

California Medicaid (Denti-Cal)

**HIPAA Transaction
Standard Companion Guide**

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

November 2018
005010 v1.13

Disclosure Statement

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

Preface

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

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

Express permission to use ASC X12 copyrighted materials has been granted.

California Medicaid (Denti-Cal) Companion Guide

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1. INTRODUCTION

1.1 Background

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

HIPAA serves to:

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

1.2 Intended Use

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

1.3 Scope

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

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

1.4 Overview

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

Providers using EDI may electronically transmit the following:

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

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

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

To participate in EDI, the following are required:

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

1.5 References

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

Denti-Cal website: <http://www.denti-cal.ca.gov>

1.6 Additional Information

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

2. GETTING STARTED

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

2.1 Working with Denti-Cal

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

2.2 Trading Partner Registration

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

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

The following links provide form access:

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

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

Provider Service Office Electronic Data Interchange Option Selection Form:

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

Electronic Remittance Advice (ERA) Enrollment Form:

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

2.3 Certification and Testing Overview

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

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

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

3. TESTING WITH DENTI-CAL

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

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

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

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

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

3.1 Test Scheduling

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

3.2 Data Communications Testing

Trading partners must demonstrate four data communications functions:

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

3.3 Data Format Testing

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

3.3.1 837 Transaction Data Format Testing

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

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

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

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

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

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

The certification process generally requires multiple iterations of the following:

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

3.3.2 276 Transaction Data Format Testing

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

3.3.3 Certification

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

3.4 Receipt of Reports and Data Testing

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

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Denti-Cal System Availability

