Mid-State Health Network PIHP
COMPANION GUIDE FOR THE
837 PROFESSIONAL/INSTITUTIONAL ENCOUNTERS VERSION 5010A1
Version Date: 10/1/2017

This document is intended as a companion to the 005010X222 and 005010X223

This document is expected to be used in conjunction with the TR3 and related Errata for the 837P / 837I transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This Companion Guide is intended to be used in conjunction with the Michigan Department of Health and Human Services (MDHHS) 837 Encounter reporting requirements, including the companion guides and financial reporting requirements. See MDHHS Reporting Requirements.

This document specifically does not address every data element, whether required or optional, nor every scenario nor situation that the National Implementation Guides address. It is vital that you, your software vendor, or claim service provider conform to the specifications as detailed in the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Professional. The purpose of this document is to assist you in the proper completion for submission to MSHN. Information provided in this guide is subject to change.

Loop	Segment	Data Element	Comments
	ISA	ISA05	"ZZ"
	ISA	ISA06	Submitter ID **Use CHAMPS CMHSP ID assigned to the submitting CMHSP**
	ISA	ISA07	"ZZ"
	ISA	ISA08	Receiver ID "**ENCOUNTER**"
	ISA	ISA15	"P" for production or "T" for test
	GS	GS02	Submitter ID (same as ISA06)
	GS	GS03	"**ENCOUNTER**" (same as ISA08)
	GS	GS08	"005010X222A1" or "005010X223A2"
	BHT – Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	Use "**RP**" (Reportable)
2010AA – Billing Provider Name			Billing provider is required Billing Provider is the organization or agency who employs the provider of services. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.
	NM1*85 Billing Provider Name	NM108	Use "XX" (NPI)

Loop	Segment	Data Element	Comments
		NM109	Billing Provider's NPI
	REF	REF01	Use "EI" (EIN)
		REF02	Billing Provider's EIN
	REF	REF01	**If the specialized residential facility is reported as the Billing Provider, the PIHP is to include the LARA license number of the specialized residential facility in the REF segment of the 2010AA loop** Use "OB"
		REF02	LARA License # of the residential facility Sample: REF*OB*AS555544444~
2000B Subscriber Hierarchical Level	SBR – Subscriber Information	SBR02 - Individual Relationship Code	Use "18" (self)
2010BA Subscriber Name	NM1*IL	NM108 – Identification Code Qualifier	Use "MI" (Member ID)
		NM109 – Subscriber Primary Identifier	Use the 10-digit Medicaid Beneficiary ID if available, otherwise use 9-digit SSN or 11-digit CMH CONID
2010BA Subscriber Name	REF – Subscriber Secondary Identification	REF01 – Reference Identification Qualifier	Use "SY" (SSN)
		REF02 – Reference Identification	Consumer SSN.
2010BB Payer Name	NM1*PR	NM101 – Entity Identifier Code	Use "PR".
		NM102 – Entity Type Qualifier	Use "2"
		NM103 – Organization Name	Use "MDHHS"
		NM108 – Identification Code Qualifier	Use "PI" (for Payer ID)
		NM109 – Payer Identifier	Use "D00111" (for MDHHS)
2000C		Loop – Patient	MDHHS business rules require that the patient is always the subscriber. Do not submit 2000C loop.

Loop	Segment	Data Element	Comments
2300 Claim Information	CLM Claim Submitter's Identifier	CLM01	Submitter's Unique Claim Identifier
2300		CLM05-3 – Claim Frequency Code	"1" on original encounter submissions "7" for encounter replacement "8" for encounter void/cancel For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number).
2300	HI – Health Care Diagnosis Code	HI01 – Principal Diagnosis	Required on every claim.
		HI01-1	'ABK' Principal Diagnosis ICD-10 Codes.
		HI01-2	Diagnosis Code without the decimal point
			Up to 3 Additional Diagnosis Codes may be sent. The Qualifier Code for these additional Diagnosis Codes would be 'ABF' for ICD-10.
2310B Rendering Provider Name			Rendering provider must be specified either in loop 2310B or 2420A for all professional services.
2310B	NM1*82 Rendering Provider Name	NM108 – Identification Code Qualifier	Use "XX" (NPI)
		NM109 Rendering Provider Identifier	Rendering provider NPI
2310B	PRV	PRV01 Provider Code	Use "PE" (Performing)
		PRV02	Use "PXC"
		PRV03	Provider Taxonomy Code
2310C (837P) Service Facility			Service Facility loop is required if service is provided by a residential facility and that residential facility is NOT reported as the billing provider.
	REF	REF01	**For specialized residential facilities:** **Use "OB"**
		REF02	LARA License # of the residential facility Sample: REF*OB*AS555544444~

