trans Type	Loop	Segment	Element/ Field	Element/Field Name	Value	Requirement
DRUG SERVICES **Identifying 340B Drugs**						
NCPDP		AM07 AM11	420-DK 423-DN	Submission Clarification Code Basis of Cost Determination	20 08	• Submission Clarification Code AND Basis of Cost Determination must be populated • Maximum number of occurrences supported for Submission Clarification Code is 1
837P	2400	SV1	01 (3-6)	Procedure Modifier	UD	• Each drug service line must contain modifier UD along with the procedure code and NDC
837I	2400	SV2	02 (3-6)	Procedure Modifier	UD	• If bill type is 13x or 83x, each drug revenue line must contain modifier UD along with the procedure code and NDC

3.2.13 Consumer Directed Attendants

3.2.13.1 Reporting Attendant Information

For services provided by Consumer Directed attendants, information about the attendant must be reported on the encounter at the line level. An internal attendant ID will be accepted. Please note that Consumer Directed Attendants are not to be confused with Transportation Attendants.

Trans Type	Doc/Line Level	Loop	Segment	Element	Value	Notes
CONSUMER DIRECTED ATTENDANTS						
837P	Document	2310D	NM1	01	DQ	• Optional when reporting services rendered by Consumer Directed Attendants
				02	1	
				03	Attendant Last Name	
				04	Attendant First Name	
			REF	01	LU	
				02	Internal Attendant ID	
	Line	2420D	NM1	01	DQ	• Required when reporting services rendered by Consumer Directed Attendants
				02	1	
				03	Attendant Last Name	
				04	Attendant First Name	
			REF	01	LU	
				02	Internal Attendant ID	

837P - Example
Consumer Directed Attendants

Loop 2000B - Subscriber

```
SBR*P*18*******MC~
NM1*IL*1*ONE*CONSUMER****MI*111111111111~
N3*123 ELM ST~
N4*MADISON HEIGHTS*VA*24572~
DMG*D8*19500101*F~
NM1*PR*2*VAMES EPS*****PI*DMAS MEDICAID~
```

Loop 2300 - Claim

```
CLM*PPL_Test_3*270***12:B:1*Y*A*Y*Y~
K3*DREC-20170813 DADJ-20170815 DPYM-20170817 PYMS-P~
K3*CN101-09~
HI*ABK:E119~
NM1*DQ*1*Attendant*One~        ⟵  Provider - Document level - OPTIONAL
REF*LU*123450~                 ⟵  Internal Attendant Identifier
SBR*P*18*******MC~
AMT*D*270~
OI***Y*P**Y~
NM1*IL*1*ONE*CONSUMER****MI*111111111111~
NM1*PR*2*MCO NAME*****PI*CP19~
```

Loop 2420D - Supervising Provider Information

```
LX*1~
SV1*HC:S5126*90.00*UN*9.00***1~
DTP*472*RD8*20170806-20170812~
K3*PYMS-P~
NM1*DQ*1*Attendant*One~        ⟵  Provider - Line level - REQUIRED
REF*LU*123450~                 ⟵  Internal Attendant Identifier (Attendant #1)
LX*2~
SV1*HC:S5126*90.00*UN*9.00***1~
DTP*472*RD8*20170806-20170812~
K3*PYMS-P~
NM1*DQ*1*Attendant*Two~        ⟵  Provider - Line level - REQUIRED
REF*LU*6789100~                ⟵  Internal Attendant Identifier (Attendant #2)
LX*3~
SV1*HC:S5126*90.00*UN*9.00***1~
DTP*472*RD8*20170806-20170812~
K3*PYMS-P~
NM1*DQ*1*Attendant*Three~      ⟵  Provider - Line level - REQUIRED
REF*LU*111213~                 ⟵  Internal Attendant Identifier (Attendant #3)
```

3.2.13.2 Adjudication/Payment Information - Additional Dates & Payment Status

For adjudication/payment information on Consumer Directed Attendant encounters, the following definitions will be used for the required additional data and payment status. Please note that these definitions override the descriptions listed in Section 3.2.10.1.