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

4.1 Process Flowcharts

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

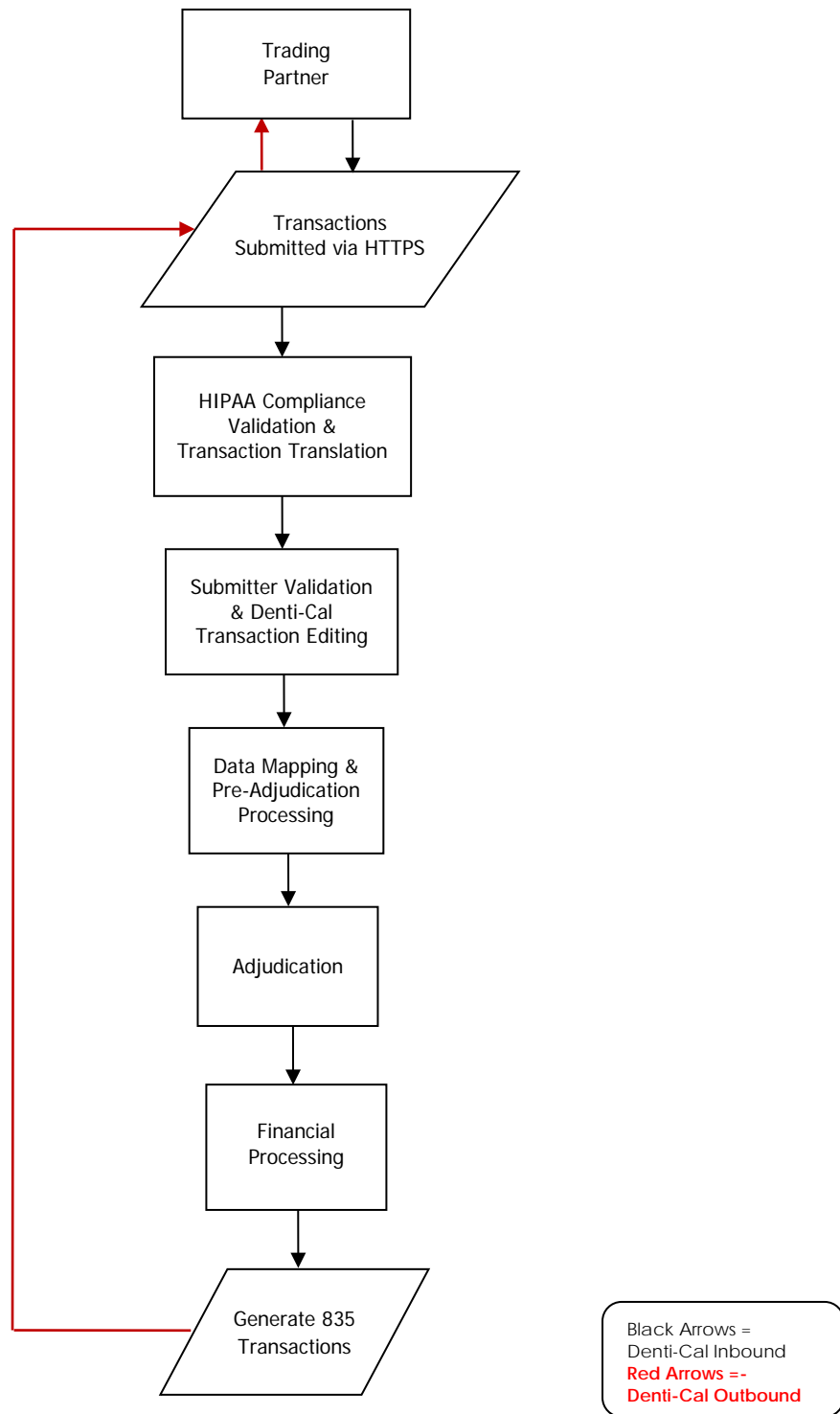


Figure 4-1. Batch Process for 837 and 835 Transactions

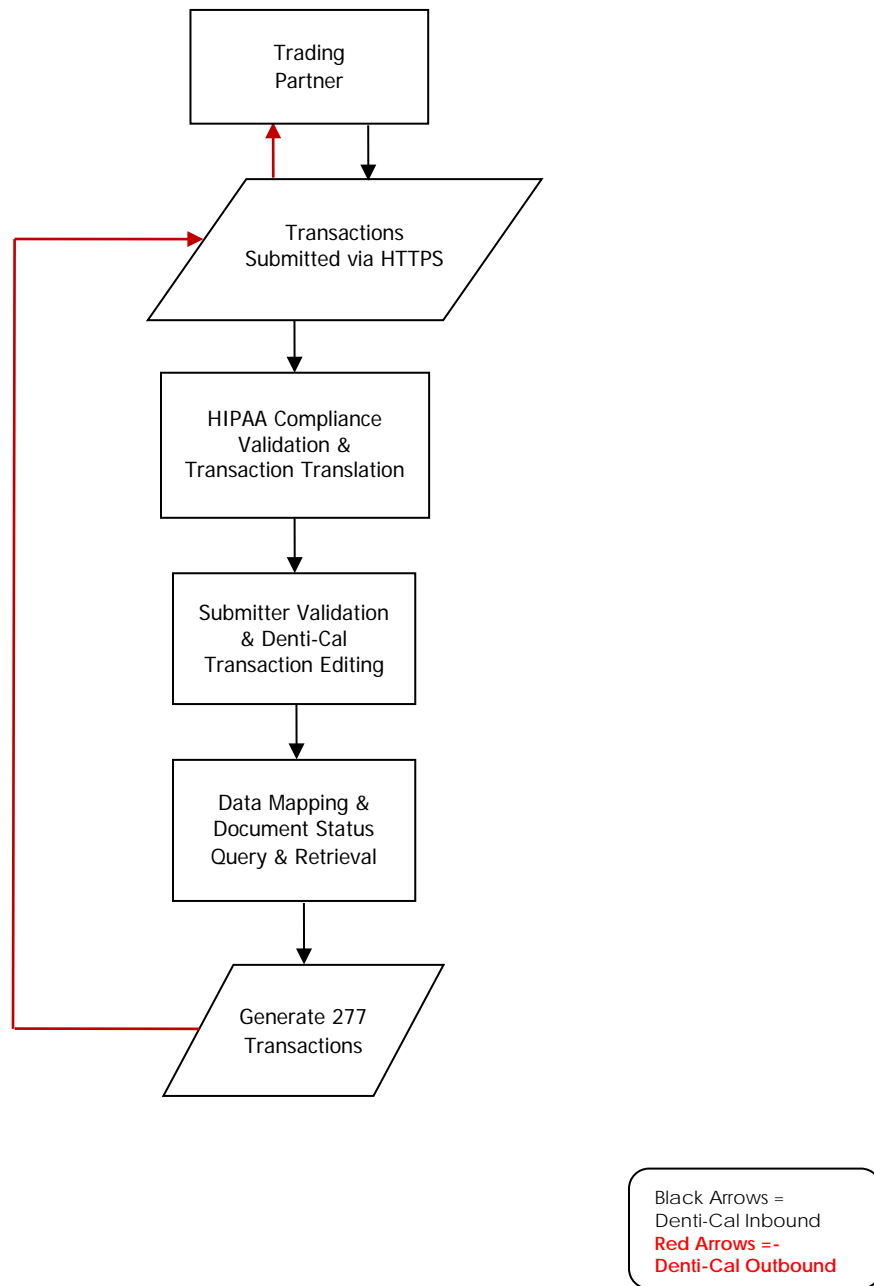


Figure 4-2. Batch Process for 276 and 277 Transactions

4.2 Transmission Administrative Procedures

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

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

4.3 Retransmission Procedure

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

4.4 Communication Protocol Specifications

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

4.5 Passwords

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

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

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

NOTE: Passwords expire and must be changed every 180 days.

5. CONTACT INFORMATION

5.1 EDI Customer Service

Contact information for Denti-Cal EDI Support:

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

5.2 EDI Technical Assistance

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

Contact information for Denti-Cal EDI Support:

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

5.3 Provider Service Number

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

5.4 Applicable Websites/Email

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

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

General Denti-Cal program information can be accessed online at:

www.denti-cal.ca.gov

6. CONTROL SEGMENTS/ENVELOPES

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

6.1 Delimiters

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

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

Figure 6-1. Delimiters for X12 Data Files

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

6.2 ISA-IEA

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

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Denti-Cal expects to receive the value listed in the codes column.
	ISA02	Authorization Information		Denti-Cal expects to receive: DENTICAL
	ISA03	Security Information Qualifier	00	Denti-Cal expects to receive the value listed in the codes column.
	ISA04	Security Information		Denti-Cal expects to receive: NONE
	ISA05	Interchange ID Qualifier	ZZ	Denti-Cal expects to receive the value listed in the codes column.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA06	Interchange Sender ID		Denti-Cal expects to receive the Submitter's Denti-Cal Remote ID.
	ISA07	Interchange ID Qualifier	ZZ	Denti-Cal expects to receive the value listed in the codes column.
	ISA08	Interchange Receiver ID		Denti-Cal expects to receive: DENTICAL
	ISA14	Acknowledgement Requested	0	Denti-Cal expects to receive the value listed in the codes column. Transactions are acknowledged in the Denti-Cal CP-O-976 and CP-O-959-P reports.

