

**MICHIGAN DEPARTMENT OF
COMMUNITY HEALTH**

**COMPANION GUIDE
FOR THE HIPAA
837 INSTITUTIONAL ENCOUNTER
ADDENDA
VERSION 4010A1**

**Medicaid Health Plans (MHPs), County
Health Plans, and MICHild Health Plans**

January 7, 2010





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This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096A1)**, dated October 2002, and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837 (004010X096)** dated May 2000. This document should be used in conjunction with all MDCH encounter submission and processing guidelines. This document follows guidelines authorized by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

Encounter data submitted to the Michigan Department of Community Health (MDCH) will be handled using the 837 transaction Provider-to-Payer-to-Payer Coordination of Benefits (COB) data model. Follow the Implementation Guide instructions for COB reporting guidelines.

(The Addenda implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at <http://aspe.os.dhhs.gov/admsimp/q0321.htm>.)

NOTE: **Page references** from the Implementation Guides refer to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837 (004010X096)** (“Version 4010”), unless otherwise noted (with an asterisk (*)) as referring to the Addenda Implementation Guides (“Version 4010A1”), **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim Addenda, ASC X12N 837 (004010X096A1)**.

Shaded areas contain added or updated information.

Only change in this version is on page 9, the row referencing page 363, Data Element should be SBR09.



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| Page | Loop | Segment | Data Element | Comments |
|------|------|----------------------------------|--|---|
| | | ISA – Interchange Control Header | ISA01 - Authorization Information Qualifier | Use “00” |
| | | ISA – Interchange Control Header | ISA02 – Authorization Information | Space Fill |
| | | ISA – Interchange Control Header | ISA03 – Security Information Qualifier | Use “00” |
| | | ISA – Interchange Control Header | ISA04 – Security Information | Space Fill |
| | | ISA – Interchange Control Header | ISA05 – Interchange ID Qualifier | Use “ZZ” |
| | | ISA – Interchange Control Header | ISA06 – Interchange Sender ID | Service Bureau ID (00XX) followed by spaces |
| | | ISA – Interchange Control Header | ISA07 – Interchange ID Qualifier | Use “ZZ” |
| | | ISA – Interchange Control Header | ISA08 – Interchange Receiver ID | Use “ENCOUNTER” |
| | | ISA – Interchange Control Header | ISA11 Interchange Control Standards Identifier | Use “U” |
| | | ISA – Interchange Control Header | ISA12 - Interchange Control Version Number | Use “00401” |
| | | ISA – Interchange Control Header | ISA13 – Interchange Control Number | Must be Identical to IEA02 |
| | | ISA – Interchange Control Header | ISA14 – Acknowledgment Requested | Use “0” A 997 acknowledgment file will be provided when translation completes. |

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



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| | | ISA – Interchange Control Header | ISA15 Usage Indicator | Use “P” - Production |
| | | ISA – Interchange Control Header | ISA16 Component Element Separator | MDCH Suggests you use “:” (colon) as the Component Element Separator |
| | | GS Functional Group Header | GS08 Version / Release / Industry Identifier Code | Use only one of the following codes: “004010X098A1” – Version 4010A1 of the X12 837 Professional Health Care Invoice “004010X096A1” – Version 4010A1 of the X12 837 Institutional Health Care Invoice |
| 56 | | ST – Transaction Set Header | | MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide. Submissions with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected. |
| | | BHT – (Header) Beginning of Hierarchical Transaction | BHT03 – Reference Identification | This number may not be used again even if the prior batch is rejected. |
| 59 | | BHT – (Header) Beginning of Hierarchical Transaction | BHT06 – Transaction Type Code | Use “RP” – Reporting. |
| 11* | | REF – (Header) Transmission Type Identification | REF02 – Transmission Type Code | Use “004010X096A1” if using October 2002 Implementation Guide. |
| 63 | 1000A | NM1 – Submitter Name | NM109 – Submitter Identifier | Use the 4-character billing agent ID assigned by MDCH. This value should match GS02 (Application Sender’s Code). |
| 68 | 1000B | NM1 – Receiver Name | NM109 – Receiver Primary Identifier | Use “D00111” for MDCH. |
| 69 | 2000A – Billing/Pay-to Provider Hierarchical Level | HL – Hierarchical Level | HL01 – Hierarchical ID Number | HL01 must begin with “1” and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01. |