Document Level
- Date of Receipt (DREC) = Payroll Start Date - date of the current pay cycle to which a timesheet has been submitted for a payment (mandatory).
- Date of Adjudication (DADJ) = Check Date – the date in the payroll cycle that the timesheet enters paid status (mandatory).
- Date of Payment (DPYM) = Date that the CD F/EA Agent is paid by the MCO (mandatory).

- Payment Status (PYMS) = Payment status will always be "P". The Contractor receives 100% voucher payment within specified payment term. As such, the 837 represents encounter data for paid claims (mandatory).

Line Level

- Payment Status (PYMS) = Payment status will always be "P". The Contractor receives 100% voucher payment within specified payment term. As such, the 837 represents encounter data for paid claims (mandatory).

<table>
<tr><td colspan="6" align="center">**837P – Consumer Directed Attendants**
Adjudication/Payment Information
Additional Payment Dates & Status</td></tr>
<tr><th>Trans Type</th><th>Doc/Line Level</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr>
<td>837P</td>
<td>Document Level</td>
<td>2300</td>
<td>K3</td>
<td>01</td>
<td>

FIELD	DESCRIPTION	USAGE	FORMAT/VALUE
DREC	Payroll Start Date	Mandatory	CCYYMMDD
DADJ	Check Date	Mandatory	CCYYMMDD
DPYM	Date CD F/EA Agent is paid by MCO	Mandatory	CCYYMMDD
PYMS	Payment Status – Paid	Mandatory	P

Note:
- **There should be at least one space between the pair values**
- **Each pair must have one hyphen (-) between the field and value**
- **The pair values may be in any order**

</td>
</tr>
<tr>
<td></td>
<td>Line Level</td>
<td>2400</td>
<td>K3</td>
<td>01</td>
<td>

FIELD	DESCRIPTION	USAGE	FORMAT/VALUE
PYMS	Payment Status - Paid	Mandatory	P

</td>
</tr>
</table>

<table>
<tr><td colspan="2" align="center">**837P - Example**</td></tr>
<tr><td>**Sample Format**</td><td>`DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-P`</td></tr>
<tr><td>**K3 Segment**</td><td>`K3*DREC-20170910 DADJ-20170915 DPYM-20170920 PYMS-P`</td></tr>
</table>

3.2.14 Newborns without Medicaid IDs

For newborns that do not have a Medicaid ID, the newborn encounter must contain a Medicaid ID that consists of the first 11-digits of the mother's Medicaid ID plus an alpha character in the 12th position. The alpha character is to be uppercase and in the range of "A" through "Z". Alpha characters should be used in succession, ascending to descending for each baby.

Example:
>Mom's   Medicaid ID = 111222333449
>Baby #1 Medicaid ID = 11122233344A
>Baby #2 Medicaid ID = 11122233344B
>Baby #3 Medicaid ID = 11122233344C

<table>
<tr><th colspan="7">Newborns without Medicaid IDs</th></tr>
<tr><th>Name</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Value</th><th>Requirements</th></tr>
<tr><td rowspan="2">Medicaid Member ID</td><td>837P
837I
837D</td><td>2010BA</td><td>NM1</td><td>09</td><td rowspan="2">Mother's Medicaid ID
+
Alpha character</td><td rowspan="2">Use first 11-digits of mother's Medicaid ID
Post-fix alpha character in the 12th position
Alpha character range "A-Z", used in succession, ascending to descending for each baby</td></tr>
<tr><td>NCPDP</td><td></td><td>AM04</td><td>302-C2</td></tr>
</table>

4   EPS Processing

The purpose of this section is to provide an overall understanding of how EPS will track and create a status on each encounter transaction. There is also discussion concerning Claim Frequency types and EPS requirements for Replacement and Void transactions.

4.1   Understanding EPS Encounter Tracking & Status

4.1.1   EPS-assigned File Identifier

Each EDI file that is submitted to DMAS will be assigned a unique File Identifier and returned to the Contractor via the Acknowledgement (ACK) file. Please see the *COV EDI Procedure Manual* for further details about the Acknowledgement file.   The File Identifier is an important number that is used by DMAS to track the file and is used for file identification when communicating with the Contractor.   The layout below displays the structure of the File ID along with an example: F17050100005CPCP01EP.