6.3 GS-GE

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

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

6.4 ST-SE

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

7. PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1 Resubmission Turnaround Document (RTD) Corrections

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

7.2 Notice of Authorization (NOA) Submissions

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

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

7.3 Document Control Numbers (DCNs)

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

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

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

7.4 Radiographs and Hardcopy Attachments for EDI Documents

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

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

7.5 Labels

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

7.6 Service Facility Phone Number

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

8. ACKNOWLEDGEMENTS AND REPORTS

8.1 Acknowledgements

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

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

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

8.2 Report Inventory

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

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

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

```

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

                                RE-EVALUATION IS REQUESTED _ (X FOR YES)

PATIENT NAME(LAST, FIRST, MI)          SEX  BIRTHDATE  MEDI-CAL-ID NO
LAST          FIRST                    X    00/00/00    000000000
                                PATIENT DENTAL RECORD NO. :
                                PROVIDER DOC CONTROL NUMBER: 000000000000000
X-RAYS ATTACHED _ (X FOR YES) HOW MANY? _ ACCIDENT / INJURY _ (X FOR YES)
OTHER ATTACHMENTS _ (X FOR YES)           EMPLOYMENT RELATED _ (X FOR YES)
OTHER DENTAL COVERAGE _ (X FOR YES)       CHDP                _ (X FOR YES)

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

ADDRESS                          EVC #: _____

CITY          CA 00000-0000

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

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

DATE PROSTHESIS ORDERED : _____ TOTAL FEE CHARGED                330.00
PROSTHESIS LINE ITEM   : _ _ _ _ _ TOTAL ALLOWANCE                330.00
                                PATIENT SHARE-OF-COST AMT. _____
                                OTHER COVERAGE AMT. _____
                                DATE BILLED _____

COMMENTS:
PAYMENT REQUEST MUST HAVE RENDERING PROV ID
** PLEASE NOTE: THIS BENEFICIARY MAY ONLY BE ELIGIBLE
UNDER A PHP, MCP, GMC, HMO OR DMC WHICH INCLUDES DENTAL.
PLEASE VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICES.

                                X _____ DATE
                                SIGNATURE                DATE

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

```

Figure 8-1. CP-O-NOA-P

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

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

```

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

ADDRESS                                             DOCUMENT TYPE: CLAIM
                                                    BEGINNING DOS: 01-02-12
CITY                CA 00000-0000                PROVIDER DCN : 0000000000000000
----- PATIENT INFORMATION -----
LAST NAME          FIRST NAME  MEDICAL ID NBR  DENTAL REC  AMOUNT  DCN
LAST              FIRST      0000000000
                                                    364.00  00000000000 0

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

X _____ DATE
                SIGNATURE

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

```

Figure 8-2. CP-O-RTD-P

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

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

REPORT ID:	CP-O-959-P	DENTI-CAL	RUN ON:	MM/DD/YY			
PERIOD ENDING:	MM/DD/YY	PROVIDER/SVC OFC	PAGE:	1			
PROGRAM ID:	DCB969BS	... DOCUMENT REJECTIONS					
PROV/SVC OR NPI	PROVIDER DCN	RECIPIENT LAST	NAME FIRST	D T	SSN/CIN OR MEDS	BASE DCN	RSN CD
0000000000	000000000000000000	LAST	FIRST	C	XXXXX0000		G
0000000000	000000000000000000	LAST	FIRST	C	000000000		G
PROVIDER/SERVICE OFC TOTALS							
A - INVALID PROV/SVC OFC	:		0				
B - INVALID C/H	:		0				
C - INVALID PROV/CH	:		0				
D - BATCH REJECTED	:		0				
E - RECORD COUNTS MISMATCH	:		0				
F - INVALID PROVIDER NAME	:		0				
G - DUPLICATE DOCUMENTS	:		0				
H - SECOND NOA ISSUED	:		0				
I - INVALID RETURN DCN	:		2				
J - SUB/PROV/SITE MISMATCH	:		0				
K - CLM OVR 90 LINES - 4010	:		0				
L - USE CIN OR BIC-NOT SSN	:		0				
M - FILE VERSION NOT AUTH	:		0				
N - PDCN REQUIRED	:		0				
P - CLM OVR 50 LINES - 5010	:		0				
TOTAL REJECTIONS	:		2				

Figure 8-3. CP-O-959-P

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

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

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

PROV/SVC OR NPI	BASE DCN	PROV DCN	RECIPIENT LAST	NAME FIRST	SSN/CIN/ OR MEDS
0000000000	0000000000	0000000000	LAST	FIRST	000000000
MEDI CAL NBR: 000000000		SYS IND:	DOC TYPE: C	SUBMIT AMOUNT:	1500.00
0000000000	0000000000	000000000000	LAST	FIRST	XXXXX0000
MEDI CAL NBR: 000000000		SYS IND:	DOC TYPE: C	SUBMIT AMOUNT:	285.00
0000000000	0000000000	00000000	LAST	FIRST	000000000
MEDI CAL NBR: 000000000		SYS IND:	DOC TYPE: T	SUBMIT AMOUNT:	300.00

