



Medicare Advantage Supplemental Dental Services Submission Guide Version 1.3

Medicare Advantage Supplemental Dental Services Submission Guide

**Instructions related to the 837D Health Care Claim: Medicare Advantage Dental Transaction
based on ASC X12 Technical Report Type 3 (TR3), Version 005010X224A2**

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1 Introduction

1.1 Statutory and Regulatory Background

CMS requires organizations providing services or items to Medicare Advantage (MA) beneficiaries to submit data that characterize the context and purpose of each item and service provided to a Medicare beneficiary, as described in regulation at 42 CFR 422.310. The regulation at 422.310(b)¹ states, “Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, institution, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.”

In 2008, CMS revised 42 CFR 422.310(d) to further clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee to fulfill the requirements provided at 422.310(b).

The requirements and authorities codified at 42 CFR 422.310 apply not only to Medicare Part A and B covered items and services but also extend to supplemental benefits offered by MA organizations, i.e., MA organizations are required to submit encounter data for supplemental benefits provided to their enrollees. While MA organizations have always been able to submit some supplemental benefits to the Encounter Data System (EDS), not all MA organizations have regularly submitted the supplemental benefits that could be submitted. Further, a number of these benefits could not be submitted because certain data elements required for the EDS to accept the data did not exist and, in some situations, CMS has not provided specific instructions for the submission of supplemental benefits. CMS did not accept the 837D on which supplemental dental benefits would be submitted.

In this document, CMS provides instructions on how to submit encounter data records (EDRs) for supplemental dental benefits into the EDS.

1.2 Scope

The purpose of this document is to provide MA organizations with instructions specific to populating and submitting encounter data records (EDRs) for supplemental dental benefit services. Supplemental dental benefits cover preventive and comprehensive dental services outside of Medicare-covered dental services; the context and purpose of these benefits are best captured via a dental-specific format. As such, supplemental dental benefits are to be reported using the X12 837D Version 5010 claims format. Medicare-covered dental services must continue to be submitted using the 837P for dental services that are Part B benefits or the 837I for dental services that are Part A benefits.

¹ Final 2009 inpatient prospective payment system (IPPS) rule, 73 Fed. Reg. 48434 (August 19, 2008).

MA organizations are responsible for referencing other documents for general EDR submission needs.

Please note that the information contained in this document will be incorporated into a future version of the *Encounter Data Submission and Processing Guide*.

For unusual scenarios, challenges faced, or any other questions related to the requirements discussed in this document, contact RiskAdjustmentOperations@cms.hhs.gov. Please specify “837D

Supplemental Benefits Submission” in the subject line. This guidance does not apply to Medicare Medicaid plans. Questions related to Medicare Advantage Supplemental Dental Services Submissions should be directed to csscooperations@palmettogba.com.

1.3 Overview

The MASDS Guide includes information required to initiate and maintain communication exchange with CMS. The Guide is organized as follows:

- Contact Information: Includes telephone numbers and email addresses for the Encounter Data Front-End System (EDFES) contacts.
- File Submission: Includes file naming conventions, file size limitations, and file structure.
- Control Segments/Envelopes: Includes information required to create the ISA/IEA, GS/GE, and ST/SE control segments for transactions to be supported by the EDFES.
- 837 Dental Data Elements: Includes information on required data elements.
- Acknowledgements and Reports: Includes information for all transaction acknowledgements and reports sent by the EDFES.
 - Transaction Specific Information: Describes the details of the HIPAA X12 TR3, using a tabular format. The tables contain a row for each segment with CMS and TR3 specific information.
- Testing and Certification Requirements.

2 Contact Information

2.1 The Customer Service and Support Center (CSSC)

The CSSC Operations help desk is available from 8:00 AM – 7:00 PM ET, Monday-Friday, except for federal holidays. MA organizations and other organizations can contact the CSSC by phone at 1-877- 534-2772, (Option 2) or by email at csscooperations@palmettogba.com.

3 File Submission

3.1 Enrolling to Submit Supplemental Dental Encounter Data

Refer to the EDI Onboarding and Connectivity section of the CSSC Operations website. <https://csscooperations.com/>.

3.2 File Naming Conventions

Refer to the Medicare Advantage and Part D Communications Handbook located on the CSSC Operations website under the EDI Onboarding and Connectivity section.

3.3 File Size Limitations

Due to system limitations, ISA/IEA transaction sets should not exceed 5,000 encounters, as EDFES processes smaller files more efficiently than larger files.

To support and provide the most efficient processing system, and to allow for maximum performance, CMS recommends that Secure File Transfer Protocol (SFTP) submitters' scripts upload no more than one (1) file per five (5) minute intervals. Zipped files should contain one (1) file per transmission. NDM/Connect:Direct users may submit a maximum of 255 files per day.

3.4 File Structure – NDM/Connect:Direct Submitters Only

NDM/Connect:Direct submitters must format all submitted files in an 80-byte fixed block format. This means MA organizations and other entities must upload every line (record) in a file with a length of 80 bytes/characters.

Submitters should create files with segments stacked, using only 80 characters per line. At position 81 of each segment, MA organizations and other entities must create a new line. On the new line starting in position 1, continue for 80 characters, and repeat creating a new line in position 81 until the file is complete. If the last line in the file does not fill to 80 characters, the submitter should space the line out to position 80 and then save the file.

Note: If MA organizations and other entities are using a text editor to create the file, pressing the Enter key will create a new line. If MA organizations and other entities are using an automated system to create the file, create a new line by using a Carriage Return Line Feed (CRLF) or a Line Feed (LF).

