North Dakota MMIS
Encounter Claims –
Frequently Asked Questions

ND Medicaid
May 2023

Preface

This Frequently Asked Questions (FAQ) document supports and assists providers and trading partners that will be engaged in the process of exchanging encounter claims with the ND Department of Human Services – Medical Services. It is a supplement to address questions that may arise out of the implementation of the encounter claim exchange. In tandem with the Encounter Claim Companion Guides to the Accredited Standards Committee (ASC) X12 Technical Report Type 3 (TR3) and associated errata adopted under HIPAA, its purpose is to clarify data content system process when exchanging electronically with the North Dakota MMIS. Transmissions based on this FAQ and the Encounter Claim Companion Guides, used in tandem with the v5010 ASC X12N Technical Report Type 3 (TR3), are compliant with both ASC X12N syntax and those guides. This FAQ and the Encounter Claim Companion Guides are intended to convey information that is within the framework of the TR3 adopted for use under HIPAA. These documents are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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Introduction

This FAQ is intended for use by North Dakota Medicaid Managed Care Organization (MCO) Trading Partners for the submission of the X12N 837x Encounter Claim transactions to ND Medicaid. It is to be used in conjunction with the ND Companion Guide 837x Encounter documents and the ASC X12N 837P National Electronic Data Interchange Technical Report Type 3 (TR3).

The ND Companion Guide 837x Encounter documents can be accessed at https://www.hhs.nd.gov/companionguides

The TR3 can be accessed at https://x12.org/products/technical-reports   (Note: select Implementation Guide – Type 3 (TR3). System will then prompt you to create a unique user ID and login password)

Frequently Asked Questions

1. What should go in the 2320 loop AMT02 element? The companion guide mentions COB Payer Paid Amount for the 2320 AMT segment. Would we put what we paid? Or 'amount paid by other'? (This is at the claim level)

    Answer: The first iteration of the 2320 loop must contain information pertaining to the MCO's action on the claim. If Delta Dental made a payment on the claim, then that payment information should be recorded in the first iteration of the 2320 loop. Any other payer information (if there is any) would be reported in subsequent 2320 loops.

2. At the claim line level, what should go in the SV3 Amount field? Submitted Amount or Paid Amount?

    Answer: The SV302 element is the Monetary Amount element, and this is where the Line Item Charge Amount is reported (Submitted Amount). The Paid Amount is recorded in the SVD02 Monetary Amount element.

3. I don't see FEIN used in the FQHC nor DHS Encounters, so I'm thinking that is obsolete and probably would not be needed for North Dakota?

    Answer: The FEIN or SSN is required per the X12 TR3 Guide. This would be for the Billing Provider Tax Information (Loop 2010AA) and the REF-Billing Provider Tax Identification segment, in element REF02, with the appropriate qualifier in REF01.

4. How does ND want us to report what the primary payer paid when we are not the primary payer?

    Answer: The first iteration of the 2320 loop must always contain Delta Dental's action on the claim. If there was a payment/partial payment/payment of $0.00/denial, it would be reported in the first iteration of the 2320 loop. Any other adjudication by previous payers would then be reporting in subsequent 2320 loops. Our system relies on this order so that it can recognize the action the MCO took on the claim versus action taken by other payers.

5. In the ND companion guide, they show some 837 transactions, so I'm basing the mapping on those, but they don't have some segments, so I'm wondering if we need them. For example, they don't have 'facility' data (NM1*77), nor tooth segments, nor some DTP segments (452, 050, 446).

    Answer: The ND Companion Guides are supporting documents to the ASC X12N 837x National Electronic Data Interchange Technical Report Type 3 (TR3) documents. The intent of the Companion Guides is to document only those instances where the ND MMIS has specific requirements WITHIN the TR3 documents. If a scenario is not documented in the Companion Guide, then the ND MMIS adheres to TR3 standards.

6. The examples do not include COB. MN DHS puts COB data in the 'other insurance' loop, with segments like SBR, AMT, OI, and at the claim line level, SVD.

    Answer: The MCO's claim level reimbursement is to be recorded in the physical first iteration of the 2320 loop. This is documented in the Companion Guide. Other COB information that may pertain to the claim should then be documented in subsequent iterations of the 2320 loop.

7. Another question is what should the amounts be – Submitted or Paid? Other/COB? The example shows an SV3, but I don't know if that is Submitted or Paid. (Same with a CLM). For MN DHS, we put submitted amounts in those segments/elements, and put paid amounts in different loops/segments that ND does not seem to have (at least not in the examples).

Answer: The amounts reported in the first iteration of the 2320 loop should be the amount Paid by the MCO.

Change Summary

Version	Date	Description	Description of Changes
1.0	05/04/2017	Initial Document for Deliverables	Initial Document Creation
1.1	02/15/2018	Updates made to various Answers	Further clarification given on various Answers
1.2	05/31/2023	Updated Logo	Updated Logo