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

Figure 8-4. CP-O-971-P

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

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

DENTI-CAL PROVIDER ID:	999999999
PATIENT MEDS ID:	XXXXXXXX
PROV. DCN:	XXXXXXXXXXXXXXXXXX
DENTI-CAL DCN:	XXXXXXXXXX
DCC:	_____
PREVIOUS X-RAYS AND/OR ATTACHMENTS:	_____
PROVIDER NAME	
ADDRESS	
CITY, STATE ZIP	
DC 018C	

Figure 8-5. CP-O-971-P

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

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

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

PROV/SVC OR NPI	PROVIDER DCN	BASE DCN	RECIPIENT LAST	NAME FIRST	SSN/CIN/ OR MEDS
0000000000	000000000000000000	000000000000	LAST	FIRST	0000000000
MEDI CAL NBR:	0000000000000000	DOC TYPE: C	SUBMITTED FEE:	100.00	
0000000000	000000000000000000	000000000000	LAST	FIRST	XXXXX0000
MEDI CAL NBR:	0000000000000000	DOC TYPE: T	SUBMITTED FEE:	300.00	
TOTAL PROV/SVC OFC DOCUMENTS :			2		

Figure 8-6. CP-O-973-P

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

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

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

PROV/SVC OR NPI	ISSUE DATE	DAYS SNCE	SSN/CIN/ OR MEDS	MEDI-CAL NUMBER	RECIPIENT LAST	NAME FIRST	TYPE OF REQUEST
0000000000	12/26/07	15	0000000000	0000-0000000000	LAST	FIRST	XRAY/ATTCH
PROV DCN:	00000000000000-0000	BASE DCN:	000000000000	DOC TYPE: T	SUB AMT:	380.00	
0000000000	12/27/07	14	0000000000	0000-0000000000	LAST	FIRST/	ADDIT DOC
PROV DCN:	00000000000000-0000	BASE DCN:	000000000000	DOC TYPE: T	SUB AMT:	990.00	
0000000000	12/27/07	14	XXXXX0000	0000-0000000000	LAST	FIRST	X/RAY/ATTCH
PROV DCN:	00000000000000-0000	BASE DCN:	000000000000	DOC TYPE: C	SUB AMT:	162.00	
TOTAL PROV/SVC OFC DOCUMENTS :					3		

Figure 8-7. CP-O-978-P

8.2.8 HTML Error Report

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

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

```

TRANSMISSION
Sequence: File="compliance_dummy_data.txt"
• TYPE 1: ACCEPT TYPE 2: ACCEPT TYPE 3: ACCEPT TYPE 4: ERRORS NOTED
•  Close INTERCHANGE Sequence: 1 Control Number: 620364334
  • TYPE 1: ACCEPT TYPE 2: ACCEPT TYPE 3: ACCEPT TYPE 4: ERRORS NOTED
  •  Close FUNCTIONAL GROUP Sequence: 1 ID: HC Control Number: 248175446
    • TYPE 1: ACCEPT TYPE 2: ACCEPT TYPE 3: ACCEPT TYPE 4: ERRORS NOTED
    •  Close TRANSACTION SET Sequence: 596 TransactionSetID: 837 Transaction Set Control Number: 000000596
      • TYPE 1: ACCEPT TYPE 2: ACCEPT TYPE 3: ACCEPT TYPE 4: REJECT
      •  Close SEGMENT At position: 22 REF (Reference Identification
        ) in loop 2010BB
          • TYPE 4: error
          •  Close ELEMENT REF01 (Reference Identification Qualifier)
            • TYPE 4: error
            • Error Code: 848 (Incorrect Data
              )
            • Error Description: 34711 2010BB NM108="XV" when 2010BB REF_2U present
          •  Close TRANSACTION SET Sequence: 597 TransactionSetID: 837 Transaction Set Control Number: 000000597
            • TYPE 1: ACCEPT TYPE 2: ACCEPT TYPE 3: ACCEPT TYPE 4: REJECT
            •  Close SEGMENT At position: 22 REF (Reference Identification
              ) in loop 2010BB
                • TYPE 4: error
                •  Close ELEMENT REF01 (Reference Identification Qualifier)
                  • TYPE 4: error
                  • Error Code: 848 (Incorrect Data
                    )
                  • Error Description: 34711 2010BB NM108="XV" when 2010BB REF_2U present
                
```

Figure 8-8. HTML Error Report

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

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

8.3 Supplemental EOB Data

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

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

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

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

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

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

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

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

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

8.3.1 Supplemental EOB Data Field Definitions by Record Type

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

Claim Header Record

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

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

Claim Service Line Detail Record

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

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

Accounts Payable Detail Record

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

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

Levy Detail Record

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

Accounts Receivable Detail Record

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

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

Check Cycle Summary Record

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

8.3.2 Supplemental EOB Record Formats

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

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

Figure 8-9. Claim Header Record

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

Figure 8-10. Claim Service Line Detail Record

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

Figure 8-11. Accounts Payable Detail Record

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

Figure 8-12. Levy Detail Record

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

Figure 8-13. Accounts Receivable Detail Record

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

Figure 8-14. Check Cycle Summary Record

8.4 Electronic Report Retrieval

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

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

reportMMDDYYHHMM.txt	=	Reports
eobMMDDYYHHMM.txt	=	Supplemental EOBs
labelMMDDYYHHMM.txt	=	Labels
835MMDDYYHHMM.txt	=	835 Transactions
999MMDDYYHHMMSSSS.txt	=	999 Acknowledgements
HTMLERRMMDDYYHHMMSSSS.html	=	HTML Error Reports
TA1MMDDYYHHMMSSSS.txt	=	TA1 Acknowledgements