For example, if the ISA record is 106 characters long:

The first line of the file will contain the first 80 characters of the ISA segment; the last 26 characters of the ISA segment continue on the second line. The next segment will start in the 27th position and continue until column 80.

```
ISA*00*  *00*  *ZZ*  ENH9999*ZZ*  80896*120816*114
4*^*00501*000000031*1*P*::~
```

Note: If a submitter has not established a sufficient number of Generated Data Groups (GDGs) to accommodate the number of files returned from the EDFES, not all of the EDFES Acknowledgement reports will be stored in the submitter's system. To prevent this situation, NDM/Connect:Direct submitters should establish a limit of 255 GDGs in their internal processing systems.

4 Control Segments/Envelopes

4.1 ISA/IEA

The term interchange denotes the transmitted ISA/IEA envelope. Interchange control is achieved through several “control” components, as defined in Table 4A. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element IEA02 of the IEA segment. MA organizations and other entities must populate all elements in the ISA/IEA interchange. There are several elements within the ISA/IEA interchange that must be populated specifically for MA Supplemental Dental (see Table 5B) purposes. Table 4A below provides those specific Interchange Control (ISA/IEA) elements.

Note: Table 4A presents only those elements that provide specific details relevant to MA organization data. When developing the Medicare Advantage data system, users should base their logic on the highest level of specificity.

First, consult the X12 TR3. Second, consult the MASDS Guide. If there are options expressed in the TR3 that are broader than the options identified in this guide, MA organizations and other entities must use the rules identified in the MASDS Guide.

LEGEND
SHADED rows represent segments in the X12N TR3
NON-SHADED rows represent data elements in the X12N TR3

TABLE 4.A - IS/IEA INTERCHANGE ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	No authorization information present
	ISA02	Authorization Information		Use 10 blank spaces
	ISA03	Security Information Qualifier	00	No security information present
	ISA04	Security Information		Use 10 blank spaces
	ISA05	Interchange ID Qualifier	ZZ	CMS expects to see a value of "ZZ" to designate that the code is mutually defined
	ISA06	Interchange Sender ID		Submitter ID assigned by Palmetto GBA
	ISA07	Interchange ID Qualifier	ZZ	CMS expects to see a value of "ZZ" to designate that the code is mutually defined
	ISA08	Interchange Receiver ID	80896	MA Supplemental Dental
	ISA11	Repetition Separator	^	
	ISA13	Interchange Control Number		Must be fixed length with nine (9) characters and match IEA02 Used to identify file level duplicate collectively with GS06, ST02, and BHT03
	ISA14	Acknowledgement Requested	1	A TA1 will be sent if the file is syntactically incorrect, otherwise only a '999' will be sent
	ISA15	Usage Indicator	T P	Test Production
IEA		Interchange Control Trailer		
	IEA02	Interchange Control Number		Must match the value in ISA13

4.2 GS/GE

The functional group is outlined by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

MA organizations and other entities must populate all elements in the GS/GE functional group. There are several elements within the GS/GE that must be populated specifically for MA Supplemental Dental data collection (see Table 5B). Table 4B below provides those specific Functional Group (GS/GE) elements.

TABLE 4B - GS/GE FUNCTIONAL GROUP ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
GS		Functional Group Header		
	GS02	Application Sender's Code		Submitter ID assigned by Palmetto GBA This value must match the value in ISA06
	GS03	Application Receiver's Code	80896	This value must match the value in ISA08
	GS06	Group Control Number		This value must match the value in GE02 Used to identify file level duplicates collectively with ISA13, ST02, and BHT03
LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
	GS08	Version/Release/Industry Identifier Code	005010X224A2	
GE		Functional Group Trailer		
	GE02	Group Control Number		This value must match the value in GS06

4.3 ST/SE

The transaction set (ST/SE) contains required, situational loops, unused loops, segments, and data elements. The transaction set is outlined by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifies the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments. Several elements must be populated specifically for MA Supplemental Dental encounter data purposes (see Table 5B).

Table 4C provides those specific Transaction Set (ST/SE) elements.

TABLE 4C - ST/SE TRANSACTION SET HEADER AND TRAILER ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
ST		Transaction Set Header		
	ST01	Transaction Set Identifier Code	837	
	ST02	Transaction Set Control Number		This value must match the value in SE02 Used to identify file level duplicates collectively with ISA13, GS06, and BHT03
	ST03	Implementation Convention Reference	005010X224A2	
LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
SE		Transaction Set Trailer		
	SE01	Number of Included Segments		Must contain the actual number of segments within the ST/SE
	SE02	Transaction Set Control Number		This value must match the value in ST02

5 837 MA Supplemental Dental: Data Elements

Within the ST/SE transaction set, there are multiple loops, segments, and data elements that provide billing provider, subscriber, and patient level information. MA organizations and other entities should reference <https://x12.org/> to obtain the most current TR3. MA organizations and other entities must submit EDFES transactions using the most current transaction version.

The 837 MA Supplemental Dental Data Element table identifies only those elements within the X12N TR3 that require comment within the context of the EDFES' submission. Tables 5A and 5B identify the 837 Dental TR3 by loop name, segment name, segment identifier, data element name, and data element identifier for cross reference. Not all data elements listed in the tables below are required, but if they are used, the table reflects the values CMS expects to see.