FILE IDENTIFIER							
	File Identifier	**Submission Date**	**File Count Per Day**	**Program Identifier**	**Service Center**	**Transaction Indicator**	**Transaction Type**
Position	1	2-7	8-12	13-14	15-18	19	20
Format/ Value(s)	F=File	YY [17-99] MM [01-12] DD [01-31]	00001-99999	CP= CCC Plus NE= Non-Emergency Medical Transportation M4=Medallion	CPxx NExx M4xx	E=Encounter F=FFS	P=837P I=837I D=837D N=NCPDP
Example	F	170501	00005	CP	CP01	E	P

4.1.2   EPS-assigned Transaction Control Number (TCN)

EPS assigns a Transaction Control Number (TCN) for every encounter transaction that is submitted to DMAS. The TCN is unique and is used for tracking the transaction through EPS processing. The layout below displays the structure of the TCN along with an example: T1705010000023BCPEPO.

Transaction Control Number (TCN)								
	Trans ID	**Submission Date**	**Trans Count Per Day**	**Submission Source**	**Program Identifier**	**Encounter / FFS**	**Trans Type**	**Claim Frequency**
Position	1	2-7	8-14	15	16-17	18	19	20
Format/ Value(s)	T = Trans ID	YY [17-99] MM [01-12] DD [01-31]	0000001-9999999	B=Batch R=Reprocess	CP= CCC Plus NE= Non-Emergency Medical Transportation M4=Medallion	E=Encounter	P=837P I=837I D=837D N=NCPDP	O=Original R=Replacement V=Void
Example	T	170501	0000023	B	CP	E	P	O

4.1.3 EPS-assigned Status

Once an Encounter is processed, the EPS will set the following statuses to define the state of the encounter: Validation Status, Active/Inactive Status, and Paid/Denied Status.

A Validation Status is set on the Encounter after all EPS business rules have been applied to the Encounter.   The Validation Status for the Encounter will be set to either PASS or FAIL after processing is complete. DMAS may override the Validation Status from FAIL to PASS, HOLD, or EXCLUDE if deemed necessary.

EPS maintains a versioning method for processed transactions. The current transaction will be flagged as ACTIVE (Validation status may be PASS or FAIL). For example, once a replacement transaction is processed by the EPS, the original transaction status is set to INACTIVE and the replacement transaction becomes ACTIVE. Inactive transactions are considered to be historical.

An EPS Paid/Denied status is set based on whether the Payer considers the claim to be paid or denied. The Payer will provide a Paid /Denied status on the inbound record (see section 3.2.10.1 PYMS Payment Status provided on the K3 segment).

EPS Status	Value	EPS Status Description
Validation Status	PASS	Transaction has passed all EPS business rules.
	FAIL	Transaction has failed one or more EPS business rules.
	HOLD	Transaction has been manually set to a HOLD status because it falsely failed an EPS business rule (transaction should have passed). Transaction will be reprocessed once the EPS business rule is functioning properly. Validation Status is assumed to be PASS for reporting purposes and for the Data Quality Scorecard.
	EXCLUDE	Transaction has been manually set to an EXCLUDE status to allow the transaction to be excluded and suppressed from all reporting. This status represents transactions that should have not been submitted to EPS. Active/Inactive Status is set to INACTIVE.
Active/Inactive Status	ACTIVE	The most recent transaction received for an encounter in EPS is considered the ACTIVE version. All prior transactions in the EPS, if any, are considered INACTIVE.
	INACTIVE	
Paid/Denied Status	PAID	The EPS Paid/Denied Status is set from the PYMS Payment Status value that is populated by the Payer on the inbound encounter transaction (K3 segment).
	DENIED	

4.2 Transaction Frequency

The EPS will accept a variety of Claim Frequency Type Codes (837) and Transaction Codes (NCPDP).   The chart below shows the values that EPS will accept.

837 Claim Frequency Type Code - EPS Acceptable Values					
Transaction Type	**Element Name**	**Loop**	**Segment**	**Element**	**Acceptable Values**
837P	Claim Frequency Type Code	2300	CLM	05-3	1, 7, 8
837I	Claim Frequency Type Code	2300	CLM	05-3	1, 2, 3, 4, 5, 7, 8, 9
837D	Claim Frequency Type Code	2300	CLM	05-3	1, 7, 8

NCPDP Transaction Code - EPS Acceptable Values					
Transaction Type	**Element Name**	**Segment**	**Element**	**Acceptable Values**	**Notes**
NCPDP	Transaction Code	Transaction Header	103-A3	B1, B2	EPS will not accept B3 (rebills).