Loop	Segment	Data Element	Comments
2310E (837I) Service Facility			Service Facility loop is required for inpatient services. Hospital location / site must be reported in this loop.
	REF	REF01	**Use "LU"**
		REF02	2-digit hospital ID type must be reported. Valid values for MDHHS: 22 – state facility 68 – IMD 73 – local psychiatric community hospital
2320 Other Subscriber Information	SBR – Subscriber Information		MDHHS requires the health plan to report Loops – 2320 Other Subscriber Information. The health plan (Mental Health Prepaid Inpatient Health Plans (PIHP) as well as any Community Mental Health Service Program (CMH) affiliate responsible for the services being reported in the encounter transaction) will be identified as a payer in Loop - 2330B Other Payer Name. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name. 2 Iterations Required: **PIHP** - Required (once) / valid PIHP CHAMPS ID required and **CMH -** Required (once) / valid CMH CHAMPS ID required Other Payers (Medicare or other commercial carriers) - If applicable REFER TO MDHHS guide for details
2320	CAS	Claim Level Adjustments	DO NOT SEND - MDHHS required all COB adjudication to be submitted at the service line level (2430)
2330A Other Subscriber	NM1	NM108	"MI"
		NM109	Use the consumer's unique 11-digit CONID assigned by the CMH
2330B Payer Information	NM1	NM103	One iteration with CMH Name and another iteration with PIHP Name (**MSHN**)
		NM108	"PI"
		NM109	One iteration with CMHSP ID (7-digit number) Another iteration with PIHP ID (for MSHN, use **2813564**)
	REF	REF01	"F8" – Other Payer Control Number

Loop	Segment	Data Element	Comments
		REF02	For encounters, MDHHS requires a unique Encounter Reference Number (ERN) to always be submitted.
2400	SV1	SV102	Line Item Charge Amount is required
2420A	NM1	NM101	"82" – Rendering Provider
		NM103	Rendering Provider Name
		NM108	"XX"
		NM109	Rendering Provider NPI
2430 Line Adjudication Information	SVD	SVD02	The amount paid to the provider by each payer (repeat 2430 for each payer)
	CAS		The adjustment amounts for the submitted charge for the line

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General Information:

- Record delimiter should be a tilde (~) followed by a carriage return and line feed.
- Field delimiter is an asterisk (*).
- Sub-element separator is a colon (:).
- **Example:** SV1*HC:99213*167*UN*1***1**N~*<CR><LF>*
- Send all records in the format where the patient is the subscriber.
- All data will be converted to upper case before importing it to the system.

Testing Instructions:

1. Create test file and check integrity (i.e. BCBSM Validator or Claredi). Be sure to put "T" in data element ISA15.
2. Contact MSHN and request login information (User ID & Password) configured to upload CMH Encounter 837 files.
3. Login to **MSHN's REMI** system.
4. Select the "**Affiliate Submissions**" menu on the left.
5. Select the "**View and Upload QI/DD Proxy and Encounter Files**" option.
6. Follow the instructions on the screen to "**Upload 837 Encounter File**".
7. After you upload the file to REMI, email Dmitriy Katsman (dkatsman@pcesystems.com) to notify of your test submission.
8. Please note - the very first submission may automatically reject (with "Unknown trading partner / Translation Error"), regardless of any errors. You will receive an email assessment of your file within 5 days explaining all errors, if any.

Error Report Information:

The system generates an Error Report in a CSV format that details errors that were found during processing of the 837. The following describes the different data elements found on the error report:

- Batch ID - internal batch record ID
- Error Message Number - error code number
- Error Message - text description of error
- Error Type - Severity of error. Possible values:
  - RB - reject batch, entire batch is rejected
  - RE - reject encounter/reject claim
  - RL - reject line (if a line is rejected on a claim, then the whole claim will be rejected. There will be an error of type RE listed to denote that)
  - IO - warning, claim is still accepted
- Claim Number - claim number as provided by submitter
- Line Number - service line number
- Error Value - value which is in error
- Service Date - service date of the service line in error

In addition, a state-formatted 4950/ETRR file is generated containing similar information.