TABLE 5A – BEGINNING OF HIERARCHIAL TRANSACTION

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
	BHT	Beginning of Hierarchical Transaction		
	BHT03	Originator Application Transaction Identifier		Must be a unique identifier across all files Used to identify file level duplicates collectively with ISA13, GS06, and ST02.
	BHT06	Claim Identifier	CH	Chargeable

TABLE 5B - 837 MA SUPPLEMENTAL DENTAL DATA ELEMENTS

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Submitter ID assigned by Palmetto GBA
1000B	NM1	Receiver Name		
	NM103	Receiver Name		MADCMS
	NM109	Receiver ID	80896	MA Supplemental Dental
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Number Code	S	MADCMS is considered the destination (secondary) payer
	SBR09	Claim Filing Indicator Code	17	MA Supplemental Dental
LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2010AA	NM1	Billing Provider Name		
	NM108	Billing Provider ID Qualifier	XX	NPI Identifier
	NM109	Billing Provider Identifier	1XXXXXXXXX	Must be populated with a ten-digit number; must begin with 1. Note: Default NPIs should only be submitted to the EDS when the provider is considered "atypical". MA Supplemental Dental Default NPI: 1999999968.
2010BA	NM1	Subscriber Name		
	NM108	Subscriber ID Qualifier	MI	Must be populated with a value of MI – Member Identification Number
	NM109	Subscriber Primary Identifier		This is the subscriber's Medicare Beneficiary Identifier (MBI) number. Must match the value in Loop 2330A, NM109.
2010BB	NM1	Payer Name		
	NM103	Payer Name		MADCMS
	NM109	Payer Identification	80896	MA Supplemental Dental
2010BB	REF	Other Payer Secondary Identifier		
	REF01	Contract ID Identifier	2U	
	REF02	Contract ID Number		MA organization or other entities Contract ID Number
2300	REF	Payer Claim Control Number		

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
	REF01	Original Reference Number	F8	
	REF02	Payer Claim Control Number		Identifies the Interchange Control Number (ICN) from the original encounter when submitting adjustments
2320	AMT	Payer Paid Amount		
	AMT01	Amount Qualifier	D	Must be populated with a value of D – Payer Amount Paid
	AMT02	Payer Paid Amount		MA Supplemental Dental plan paid amount

6 Acknowledgements and/or Reports

6.1 TA1 – Interchange Acknowledgement

The TA1 report enables the receiver to notify the sender when there are problems with the interchange control structure. As the interchange envelope enters the EDFES, the Electronic Data Interchange (EDI) translator performs TA1 validation of the control segments/envelope. The sender will only receive a TA1 if there are syntax errors in the file. Errors found in this stage will cause the entire X12 interchange to be rejected with no further processing.

MA organizations and other entities will receive a TA1 interchange report acknowledging the syntactical inaccuracy of an X12 interchange header ISA and trailer IEA and the envelope's structure. Encompassed in the TA1 is the interchange control number, interchange date and time, interchange acknowledgement code, and interchange note code. The interchange control number, date, and time are identical to those populated on the original 837-D ISA line, which allows for MA organizations and other entities to associate the TA1 with a specific file previously submitted.

Within the TA1 segment, MA organizations and other entities will be able to determine if the interchange was rejected by examining the interchange acknowledgement code (TA104) and the interchange note code (TA105). The interchange acknowledgement code stipulates whether the interchange (ISA/IEA) was rejected due to syntactical errors. An "R" in the TA104 data element indicates the interchange rejected due to errors. The interchange note code is a numeric code that notifies MA organizations and other entities of the specific error. If a fatal error occurs, the EDFES generates and returns the TA1 interchange acknowledgement report within 24 hours of the interchange submission. If a TA1 interchange control structure error is identified, MA organizations and other entities must correct the error and resubmit the interchange file.

6.2 999 – Functional Group Acknowledgement

After the interchange passes the TA1 edits, the next stage of editing is to apply TR3 edits and verify the syntactical correctness of the functional group(s) (GS/GE). Functional groups allow for organization of like data within an interchange; therefore, more than one (1) functional group with multiple claims within the functional group can be populated in a file. The 999-acknowledgement report provides information on the validation of the GS/GE functional group(s) and the consistency of the data. The 999 report provides MA organizations and other entities with information on whether the functional groups were accepted or rejected.

If a file has multiple GS/GE segments and errors occurred at any point within one of the syntactical and TR3 level edit validations, the GS/GE segment will be rejected, and processing will continue to the next GS/GE segment. For instance, if a file is submitted with three (3) functional groups and there are errors in the second functional, the first functional group will accept, the second functional group will reject, and processing will continue to the third functional group.

The 999-transaction set is designed to report on adherence to TR3 level edits and CMS standard syntax errors as depicted in the CMS edit spreadsheet. Three (3) acknowledgement values are:

- “A” – Accepted
- “R” – Rejected
- “P” – Partially Accepted, At Least One Transaction Set Was Rejected

When viewing the 999 report, MA organizations and other entities should navigate to the IK5 and AK9 segments. If an “A” is displayed in the IK5 and AK9 segments, the claim file is accepted and will continue processing. If an “R” is displayed in the IK5 and AK9 segments, an IK3 and an IK4 segment will be displayed. These segments indicate what loops and segments contain the error that needs correcting so the interchange can be resubmitted. The third element in the IK3 segment identifies the loop that contains the error. The first element in the IK3 and IK4 indicates the segment and element that contains the error. The third element in the IK4 segment indicates the reason code for the error.

6.3 Dental Validation Report

Effective in Phase 2, the Dental Validation Report will no longer be issued for submissions. It is replaced by the 277CA report. After the file is accepted at the interchange and functional group levels, the third type of report MA organizations will receive is a 277CA report. If an encounter is accepted, the 277CA report will provide the ICN assigned to that encounter.

6.3.1 277CA Report

The 277CA is an unsolicited Acknowledgement Report from CMS to MAOs and other entities. The 277CA Acknowledgement Report provides the status of each EDR or CRR as either accepted or rejected due to CCEM edits.