Where: MMDDYY = Month, Day, Year file was created
 HHMMSSSS = Hour, Minute, Seconds (when applicable) file
 was placed in mailbox
 (Note: Time is always reflected in Eastern Time)

If file is zipped, the file extension will be “.zip”

Figure 8-15. File Naming Standards

8.5 Report and Data Enveloping

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

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

Figure 8-16. Standard X12 Enveloping Structure

9. TRADING PARTNER AGREEMENTS

A Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement (Trading Partner Agreement) must be submitted and processed before transactions may be sent to or received from Denti-Cal. Following is a link to this document:

- Telecommunications Provider and Biller Application/Agreement:
https://www.denti-cal.ca.gov/DC_documents/providers/EDI_Application_Agreement.pdf

10. TRANSACTION-SPECIFIC INFORMATION

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

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

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

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

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

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
66		BHT	Beginning of Hierarchical Transaction			
		BHT06	Claim or Encounter Identifier	CH		Denti-Cal expects to receive the value listed in the codes column.
69	1000A	NM1	Submitter Name			
		NM109	Submitter Identifier			Denti-Cal expects to receive the Submitter's Denti-Cal Remote ID.
74	1000B	NM1	Receiver Name			
		NM103	Receiver Name			Denti-Cal expects to receive: DENTICAL
		NM109	Receiver Primary Identifier			Denti-Cal expects to receive: 1822287119
78	2000A	PRV	Billing Provider Specialty Information			The Provider Specialty Information on file with the Denti-Cal Provider Enrollment Unit is used as needed.
79	2000A	CUR	Foreign Currency Information			Denti-Cal does not use the information sent in this segment. All amounts are processed in U.S. currency.
82	2010AA	NM1	Billing Provider Name			By failing to submit rendering provider information in either Loop 2310B or Loop 2420A, the provider is certifying the billing provider is the rendering provider, and the transaction is processed accordingly.
86	2010AA	N3	Billing Provider Address			The billing address on file with the Denti-Cal Provider Enrollment Unit is used.
87	2010AA	N4	Billing Provider City, State, ZIP Code			The billing address on file with the Denti-Cal Provider Enrollment Unit is used.
89	2010AA	REF	Billing Provider Tax Identification			The Tax Identification Number on file with the Denti-Cal Provider Enrollment Unit is used for income reporting on the 1099 forms.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
91	2010AA	REF	Billing Provider UPIN/License Information			Denti-Cal does not use this segment for provider identification.
96	2010AB	NM1	Pay-to Address Name			The pay-to information on file with the Denti-Cal Provider Enrollment Unit is used to direct payment.
101	2010AC	NM1	Pay-to Plan Name			Denti-Cal does not currently process subrogation payment requests.
114	2010BA	NM1	Subscriber Name			
		NM108	Identification Code Qualifier	MI		Denti-Cal expects to receive the value listed in the codes column.
		NM109	Subscriber Primary Identifier			Denti-Cal processing requires the ID be submitted as it appears on the Medi-Cal identification card; always use uppercase alpha characters. Do not submit an SSN, as the transaction will be rejected.
122	2010BA	REF	Subscriber Secondary Identification			Denti-Cal strongly discourages the transmission of a secondary subscriber ID as the submission of an SSN causes a rejected transaction.
124	2010BB	NM1	Payer Name			
		NM103	Payer Name			Denti-Cal expects to receive: DENTICAL
		NM109	Payer Identifier			Denti-Cal expects to receive: 94146
129	2010BB	REF	Payer Secondary Identification			Denti-Cal does not use this segment for payer identification.
131	2010BB	REF	Billing Provider Secondary Identification			
		REF01	Reference Identification Qualifier	LU		When a single NPI is registered with Denti-Cal for more than one Service Office (in which case the NPI is considered non-subparted), Denti-Cal expects to receive the value shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
133	2000C	HL	Patient Hierarchical Level			Denti-Cal recipients are identified by a unique identification number; therefore all patients/recipients are considered the subscriber and must be identified at the Subscriber Level.
137	2010CA	NM1	Patient Name			Denti-Cal recipients are identified by a unique identification number; therefore all patients/recipients are considered the subscriber and must be identified at the Subscriber Level.
145	2300	CLM	Claim Information			
		CLM01	Patient Control Number		17	Denti-Cal processes only the first 17-characters; ensure the first 17-characters of this field represents a unique value.
		CLM05-3	Claim Frequency Code	1 7		Denti-Cal expects to receive the values listed in the codes column.
		CLM11-1	Related Causes Code	OA EM AA		Denti-Cal expects to receive the values listed in the codes column.
		CLM11-2	Related Causes Code	OA EM AA		Denti-Cal expects to receive the values listed in the codes column.
		CLM12	Special Program Indicator			Denti-Cal does not use the information sent in this element.
		CLM19	Predetermination of Benefits Code			Denti-Cal does not use the information sent in this element.
		CLM20	Delay Reason Code			Denti-Cal does not use the information sent in this element.
153	2300	DTP	Date – Appliance Placement			Denti-Cal does not use the information sent in this segment.
154	2300	DTP	Date – Service Date			