4.2.1   Replacement Transactions

4.2.1.1   Professional and Institutional (837) Encounters

A professional or institutional (837) encounter with a Claim Frequency Code of "7" indicates a Replacement encounter transaction. The Replacement transaction must contain a "pointer" to the encounter that is to be replaced in the EPS (original or replacement). For the Replacement transaction to process successfully in the EPS, the following rules apply:

- The "pointer" value on the Replacement transaction must equal the Payer Claim ID of the encounter in EPS that is to be replaced.
- Using the "pointer" value on the Replacement transaction, the EPS must be able to locate the encounter in EPS that is to be replaced
- The encounter that is to be replaced must have a Validation status of PASS in order for the replacement to process successfully without DMAS intervention
- The encounter that is to be replaced must have an ACTIVE status
- An encounter with a PAID or DENIED status may be replaced
- Replacement of a previously replaced transaction is allowed
- Replacement transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures. See section 5 for Correcting Encounter data in EPS

837 Replacement Transaction						
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**	**Notes**
837P 837D 837I	Patient Control Number	2300	CLM	01	Unique Payer Claim ID	Must be unique
	Claim Frequency Code	2300	CLM	05-3	7	Indicates replacement
	REF – Payer Claim Control Number	2300	REF	01 02	F8 Payer Claim ID of encounter that is to be replaced (Original or Replacement)	"Points" to encounter that is to be replaced

4.2.1.2 Pharmacy (NCPDP) Encounters

For Pharmacy Encounters (NCPDP), the EPS does not accept Rebill (B3) transactions. In place of the rebill, the Payer should submit a Void/Reversal (B2) transaction, confirm that the Void/Reversal (B2) transaction has a PASS status, and then submit a New Billing/Original (B1) transaction with the replacement data.

4.2.2 Void Transactions

4.2.2.1 Professional and Institutional (837) Encounters

A professional or institutional (837) Encounter with a Claim Frequency Code of "8" indicates a Void encounter transaction. The Void transaction must contain a "pointer" to the encounter that is to be voided in the EPS.

For the Void transaction to process successfully in the EPS, the following rules apply:

- The "pointer" value on the Void transaction must equal the <u>Payer Claim ID</u> of the encounter in EPS that is to be voided
- Using the "pointer" value on the Void transaction, the EPS must be able to locate the encounter in EPS that is to be voided
- The encounter that is to be voided must have a Validation status of PASS in order for the void to process successfully without DMAS intervention
- The encounter that is to be voided must have an ACTIVE status
- An original or replaced encounter may be voided
- An encounter with a PAID or DENIED status may be voided
- Once voided, no subsequent transactions (replacement or void) are allowed
- Void transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures. See section 5 for Correcting Encounter data in EPS

837 Void Transaction						
Trans Type	Element Name	Loop	Segment	Element	Value	Notes
837P 837D 837I	Patient Control Number	2300	CLM	01	Unique Payer Claim ID	Must be unique
	Claim Frequency Code	2300	CLM	05-3	8	Indicates Void
	REF – Payer Claim Control Number	2300	REF	01 02	F8 Payer Claim ID of encounter that is to be voided (Original or Replacement)	"Points" to encounter that should be voided.

4.2.2.2 Pharmacy (NCPDP) Encounters

For Pharmacy encounters (NCPDP), a reversal transaction (B2) must be used to reverse/void the Original Encounter. The reversal transaction must contain a set of keys that will be used as a "pointer" to the encounter that is to be reversed. Only a New Billing/Original may be voided.