The 277CA is used to acknowledge the acceptance or rejection of encounters submitted using a hierarchical level (HL) structure. There are four hierarchical levels:

- 1) Information Source (HL Code = 20); Sender of the 277CA (for example, Palmetto GBA)
- 2) Information Receiver (HL Code = 21); Submitter of data to CMS
- 3) Provider of Service (HL Code = 19); Billing Provider
- 4) Patient (HL Code = PT); Beneficiary

Acceptance or rejection at this level is based on the TR3 guides, and the CMS 5010 Edit Spreadsheets. Edits received at any hierarchical level will stop, and no further editing will take place. For example, if there is a problem with the Billing Provider of Service submitted on the EDR, individual patient edits will not be performed.

When the EDR is rejected at any hierarchical level, the entire EDR will reject and the submitter will be required to correct and resubmit the encounter until it is accepted. For example, if there is a problem with the Billing Provider of Service submitted on the 837, individual patient edits will not be performed.

The STC03 data element value will indicate the status of the HL:

“WQ” if the HL was accepted

“U” if the HL was rejected

If an EDR is accepted, the 277CA will provide the Internal Control Number (ICN) assigned to that encounter. The ICN segment for the accepted encounter will be located in 2200D REF segment, REF01=IK and REF02=ICN. The ICN is a unique 13-digit number.

6.4 Reports File Naming Conventions

For MA organizations and other entities to receive and identify the EDFES acknowledge reports (TA1, 999, and 277CA) specific report file naming conventions have been used. The file name ensures that the specific reports are appropriately distributed to each secure, unique mailbox. The EDFES has established unique file naming conventions for reports distributed during testing and production.

MA Organizations and other entities are encouraged to review the Medicare Advantage and Part D Communications Handbook to obtain the necessary information regarding Response Report Naming Conventions, the structure of the file naming conventions, and other guidance related to reports and file submissions. The handbook is available on the CSSC Operations website.

7 MA Supplemental Dental Testing and Certification for New Submitters

MA organizations will be required to submit test files to ensure the submitter’s systems are properly configured for data submission. Before exchanging production transactions, each plan must complete testing to become certified. This process allows MA organizations to confirm that the CMS operational guidance has been properly programmed in their systems. (**Note:** MA organizations must first enroll to submit MA organization data before any testing occurs.)

MEDICARE ADVANTAGE SUPPLEMENTAL DENTAL TESTING/CERTIFICATION	
All Plans (Medicare Advantage, Cost, PACE) and Third-Party Submitters	1 file containing a minimum of 25 encounters
Submission Requirements: <ul style="list-style-type: none">• Files must be identified using the Authorization Information Qualifier data element “Additional Data Identification” in the ISA segment (ISA01 = 03).• Files must be identified using the Authorization Information data element to identify the “Test Certification File” in the ISA segment (ISA02 = TSTCERTFIL).• Files must be identified as “Test” in the ISA segment (ISA15 = T).• All files must pass with 100% acceptance rate.• In the event more than the required number of encounters are submitted, the file must still receive a 100% acceptance rate.	

8 MAO-001 and MAO-002 Updates

To support the unique data received on the 837D, while maintaining the length and format of the established MAO-001 and MAO-002 reports, CMS utilized spaces that for Professional, Institutional and DME submissions.

The MAO-001 will have a new version the MAO-001 DEN, specific to reporting on the duplicate supplemental dental submissions. The MAO-001 DEN re-purposes positions 134-136 from available filler for reporting the tooth number.

The MAO-002 report will include new values in certain fields to delineate the report as dental. Within the MAO-002 report there are new values added to positions 106-108 "Record Type" in the header record and position 92-94 "Prelim RA Flag" in the detail record.

'Record Type', positions 106-108 in the header record will now include DEN, for dental. This will appear on MAO-001 and MAO-002 reports associated with 837D submissions.

'Prelim RA Flag', positions 92-94 in the detail record can now also be blank or have no values. The Prelim RA Flag will be blank on the MAO-002 reports for supplemental dental encounters.

9 Encounter Data System Edits

Starting with the implementation of Phase 2 Dental submissions, all MA submissions on the X12 837 5010 Dental format will be validated in the Encounter Data Processing System (EDPS).

These validations include new and updated edits for supplemental dental encounters. Dental-specific edits will follow the 60XXX format.

Edit 60000 - Line Level DOS Required' is a dental line level reject edit that validates the submission of the specific service date at the line when the header service date is greater than 1 day.

Edit 60005 - Service Date Greater Than ICN Date' is a dental header and line level reject edit that validates the encounter submission date (ICN date) is not before the service date on the encounter. The line level portion of this edit validates the line level service date is greater than the receipt date within ICN date. The header level portion of this edit validates the submitter 'to' service date is greater than the ICN Date.

Edit 60010 - 'DOS Prior to 2024' is a dental header and line level reject edit that validates the header or line service date is after January 1, 2024. CMS announced the collection of dental encounters in August of 2024 starting with service dates on or after January 1, 2024.

Edit 60015 - 'Service Line Duplicated' is a dental line level reject edit that validates the following criteria submitted on the encounter are not the same as a previously submitted line or line within the encounter: Beneficiary Identifier, Line Service Date, Place of Service, Procedure Code, Modifiers, Rendering Provider NPI, Service Line Billed amount, Area of Oral Cavity, Tooth Number, Tooth Surface Code.

Edit 60020 - 'Invalid Assistant Surgeon NPI' is a dental header and line level reject edit that validates the submitted assistant surgeon NPI is not a dental atypical provider NPI and is not found in the NPPES reference data for the from service date.

Edit 60025 – ‘Invalid Supervising Provider NPI’ a dental header and line level reject edit that validates the submitted supervising provider NPI is not a dental atypical provider NPI and is not found in the NPPES reference data for the from Service Date.

9.1 Common Edits for Dental Encounters

The list of edits below represents existing encounter edits that will be applied to dental encounters. Appendix A includes the logic for each edit.