		DTP02	Date Time Period Format Qualifier	D8		Denti-Cal expects to receive the value listed in the codes column.
156	2300	DN1	Orthodontic Total Months of Treatment			Denti-Cal does not use the information sent in this segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
158	2300	DN2	Tooth Status			
		DN202	Tooth Status Code	M		Denti-Cal expects to receive the value listed in the codes column.
159	2300	PWK	Claim Supplemental Information			
		PWK01	Attachment Report Type	RB OZ		Denti-Cal expects to receive the values listed in the codes column.
		PWK02	Attachment Transmission Code	BM FT		Denti-Cal expects to receive the values listed in the codes column. Denti-Cal accepts digitized images submitted through certified electronic attachment vendors. For a listing of certified vendors, refer to Section 3 of the Medi-Cal Dental Program Provider Handbook. When submitting digitized radiographs and attachments through a certified vendor, use Attachment Transmission Code 'FT' and submit the Attachment Control Number in PWK06.
		PWK06	Identification Code			The Attachment Control Number for digitized radiographs and attachments MUST be submitted in the following format: DentalXChange Users: 'EHG#99999999' NEA Users: 'NEA#99999999' Tesia/Renaissance Users: 'DTX#99999999'
165	2300	REF	Predetermination Identification			Denti-Cal does not use the information sent in this segment.
166	2300	REF	Service Authorization Exception Code			Denti-Cal does not use the information sent in this segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
168	2300	REF	Payer Claim Control Number			Submit this segment only when submitting an adjustment request (when CLM05-3 = '7'). Do not use this segment when submitting NOAs for payment. The REF – Prior Authorization segment (using Reference Identification Qualifier 'G1') should be transmitted when submitting a NOA for payment.
		REF02	Payer Claim Control Number			Submit the original Denti-Cal DCN associated with the transaction to be reprocessed.
171	2300	REF	Prior Authorization			Submit this segment only when submitting a NOA for payment.
		REF02	Prior Authorization Number			Submit the original Denti-Cal DCN associated with the approved TAR.
175	2300	REF	Claim Identifier for Transmission Intermediaries			Denti-Cal does not capture the information sent in this segment.
180	2300	HI	Health Care Diagnosis Code			Denti-Cal does not use the information sent in this segment.
193	2310A	PRV	Referring Provider Specialty Information			Denti-Cal does not use the information sent in this segment for adjudication.
194	2310A	REF	Referring Provider Secondary Identification			Denti-Cal does not use for provider identification.
196	2310B	NM1	Rendering Provider Name			Rendering Provider information submitted in this loop is applied to all dated service lines unless overridden by the presence of segment NM1 in Loop 2420A.
199	2310B	PRV	Rendering Provider Specialty Information			The Provider Specialty Information on file with the Denti-Cal Provider Enrollment Unit is used as needed.
200	2310B	REF	Rendering Provider Secondary Identification			Denti-Cal does not use for provider identification.
208	2310C	REF	Service Facility Location Secondary Identification			Denti-Cal does not use for facility identification.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
210	2310D	NM1	Assistant Surgeon Name			Denti-Cal does not use the information sent in this Loop.
216	2310E	NM1	Supervising Provider Name			Denti-Cal does not use the information sent in this Loop.
282	2400	SV3	Dental Service			
		SV304	Oral Cavity Designation Code			Denti-Cal processes only one oral cavity code per service.
288	2400	TOO	Tooth Information			Although this segment may be repeated up to 32 times, Denti-Cal processes only the first occurrence of the transmitted segment.
291	2400	DTP	Date – Prior Placement			Denti-Cal does not use the information sent in this segment.
292	2400	DTP	Date – Appliance Placement			Denti-Cal does not use the information sent in this segment.
293	2400	DTP	Date – Replacement			Denti-Cal does not use the information sent in this segment.
294	2400	DTP	Date – Treatment State			Denti-Cal does not use the information sent in this segment.
295	2400	DTP	Date – Treatment Completion			Denti-Cal does not use the information sent in this segment.
298	2400	REF	Service Predetermination Identification			Denti-Cal does not use the information sent in this segment.
300	2400	REF	Prior Authorization			Denti-Cal processes prior authorization information submitted in Loop 2300 only. Prior Authorization information sent in this loop is not used.
308	2400	AMT	Sales Tax Amount			Denti-Cal does not use the information sent in this segment.
316	2420A	NM1	Rendering Provider Name			Denti-Cal strongly encourages submission of rendering provider information in Loop 2420A. If rendering provider data is not present in Loop 2420A, data sent in Loop 2310B is applied to all dated service lines. By failing to submit rendering provider information in either Loop 2420A or 2310B, the provider is certifying the billing

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						provider is the rendering provider; therefore, the transaction is processed accordingly.
319	2420A	PRV	Rendering Provider Specialty Information			The Provider Specialty Information on file with Denti-Cal Provider Enrollment Unit is used as needed.
320	2420A	REF	Rendering Provider Secondary Identification			Denti-Cal does not use for provider identification.
333	2420D	NM1	Service Facility Location Name			Denti-Cal processes Service Facility Location information submitted in Loop 2310C only. Service Facility Location information sent in this Loop is not used.