For the Reversal transaction to process successfully in the EPS, the following rules apply:

- Using the "pointer" keys, the EPS must be able to locate the original of the encounter that is to be reversed
- The encounter that is to be reversed/voided must have a Validation status of PASS
- The encounter that is to be reversed/voided must have an ACTIVE status
- Only a new billing/original may be voided
- Once voided, no subsequent reversals are allowed

NCPDP Reversal (B2) Transaction					
Trans Type	Element Name	Segment	Element	Value	Notes
NCPDP	Service Provider ID (Pharmacy NPI)	Transaction Header	201-B1	Pharmacy NPI of claim that is to be reversed	""Pointer" key values used to locate the encounter that is to be reversed
	Date of Service	Transaction Header	401-D1	Date of Service of the encounter that is to be reversed	
	Prescription No.	Claim	402-D2	Prescription No. of the encounter that is to be reversed	
	NDC	Claim	407-D7	NDC on the encounter that is to be reversed	

4.2.3 "Best Practices" for Replacement and Void Transactions

To ensure success of replacement and void/reversal transactions in the EPS, a best practice is to confirm that the companion transaction (original or prior replacement) has a Validation status of PASS in the EPS before submitting the replacement or void transaction to DMAS.

When EPS receives a replacement or void transaction originating from the Payer's Claim Adjudication/Processing system, the encounter transaction that resides in EPS must have a Validation status of PASS for EPS to allow the update. If the EPS transaction to be updated has a status of FAIL, all subsequent replacement or void transactions will also result in a FAIL status. The DMAS Encounter teams will work with the Payer in processing these transactions.

5 Correcting Encounter Data in EPS

The Payer must correct all EPS Validation errors ("E" errors). Encounter data correction must occur with a RESEND or RESUBMISSION transaction when the data will not be corrected from transactions processed by the Payer's Claim Adjudication/Processing system. Replacement or Void transactions that are processed by the Payer's Claim Adjudication/Processing system and result in the correction of an EPS encounter error do not require a RESEND or RESUBMISSION transaction. Replacement or Void transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures.

It is important to note that DMAS will reconcile EPS Encounter transaction counts with transaction counts from the Payer's Claim Adjudication/Processing system to determine "Encounter Completeness". It is essential that the EPS encounter transaction counts match Payer's <u>claim</u> transaction counts.

There are several methods available in EPS that can be used for correcting Encounter data when the correction will not occur via Replacement/Void transactions originating from the Payer's Claim Adjudication/Processing system. The method selected will depend on the EPS Validation status (PASS/FAIL) of the erroneous encounter transaction. EPS will only allow corrections to encounter transactions with an ACTIVE status. Corrections to transactions with an INACTIVE status are not allowed.

- Use the EPS **RESEND** method when the encounter transaction has a Validation status of **FAIL**
- Use EPS **RESUBMISSION** method when the encounter transaction has a Validation status of **PASS**

5.1 Using the RESEND method

An EPS RESEND is to be used when the EPS encounter transaction has a Validation status of FAIL and the data will not be corrected from transactions processed by the Payer's Claim Adjudication/Processing system. An EPS Validation status of FAIL indicates that one or more "E" errors have been flagged on the encounter transaction.

Instructions for creating a RESEND transaction:

- Update/correct the data that was flagged as an EPS "E" error on the erroneous transaction
- Using the <u>same</u> Payer Claim ID, submit the corrected encounter transaction to EPS
- Note: There is no "resend indicator" on the transaction. EPS will recognize the transaction as a RESEND when an encounter with the matching Payer Claim ID is found in EPS and the Validation status is FAIL. If an encounter with the matching Payer Claim ID is found in EPS and the Validation status is PASS, EPS will flag the RESEND transaction as a duplicate.

For the RESEND transaction to process successfully in the EPS, the following rules apply:

- The <u>same</u> Payer Claim ID as the erroneous transaction must be used on the RESEND transaction
- EPS must be able to locate the erroneous encounter
- The erroneous encounter in EPS must have a Validation status of FAIL
- The erroneous encounter in EPS must have an ACTIVE status. Encounters in EPS that have an INACTIVE status may not be corrected

837 - Resend						
Trans Type	Element Name	Loop	Segment	Element	Value	Notes
837P 837D 837I	Patient Control Number	2300	CLM	01	Payer Claim ID	Must match the Payer Claim ID of the encounter that needs to be corrected

NCPDP – Resend						
Trans Type	Element Name	Loop	Segment	Element	Value	Notes
NCPDP	Payer Claim ID		AM01	CX	99	Must match the Payer Claim ID of the encounter that needs to be corrected
				CY	Payer Claim ID	