- Edit 00035 – ‘ICD-9 Codes Not Allowed’
- Edit 00265 – ‘Correct/Replace or Void ICN Not in EDPS’
- Edit 00699 – ‘Void Must Match Original’
- Edit 00755 – ‘Void Encounter Already Void/Adjusted’
- Edit 00760 – ‘Adjusted Encounter Already Void/Adjusted’
- Edit 00762 – ‘Unable to Void Rejected Encounter’
- Edit 00775 – ‘Unable to Adjust Rejected Encounter’
- Edit 00780 – ‘Adjustment Must Match Original’
- Edit 00800 – ‘Parent ICN Not Allowed for Original’
- Edit 01405 – ‘Sanctioned Provider’
- Edit 01410 – ‘Invalid Billing Provider NPI’
- Edit 01425 – ‘Invalid Rendering Provider NPI’
- Edit 01430 – ‘Invalid Referring Provider NPI’
- Edit 02106 – ‘Invalid Beneficiary Last Name’
- Edit 02110 – ‘Beneficiary ID Not on File’
- Edit 02112 – ‘DOS After Beneficiary DOD’
- Edit 02120 – ‘Beneficiary Sex Mismatch’
- Edit 02125 – ‘Beneficiary DOB Mismatch’
- Edit 02240 – ‘Beneficiary Not Enrolled in MAO for DOS’
- Edit 02256 – ‘Beneficiary Not Part C Eligible for DOS’
- Edit 03015 – ‘HCPCS Code Invalid for DOS’

10 MAO-001 DEN Format

HEADER RECORD There is only one header per record per file.				
Position(s)	Item	Notes	Length	Format
1	Record Type	0=Header	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "MAO-001"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Report Date	Date that the report was created by EDPS.	8	Numeric, format CCYYMMDD
19	Delimiter		1	Uses the * character value
20-27	Transaction Date		8	Numeric, format CCYYMMDD
28	Delimiter		1	Uses the * character value
29-67	Report Description	Value is "Encounter Data Duplicates Report"	39	Alpha Numeric, Left justify, blank fill
68	Delimiter		1	Uses the * character value
69-73	Filler		5	Blank – (Removal of Contract ID)
74	Delimiter		1	Uses the * character value
75-104	Submission Interchange Number	Interchange Sender ID (ISA06) + Interchange Control Number (ISA13) + Interchange Date (ISA09)	30	Alpha Numeric
105	Delimiter		1	Uses the * character value
106-108	Record Type	Value is "INS", "PRO", "DME", "DEN"	3	Alpha Numeric
109	Delimiter		1	Uses the * character value

Position(s)	Item	Notes	Length	Format
110-113	Submission File Type	Value is "TEST" or "PROD"	4	Alpha Numeric
114	Delimiter		1	Uses the * character value
115-200	Filler		86	Spaces
DETAIL RECORD There may be multiple detail records per file.				
Position(s)	Item	Notes	Length	Format
1	Record Type	1=Detail	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "MAO-001"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-15	Medicare Advantage Contract ID	Medicare Contract ID assigned to the MA Plan	5	Alpha Numeric
16	Delimiter		1	Uses the * character value
17-36	Plan ID (CCN)	Plan internal control number.	20	Alpha Numeric
37	Delimiter		1	Uses the * character value
38-56	Encounter ICN	Internal Control Number. In encounter data, only 13 spaces represent the ICN; however additional spaces allow for other use.	19	Alpha Numeric
57	Delimiter		1	Uses the * character value
58-60	Encounter Line Number	Internal line number generated by EDPS.	3	Numeric, no commas and/or decimals
61	Delimiter		1	Uses the * character value
62-81	Duplicate Plan Encounter ID (CCN)	Duplicate Plan ID stored in EDPS	20	Alpha Numeric
82	Delimiter		1	Uses the * character value

Position(s)	Item	Notes	Length	Format
83-101	Duplicate Encounter ICN	Duplicate Encounter ICN identified in EDPS. In encounter data, only 13 spaces represent the ICN. Additional spaces allow for other use.	19	Alpha Numeric
102	Delimiter		1	Uses the * character value
103-105	Duplicate Encounter Line Number	Internal line number generated by EDPS.	3	Numeric, no commas and/or decimals
106	Delimiter		1	Uses the * character value
107-118	Beneficiary HICN	Beneficiary Health Insurance Encounter Number	12	Alpha Numeric
119	Delimiter		1	Uses the * character value
120-127	Date of Service		8	Numeric, format CCYYMMDD
128	Delimiter		1	Uses the * character value
129-133	Error Code	Error Code	5	Alpha Numeric
134	Delimiter		1	Uses the * character value
135-136	Tooth Number	Tooth Number	2	Alpha Numeric
137	Delimiter		1	Uses the * character value
138-200	Filler		63	Spaces

TRAILER (TOTALS) RECORD There is only one trailer per record file.

Position(s)	Item	Notes	Length	Format
1	Record Type	9=Trailer	1	Numeric, no commas and/or decimals
2	Delimiter		1	Uses the * character value
3-9	Report ID	Value is "MAO-001"	7	Alpha Numeric
10	Delimiter		1	Uses the * character value
11-18	Total Number		8	Numeric, no commas and/or decimals

Position(s)	Item	Notes	Length	Format
	of Duplicate Encounter Lines Rejected			
19	Delimiter		1	Uses the * character value
20-27	Total Number of Encounter Lines Submitted		8	Numeric, no commas and/or decimals
28	Delimiter		1	Uses the * character value
29-36	Total Number of Encounter Records Submitted		8	Numeric, no commas and/or decimals
37	Delimiter		1	Uses the * character value
38-200	Filler		163	Numeric, no commas and/or decimals