10.2 005010X212 Health Care Claim Status Request (276)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
41	2100A	NM1	Payer Name			
		NM103	Payer Name			Denti-Cal expects to receive: DENTICAL
		NM108	Identification Code Qualifier	PI		Denti-Cal expects to receive the value listed in the codes column.
		NM109	Payer Identifier			Denti-Cal expects to receive: 94146
45	2100B	NM1	Information Receiver Name			
		NM109	Information Receiver Identification Number			Denti-Cal expects to receive the Submitter's Denti-Cal Remote ID.
49	2100C	NM1	Provider Name			
		NM108	Identification Code Qualifier	XX		Denti-Cal expects to receive the value listed in the codes column.
56	2100D	NM1	Subscriber Name			
		NM108	Identification Code Qualifier	MI		Denti-Cal expects to receive the value listed in the codes column.
		NM109	Subscriber Identifier			Denti-Cal processing requires the ID be submitted as it appears on the Medi-Cal identification card. Always use uppercase alpha characters. Do not submit an SSN as transaction will be rejected.
63	2200D	REF	Patient Control Number			
		REF02	Patient Control Number		17	
66	2200D	AMT	Claim Submitted Charges			Denti-Cal does not use the information sent in this segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
67	2200D	DTP	Claim Service Date			Denti-Cal only uses dates of service submitted in this Loop. Denti-Cal does not use dates of service submitted in Loop 2210D.
		DTP02	Date Time Period Format Qualifier			Submit 'D8' when inquiring on claims or NOAs that include a single date of service. Submit 'RD8' when inquiring on claims or NOAs that include multiple dates of service.
69	2210D	SVC	Service Line Information			Denti-Cal does not use information sent in this Loop. Information submitted in Loop 2200D is used to determine claim status. Data submitted in Loop 2210D is not used.
75	2200E	HL	Dependent Level			Denti-Cal recipients are identified by a unique identification number; therefore, all patients/recipients are considered the subscriber and must be identified in the Subscriber Loop (2000D).

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

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

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
111	2100A	NM1	Payer Name			
		NM108	Identification Code Qualifier	PI		Denti-Cal populates this data element with the code value shown in the codes column.
		NM109	Payer Identifier			Denti-Cal populates this data element with the value: DENTAL
118	2100B	NM1	Information Receiver Name			
		NM109	Information Receiver Identification Number			Denti-Cal populates this data element with the Receiver's Denti-Cal Remote ID.
126	2100C	NM1	Provider Name			
		NM108	Identification Code Qualifier	XX		Denti-Cal populates this data element with the code value shown in the codes column.
135	2100D	NM1	Subscriber Name			
		NM108	Identification Code Qualifier	MI		Denti-Cal populates this data element with the code value shown in the codes column.

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

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

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
69		BPR	Financial Information			
		BPR01	Transaction Handling Code	I		Denti-Cal populates this data element with the code value shown in the codes column.
		BPR03	Credit or Debit Flag Code	C		Denti-Cal populates this data element with the code value shown in the codes column.
		BPR04	Payment Method Code	CHK		Denti-Cal populates this data element with the code value shown in the codes column.
77		TRN	Reassociation Trace Number			
		TRN03				Denti-Cal populates this data element with the value: 1822287119
79		CUR	Foreign Currency Information			This segment is not sent. All Denti-Cal payments are made in U.S. dollars.
82		REF	Receiver Identification			This segment is only included in transactions submitted to clearinghouses registered with Denti-Cal.
		REF02	Receiver Identification			Denti-Cal populates this data element with the Denti-Cal assigned clearinghouse registration number.
87	1000A	N1	Payer Identification			
		N102	Payer Name			Denti-Cal populates this data element with the value: DENTAL
89	1000A	N3	Payer Address			
		N301	Payer Address Line			Denti-Cal populates this data element with: P.O. BOX 15609