5.2   Using the RESUBMISSION method

An EPS RESUBMSSION is to be used when the EPS encounter transaction has a Validation status of PASS and the data will not be updated from transactions processed by the Payer's Claim Adjudication/Processing system. Most likely, this method will be used infrequently as the encounter transaction in EPS has met all data requirements. However, there can be rare situations where the Payer needs to update the EPS encounter transaction due to an issue within their internal systems. Example: An encounter transaction is submitted to EPS. EPS does not flag any errors on the transaction resulting in an EPS Validation of PASS. The Payer realizes that a mapping error occurred during the encounter extraction process and a corrected version of the encounter transaction needs to be submitted to EPS. The RESUBMISSION method must be used to submit the updated transaction to EPS.

Instructions for creating a RESUBMISSION transaction:

- The encounter must contain the "Date of Resubmission" as shown below. The "Date of Resubmission" should be the date that the encounter is resubmitted to DMAS.
- Resubmit the corrected encounter transaction to EPS using the same Payer Claim ID and including the "Date of Resubmission".

For the RESUBMISSION transaction to process successfully in the EPS, the following rules apply:

- The encounter must contain the "Date of Resubmission" as this will inform EPS that the transaction is being resubmitted. Otherwise, EPS will flag the transaction as a duplicate.
- The same Payer Claim ID as the encounter that needs to be updated must be used on the resubmitted transaction
- EPS must be able to locate the encounter that needs to be updated
- The encounter in EPS that needs to be updated must have a Validation status of PASS
- The encounter in EPS that needs to be updated must have an ACTIVE status. Encounters in EPS that have an INACTIVE status may not be updated.

837 - Resubmission

Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Document Level	837P 837D 837I	2300	CLM	01	Must match the Payer Claim ID of the encounter that needs to be modified.
			K3	01	

FIELD	DESCRIPTION	USAGE	FORMAT/VALUE
DREC	Date of Receipt	Mandatory	CCYYMMDD
DADJ	Date of Adjudication	Mandatory	CCYYMMDD
DPYM	Date of Payment	Mandatory	CCYYMMDD
DRES	Date of Resubmission	Mandatory for Resubmission	CCYYMMDD
PYMS	Payment Status - Paid Payment Status - Denied	Mandatory	P D

Note:
- There should be at least one space between the pair values
- Each pair must have one hyphen(-) between the field and value
- The pair values may be in any order

837 Example

Sample Format	`DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-x`

K3 Segment	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P`
	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D`
	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-P`
	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-D`

NCPDP – Resubmission

Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Document Level	NCPDP	AM	AM01	CX	Value must be 99
				CY	Must match the Payer Claim ID of the encounter that needs to be modified.
				HN	

FIELD	DESCRIPTION	USAGE	FORMAT/VALUE
DREC	Date of Receipt	Mandatory	CCYYMMDD
DADJ	Date of Adjudication	Mandatory	CCYYMMDD
DPYM	Date of Payment	Mandatory	CCYYMMDD
DRES	Date of Resubmission	Mandatory for resubmission	CCYYMMDD
PYMS	Payment Status - Paid Payment Status - Denied	Mandatory	P D

Note:
- There should be at least one space between the pair values
- Each pair must have one hyphen(-) between the field and value
- The pair values may be in any order

NCPDP Example	
Sample Format	`DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-x`
HN Field	`HNDREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-P` `HNDREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-D`

6 EPS Business Rules

One of the features of EPS is that business rules are defined, packaged, and applied by Contract. This means that the DMAS business teams have the ability to create and apply business requirements differently for CCC Plus, Medallion 4.0, and FFS NEMT encounters. Although separate, the majority of the business rules are commonly defined across all contracts to ensure that DMAS receives encounter data that is as consistent as possible. Differences in business rules may be related to the specific population served by the contract (e.g. CCC Plus contract provides services at nursing homes whereas the Medallion 4.0 contract does not).

The EPS business rules for each contract may be found on the EPS portal. The portal provides details about each business rule including the applicability of the rule to the transaction type, claim frequency, and paid vs. denied status. In addition, supporting EDI elements used in the business rule logic are defined. Periodically, DMAS will issue a consolidated EPS Business rule list via email that also shows the same detailed information.