Figure 10.1 MAO-001 DEN Formatted Report Example

Encounter Data Duplicates Report											
Report Run Date 09/05/2024 12:11PM											
Medicare Advantage Contract ID: H9999											
PROD											
Page 1											
Submission Interchange Number: EHC00000000000000000000											
Report Date: 09/05/2024											
Transaction Date: 09/05/2024											
Report ID: MAO-001											
Plan	Encounter ID (CCN)	Encounter ICN	Encounter Line Number	Duplicate Plan	Duplicate Encounter ID (CCN)	Duplicate Encounter ICN	Duplicate Encounter Line Number	Beneficiary ID	Date of Service	Error Code	Tooth Number
DEN	DUMMY_DATA	1234567890011	001	DUMMY_DATA	1234567890001	011	011	111111111111	06/01/2024	60015	21
DEN	DUMMY_DATA	1234567890012	002	DUMMY_DATA	1234567890002	012	012	222222222222	06/05/2024	60015	21
TOTALS:											
Total Number of Duplicate Encounter Lines Rejected: 2											
Total Number of Encounter Lines Submitted: 68											
Total Number of Encounter Records Submitted: 20											

Figure 10.2 MAO-001 DEN Text Report Example

0*MAO-001*20240905*20240905*Encounter Data Duplicates Report	*	*ENH99990000000000000000	*DEN*PROD*
1*MAO-001*H9999*DUMMY_DATA	*123456789001111	*001*DUMMY_DATA	*1234567890001 *001*111111111111 *20240601*60015*21*
1*MAO-001*H9999*DUMMY_DATA	*123456789002222	*002*DUMMY_DATA	*1234567890002 *002*222222222222 *20240605*60015*21*

11 MAO-002 Report for supplemental dental encounters

Figure 11.1 MAO-002 DEN Formatted Report Example

Encounter Data Processing Status Report									
Report Run Date 09/05/2024 12:11PM									
Medicare Advantage Contract ID: H9999									
PROD									
Page	1								Submission Interchange Number: ENC0000000000000000
Report ID: MAO-002									Report Date: 09/05/2024
								Transaction Date: 09/05/2024	
Record Type	Plan	Encounter ID (CCN)	Encounter ICN	PRELIM RA FLAG	PRELIM RA RSN CODE	Encounter Line Number	Encounter Status	Error	Description
DEN	DUMMY_DATA		123456789001111			000	Accepted	-	-
						001	Accepted	-	-
						002	Accepted	-	-
DEN	DUMMY_DATA		123456789001112			000	Accepted	-	-
						001	Accepted	-	-
						002	Accepted	-	-

Figure 11.2 MAO-002 DEN Text Report Example

```

0*MAO-002*20240905*20240905*Encounter Data Processing Status Report* *ENC00000000000000000001 *DEN*PROD*
1*MAO-002*H9999*DUMMY_DATA *123456789001111 * * *000*Accepted* *
1*MAO-002*H9999*DUMMY_DATA *123456789001112 * * *001*Accepted* *
9*MAO-002*00000000*00000064*00000000*00000002*00000002*00000000*00000002*
  
```

12 Acronyms

The Acronym Table below outlines a list of acronyms that are currently used in documentation, materials, and reports distributed to MA organizations and other entities. This list is not all-inclusive and should be considered a living document; as acronyms will be added, as required.

ACRONYMS	
ACRONYM	DEFINITION
C	
CMS	Centers for Medicare & Medicaid Services
CRLF	Carriage Return Line Feed
CSSC	Customer Service and Support Center
E	
EDFES	Encounter Data Front-End System
EDI	Electronic Data Interchange
EDR	Encounter Data Record
G	
GDG	Generated Data Group
I	
ICN	Interchange Control Number
L	
LF	Line Feed
M	
MA	Medicare Advantage
MASDS	Medicare Advantage Supplemental Dental Services
MBI	Medicare Beneficiary Identifier
P	
PACE	Programs of All-Inclusive Care for the Elderly
S	
SFTP	Secure File Transfer Protocol
T	
TR3	ASC X12 Technical Report Type 3

Appendix A

Edit 60000 – ‘Line Level DOS Required’

- Encounter header ‘From’ and ‘To’ date span is greater than 1 day and
- Line Service Date is not present on the encounter.

Note: For an encounter with one day span, the system will continue to adjudicate the encounter using the header level DOS. This is a mandatory edit.

Edit 60005 – ‘Service Date Greater Than ICN Date’

- Encounter line Service Date is greater than the receipt date portion of the ICN

OR

- EDPS shall post the header level Edit 60005 – ‘Service Date Greater Than ICN Date’ when the following condition is met:
 - Encounter header ‘To’ Service Date is greater than the receipt date portion of the ICN.

Edit 60010 – ‘DOS Prior to 2024’

- Encounter line Service Date is prior to 01/01/2024.

OR

- EDPS shall post the header level Edit 60010 – ‘DOS Prior to 2024’ when the following condition is met:
 - Encounter header ‘From’ Service Date is prior to 01/01/2024.

Note: This is a mandatory edit.

Edit 00035 – ‘ICD-9 Codes Not Allowed’

- Encounter contains ICD-9 Diagnoses codes.

Edit 00265 – ‘Correct/Replace or Void ICN Not in EDPS’

- Claim Frequency is ‘7’ or ‘8’ and
- Parent/Original ICN is not found on the EDPS history.

Edit 00699 – ‘Void Must Match Original’

- The current encounter is a Void/Delete encounter with a Claim Frequency code of ‘8’ and
- The Parent/Original encounter ICN is present in the EDPS and
- The status of the original encounter is ‘Accepted’ and
- One of the following data elements is not the same for the current Void and Original/History encounters:
 - Medicare Beneficiary Identifier (MBI) – header level.
 - Last Name (first 5 characters) – header level
 - First Name (first character) – header level
 - Place of Service – header level
 - Submitted Charges – header level
 - Date of Service – header level
 - Number of encounter lines – line level
 - Billing Provider NPI – header level
 - Rendering Provider NPI – header level
 - Payer ID

Notes: If the Last Name (first 5 characters)/ First Name (first character) on the current encounter doesn’t match with original/parent encounter, EDPS will validate names against the beneficiary data received in CMS beneficiary reference data.