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
90	1000A	N4	Payer City, State, ZIP Code			
		N401	Payer City Name			Denti-Cal populates this data element with: SACRAMENTO
		N402	Payer State Code			Denti-Cal populates this data element with: CA
		N403	Payer Postal Zone or ZIP Code			Denti-Cal populates this data element with: 958520609
97	1000A	PER	Payer Technical Contact Information			
		PER01	Contact Function Code	BL		Denti-Cal populates this data element with the code value shown in the codes column.
		PER02	Payer Technical Contact Name			Denti-Cal populates this data element with: DENTI-CAL EDI SUPPORT GROUP
		PER03	Communication Number Qualifier	EM		Denti-Cal populates this data element with the code value shown in the codes column.
		PER04	Payer Contact Communication Number			Denti-Cal populates this data element with: DENTI-CALEDI@DELTA.ORG
		PER05	Communication Number Qualifier	TE		Denti-Cal populates this data element with the code value shown in the codes column.
		PER06	Payer Technical Contact Communication Number			Denti-Cal populates this data element with: 9168537373
102	1000B	N1	Payee Identification			
		N103	Identification Code Qualifier	FI XX		Denti-Cal populates this data element with the code values shown in the codes column.
107	1000B	REF	Payee Additional Identification	PQ TJ		Denti-Cal populates this data element with the code values shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
123	2100	CLP	Claim Payment Information			
		CLP01	Patient Control Number		17	
		CLP02	Claim Status Code	1 22		Denti-Cal populates this data element with the code values shown in the codes column.
		CLP06	Claim Filing Indicator	MC		Denti-Cal populates this data element with the code value shown in the codes column.
		CLP09	Claim Frequency Code	1 7		Denti-Cal populates this data element with the code values shown in the codes column.
129	2100	CAS	Claim Adjustment			Denti-Cal claim adjustment amounts are sent at the CAS segment at the service level in Loop 2110.
137	2100	NM1	Patient Name			
		NM108	Identification Code Qualifier	MR		Denti-Cal populates this data element with the code value shown in the codes column.
146	2100	NM1	Service Provider Name			If multiple rendering providers are associated with a document, Denti-Cal will send information associated with the first rendering provider processed on the document. For rendering provider information specific to each submitted service, use the rendering provider information (REF segment) in Loop 2110.
		NM108	Identification Code Qualifier	MC XX		Denti-Cal populates this data element with the code values shown in the codes column.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
186	2110	SVC	Service Payment Information			
		SVC01-1	Product/Service ID Qualifier	AD		Denti-Cal populates this data element with the code value shown in the codes column.
		SVC06-1	Product/Service ID Qualifier	AD		Denti-Cal populates this data element with the code value shown in the codes column.
195	2110	DTM	Service Date			
		DTM01	Date Time Qualifier	472		Denti-Cal populates this data element with the code value shown in the codes column.
196	2110	CAS	Service Adjustment			
		CAS01	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
		CAS05	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
		CAS08	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
		CAS11	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
		CAS14	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
		CAS17	Claim Adjustment Group Code	CO OA PR		Denti-Cal populates this data element with the code values shown in the codes column.
204	2110	REF	Service Identification			Denti-Cal does not send this segment.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
207	2110	REF	Rendering Provider Information			
		REF01	Reference Identification Qualifier	1D HPI		Denti-Cal populates this data element with the code values shown in the codes column.
217		PLB	Provider Adjustment			
		PLB02	Fiscal Period Date			Denti-Cal populates this element with December 31 of the current year, (e.g., 20121231).
		PLB05-1	Adjustment Reason Code	51 CS IS L3 LE WO		Denti-Cal populates this data element with the code values shown in the codes column.
		PLB07-1	Adjustment Reason Code	51 CS IS L3 LE WO		Denti-Cal populates this data element with the code values shown in the codes column.
		PLB09-1	Adjustment Reason Code	51 CS IS L3 LE WO		Denti-Cal populates this data element with the code values shown in the codes column.
		PLB11-1	Adjustment Reason Code	51 CS IS L3 LE WO		Denti-Cal populates this data element with the code values shown in the codes column.
		PLB13-1	Adjustment Reason Code	51 CS IS L3 LE WO		Denti-Cal populates this data element with the code values shown in the codes column.

11. APPENDIX

11.1 Implementation Checklist

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

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

11.2 Business Scenarios

Denti-Cal has no business scenarios to document at this time.

11.3 Frequently Asked Questions

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

[https://www.denti-cal.ca.gov/DC_documents/providers/Denti-Cal EDI How To Guide.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/Denti-Cal%20EDI%20How%20To%20Guide.pdf)

11.4 Version History

Version Number	Date	Reason for Revision	Notes/Comments
1.0	December 28, 2012	Initial release.	Companion Guide was reformatted to comply with Operating Rules.
1.1	May 17, 2013	Updates made to comply with ASC X12 Intellectual Property policies.	
1.2	September 6, 2013	Update CP-O-959-P Report with new rejection code N.	
1.3	March 26, 2014	Eliminate Dial-up Asynchronous Communications.	
1.4	April 22, 2014	Update to include Electronic Remittance Advice (ERA) Enrollment Form information.	

Version Number	Date	Reason for Revision	Notes/Comments
1.5	August 6, 2014	Updated 837D Transaction to clarify Denti-Cal use of TOO Segment.	
1.6	February 13, 2015	Update CP-O-959-P Report with revised rejection code K and new rejection code P. Delete rejection code O.	
1.7	April 8, 2015	Include information that providers may discontinue receipt of paper EOBs.	
1.8	June 4, 2015	Update Data Format Testing section, which includes certain doc types for testing.	
1.9	March 24, 2016	Minor revisions to pages 26, 31, 33.	
1.10	March 9, 2017	Update to 835 transaction code, page 59.	
1.11	November 2017	Updates to incorporate new EDI compliance processing, 999 transaction and HTML Error Report.	
1.12	February 2018	Minor revisions to: <ul style="list-style-type: none"> • Provide updated links to referenced documents, • Inform trading partners of Denti-Cal's requirement for a CRLF at the end of each segment, and • Provide the new Denti-Cal Receiver Primary Identifier for use in 837D and 835 transactions. 	
1.13	November 2018	Retrofit changes due to MCD 1612 Page 45 Update to PWK06 Identification Code for DentalXChange users.	