Rendering Provider NPI will be validated only if submitted on current and original/parent encounters.

Edit 00755 – ‘Void Encounter Already Void/Adjusted’

- The current encounter is a Void/Delete encounter with a Claim Frequency code of ‘8’ and
- The Parent/Original encounter ICN is present in the EDPS and
- The status of the original encounter is ‘Voided’ or ‘Adjusted’ or ‘Credited.’

Edit 00760 – ‘Adjusted Encounter Already Void/Adjusted’

- The current encounter is a Correct/Replace encounter with a Claim Frequency code of ‘7’ and
- The Parent/Original encounter ICN is present in the EDPS and
- The status of the original encounter is ‘Voided’ or ‘Adjusted’ or ‘Credited.’

Edit 00762 – ‘Unable to Void Rejected Encounter’

- The current encounter is a Void/Delete encounter with a Claim Frequency code of ‘8’ and
- The Parent/Original encounter ICN is present in the EDPS and

- The status of the original encounter is 'Rejected.'

Edit 00775 – 'Unable to Adjust Rejected Encounter'

- The current encounter is a Correct/Replace encounter with a Claim Frequency code of '7' and
- The Parent/Original encounter ICN is present in the EDPS and
- The status of the original encounter is 'Rejected.'

Edit 00780 – 'Adjustment Must Match Original'

- The current encounter is a Correct/Replace encounter with a Claim Frequency code of '7' and
- The Parent/Original encounter ICN is present in the EDPS and
- The status of the original encounter is 'Accepted' and
- One of the following data elements is not the same for the current Adjustment and Original/History encounters:
 - Medicare Beneficiary Identifier (MBI) – header level.
 - Last Name (first 5 characters) – header level
 - First Name (first character) – header level
 - Place of Service – header level
 - Billing Provider NPI – header level
 - Payer ID

Note: If the current encounter's Last Name (first 5 characters)/ First Name (first character) doesn't match with original/parent encounter, EDPS will validate names against beneficiary data from CMS beneficiary reference data, Beneficiary in Cloud (BIC).

Edit 00800 – 'Parent ICN Not Allowed for Original'

- The current encounter is an original (claim frequency other than '7' or '8') and Parent ICN is present on the encounter.

Edit 01405 – 'Sanctioned Provider'

- Validate the Billing Provider at the Header level and
- Validate the Rendering Provider at the Header level and
- Validate the Rendering Provider at the Line level and

Post this edit when:

- Billing Provider or Rendering Provider (header and/or line level) submitted on the encounter has a Sanction date and the header 'from' date of service or the line Service Date is within the sanction begin date and the reinstatement date and

Note: Bypass this edit if the Billing and Rendering (header and/or line level) provider exists on the waiver file and the header 'from' date of service or the line Service Date is between the waiver effective date and waiver end date.

Edit 01410 – 'Invalid Billing Provider NPI'

- Billing Provider NPI is NOT a Dental Atypical NPI 1999999968 and
- Billing Provider NPI is not found in the NPPES data file for the encounter header 'From' Service Date.

Edit 01425 – 'Invalid Rendering Provider NPI'

- Rendering Provider NPI submitted on the encounter header is NOT a Dental Atypical Provider NPI 1999999968 and
- Rendering Provider NPI submitted on the encounter header is NOT found in the NPPES for the encounter header 'From' Service Date

OR

- Rendering Provider NPI submitted on the encounter service line is NOT a Dental Atypical Provider NPI 1999999968 and
- Rendering Provider NPI submitted on the encounter service line is NOT found in the NPPES for the encounter line Service Date.

Note: If line Service Date is not submitted, header Service Date will be used.

Edit 01430 – 'Invalid Referring Provider NPI'

- Referring Provider NPI submitted on the encounter header is NOT a Dental Atypical Provider NPI 1999999968 and

Referring Provider NPI submitted on the encounter header is NOT found in the NPPES for the encounter header 'From' Service Date.

Edit 60020 – 'Invalid Assistant Surgeon NPI'

- Assistant Surgeon NPI submitted on the encounter header is NOT a Dental Atypical Provider NPI 1999999968 and
- Assistant Surgeon NPI submitted on the encounter header is NOT found in the NPPES for the encounter header 'From' Service Date.

OR

- Assistant Surgeon NPI submitted on the encounter service line is NOT a Dental Atypical Provider NPI 1999999968 and

- Assistant Surgeon NPI submitted on the encounter service line is NOT found in the NPPES for the encounter line Service Date.

Note: If line Service Date is not submitted, header Service Date will be used.

Edit 60025 – ‘Invalid Supervising Provider NPI’

- Supervising Provider NPI submitted on the encounter header is NOT a Dental Atypical Provider NPI 1999999968 and
- Supervising Provider NPI submitted on the encounter header is NOT found in the NPPES for the encounter header ‘From’ Service Date.

OR

- Supervising Provider NPI submitted on the encounter service line is NOT a Dental Atypical Provider NPI 1999999968 and
- Supervising Provider NPI submitted on the encounter service line is NOT found in the NPPES for the encounter line Service Date.

Note: If line Service Date is not submitted, header Service Date will be used.

Edit 02106 – ‘Invalid Beneficiary Last Name’

- Beneficiary ID submitted on the encounter exists in the Beneficiary in Cloud (BIC) response.
- The first 5 positions of the Beneficiary Last Name do not match the first 5 positions of the Last Name found in BIC for the submitted Beneficiary ID

Note: If the Last Name (first 5 characters) doesn’t match, EDPS will validate the name against the beneficiary's history received in BIC response.

Edit 02110 – ‘Beneficiary ID Not on File’

- Beneficiary ID submitted on the encounter is not found in the Beneficiary in Cloud (BIC) response.

Edit 02112 – ‘DOS After Beneficiary DOD’

- Beneficiary ID submitted on the encounter exists in the Beneficiary in Cloud (BIC) response.
- The encounter line Service Date is after the beneficiary date of death found in the Beneficiary in Cloud (BIC) response for the Beneficiary ID submitted on the encounter.

Note: If line Service Date is not submitted, header ‘From’ Service Date will be used.

Edit 02120 – ‘Beneficiary Sex Mismatch’

- Beneficiary ID submitted on the encounter exists in the Beneficiary in Cloud (BIC) response.

- The Beneficiary's sex code submitted on the encounter does not match the Beneficiary's sex code found in the Beneficiary in Cloud (BIC) response for the Beneficiary ID submitted on the encounter.

Edit 02125 – 'Beneficiary DOB Mismatch'

- Beneficiary ID submitted on the encounter exists in the Beneficiary in Cloud (BIC) response and
- Month of the beneficiary's date of birth received on the encounter does not match the month of the beneficiary's date of birth stored in the Beneficiary in Cloud (BIC) response for the submitted Beneficiary ID.

OR

- Day of the beneficiary's date of birth received on the encounter does not match the day of the beneficiary's date of birth stored in Beneficiary in Cloud (BIC) response for the submitted Beneficiary ID.

OR

- The year of the beneficiary's date of birth received on the encounter is greater than plus or minus two (2) years of the year of the beneficiary's date of birth stored in Beneficiary in Cloud (BIC) response for the submitted Beneficiary ID.

Example Scenario:

Beneficiary's DOB: 1965-05-01

Allowed DOB on the encounter: 1963-05-01, 1964-05-01, 1965-05-01, 1966-05-01, 1967-05-01

Edit 02240 – 'Beneficiary Not Enrolled in MAO for DOS'

- The Contract ID in the Beneficiary in Cloud (BIC) response for the Beneficiary ID submitted on the encounter matches the Contract ID submitted on the encounter, but the Encounter header 'From' date of service or 'To' date of service is not within the Contract ID effective and termination dates.

OR

- Contract ID submitted on the encounter for the Beneficiary ID does not match the Contract ID found in the Beneficiary in Cloud (BIC) response.

Note: Bypass this edit when the Encounter 'From' date of service" is equal to or prior to the Contract ID termination date and the 'To' date of service" is after the Contract ID termination date and Place of Service is equal to 21, 31, 32, 51, 55, 56, OR 61 on the header.

Edit 02256 – 'Beneficiary Not Part C Eligible for DOS'

- Encounter line Service Date is before the Beneficiary Part C entitlement start date.

OR

- Encounter line Service Date is after the Beneficiary Part C entitlement end date.

OR

- Encounter header Service Date is before the Beneficiary Part C entitlement start date when line Service Date is not submitted.

OR

- Encounter header Service Date is after the Beneficiary Part C entitlement end date when line Service Date is not submitted.

OR

- Treatment Start Date is within the Beneficiary Part C entitlement start and end dates and Treatment End date is after the entitlement end date when line Service Date is not submitted, and both Treatment Start and End dates are submitted.

Notes: Bypass this edit when the Treatment Start date is within the Contract ID effective and termination dates and the Treatment End date is after the Contract ID termination date and the Place of Service is equal to 21, 31, 32, 51, 55, 56, or 61 on the service line.

If the line POS is not submitted, header POS will be used.

Edit 60015 – ‘Service Line Duplicated’

When the encounter service lines are submitted with exact same data elements as listed below:

- Beneficiary Identifier
- Line Service Date
- Place of Service
- Procedure code
- Modifiers
- Rendering Provider NPI
- Service Line Billed Amount
- Area of the Oral Cavity, if recommended by ADA for Procedure Code (SV304)
- Tooth Number, if recommended by ADA for Procedure Code (TOO02)
- Tooth Surface code, if recommended by ADA for Procedure Code (TOO03)

Notes: 1. EDPS validates the data elements within the same encounter and against the accepted history service.

2. If the line Service Date is not submitted, header Service Date(s) will be used.

3. The following reference data must be loaded and maintained, and it will be utilized in Duplicate check to validate the Area of Oral Cavity, Tooth Number, and Tooth Surface codes: [ADA Guide to Dental Procedures Reported with Area of the Oral Cavity or Tooth Anatomy \(or Both\)](#)

4. If any of the Area of Oral Cavity is recommended for the CDT code (Entire, Arch, and/or Quadrant), the submitted Area of Oral Cavity will be validated in duplicate editing regardless of which Area of the Oral Cavity code is submitted.

5. If Tooth Number and/or Tooth range are recommended for the CDT code, the submitted Tooth Number will be validated in duplicate editing.

6. If the Tooth Surface code is recommended for the CDT code, the submitted Tooth Surface code will be validated in duplicate editing.

7. This edit will post on service lines with multiple TOO segments when the Tooth Number and Tooth Surface codes are duplicated regardless of whether the Tooth Number and Tooth Surface codes are ADA recommended.

Edit 03015 – ‘HCPCS Code Invalid for DOS’

- The Procedure code submitted on the service line exists in the Procedure reference tables and
- The line Service Date is before the Procedure code effective date or
- The line Service Date is after the Procedure code termination date

Note: If the line Service Date is not submitted, header ‘From’ Service Date will be used.