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| 12* | 2000A – Billing/Pay-to Provider Hierarchical Level | PRV – Billing/Pay-to Provider Specialty Information | PRV03 – Provider Taxonomy Code | MDCH requires taxonomy code to identify the provider specialty. MDCH expects the HIPAA-mandated Health Care Provider Taxonomy Code List will be used to identify the specialty code. |
| 77 | 2010AA – Billing Provider Name | NM1 – Billing Provider Name | NM108 – Identification Code Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “XX” (NPI) <u>May 23, 2007 and After – Atypical Providers:</u> - Use “24” (EIN) or “34” (SSN). |
| 78 | 2010AA – Billing Provider Name | NM1 – Billing Provider Name | NM109 – Billing Provider Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report the NPI value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier). <u>May 23, 2007 and After – Atypical Providers</u> - Report the EIN or SSN value assigned to the provider ID identified in Loop 2010AA REF02 (Billing Provider Additional Identifier). |
| 83 | 2010AA – Billing Provider Name | REF – Billing Provider Secondary Identification | REF01 – Reference Identification Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “E1” (EIN) or “SY” (SSN) <u>May 23, 2007 and After – Atypical Providers</u> - Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number). |
| 84 | 2010AA – Billing Provider Name | REF – Billing Provider Secondary Identification | REF02 – Billing Provider Additional Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report either the EIN or the SSN. <u>May 23, 2007 and After – Atypical Providers</u> - Report the Medicaid ID. If the provider does not have a Medicaid ID, report the state license number. |
| 102 | 2000B – Subscriber Hierarchical Level | SBR – Subscriber Information | SBR01 – Payer Responsibility Sequence Number Code | To identify MDCH’s level of responsibility use “S” if the capitated plan is the only payer (that is, patient has no other insurance), “T” if there are any other payers. |
| 103 | 2000B – Subscriber Hierarchical Level | SBR – Subscriber Information | SBR04 – Insured Group Name | Use “MICHILD” for children enrolled in the MICHild Program. Use “ABWI” for those enrolled in the Adult Benefit Waiver Phase I Program. |

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| 104 | 2000B – Subscriber Hierarchical Level | SBR – Subscriber Information | SBR09 – Claim Filing Indicator Code | Use “MC” (Medicaid) for Michigan Medicaid, “TV” (Title V) for CSHCS, “OF” (Other Federal) for MICHild or Adult Benefit Waiver Program Phase I. If recipient qualifies for more than one program, or other MDCH program not listed, use “MC” (Medicaid). |
| 110 | 2010BA – Subscriber Name | NM1 – Subscriber Name | NM108 – Identification Code Qualifier | Use “MI” (Member Identification). |
| 110 | 2010BA – Subscriber Name | NM1 – Subscriber Name | NM109 – Subscriber Primary Identifier | Use the patient’s 10-digit beneficiary ID number assigned by MDCH. For MICHild enrollees use the 10-digit Client Identification Number (CIN) assigned by the enrollment broker. |
| 117 | 2010BA – Subscriber Name | REF – Subscriber Secondary Identification | REF01 – Reference Identification Qualifier | Use “SY” (Social Security Number). |
| 118 | 2010BA – Subscriber Name | REF – Subscriber Secondary Identification | REF02 – Subscriber Supplemental Identifier | Use the patient’s Social Security Number. |
| 127 | 2010BC – Payer Name | NM1 – Payer Name | NM108 – Identification Code Qualifier | Use “PI” (Payor Identification). |
| 128 | 2010BC – Payer Name | NM1 – Payer Name | NM109 – Payer Identifier | Use “D00111” for MDCH. |
| 139 | 2000C – Patient Hierarchical Level | | | MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Levels) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected. |
| 157 | 2300 – Claim Information | | | Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B (Subscriber Hierarchical Level) will be rejected. |

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| 157 | 2300 – Claim Information | CLM – Claim Information | CLM02 – Total Claim Charge Amount | This element indicates the total amount of all submitted charges for this encounter. Zero (0) is a valid amount if: <ol style="list-style-type: none"> 1) the health plan has a subcapitated contract arrangement with the provider as designated in Loop 2300 CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 2) the service(s) is/are recognized by MDCH as having no associated charge(s), for example, vaccines. |
| 159 | 2300 – Claim Information | CLM – Claim Information | CLM05-1 – Facility Code Value | Place of service codes are defined by the Center for Medicare and Medicaid Services (formerly HCFA). |
| 159 | 2300 – Claim Information | CLM – Claim Information | CLM05-3 – Claim Frequency Type Code | Use “1” on original encounter submissions; use “7” for encounter replacement, and use “8” for encounter void/cancel. For both “7” and “8”, include the original Encounter Reference Number (ERN), as indicated in Loop 2330B REF02 (Original Reference Number). |
| 176 | 2300 – Claim Information | CN1 – Contract Information | CN101– Contract Type Code | MDCH requires this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service. |
| 208 | 2300 – Claim Information | NTE – Billing Note | NTE01 – Note Reference Code | Use “ADD” (Additional Information). |
| 209 | 2300 – Claim Information | NTE – Billing Note | NTE02 – Billing Note Text | Provide free-text remarks, if needed. |
| 230 | 2300 – Claim Information | HI – Health Care Information | HI01-2 – Diagnosis Related Group (DRG) Code | MDCH requires the DRG Code when an inpatient hospital is under DRG contract with the health plan. |
| 232-240 | 2300 – Claim Information | HI – Health Care Information | HI01-1, HI02-1, . . . , HI12-1 – Diagnosis Code | Use “BF” (ICD-9-CM Diagnosis). Do not use decimal point. |
| 242 | 2300 – Claim Information | HI – Principal Procedure Information | HI01–1 – Code List Qualifier Code | Use “BR” (ICD-9-CM Principal Procedure). |
| 242 | 2300 – Claim Information | HI – Principal Procedure Information | HI01–2 – Principal Procedure Code | See the ICD-9 CM Code book for allowable procedure codes. |
| 244 – 255 | 2300 – Claim Information | HI – Other Procedure Information | HI0–1, HI02–1, . . . , HI12–1 – Code List Qualifier Code | Use “BQ” (ICD-9-CM Procedure). |
| 245 – 255 | 2300 – Claim Information | HI – Other Procedure Information | HI01–2, HI02–2, . . . , HI12–2 – Procedure Code | See the ICD-9 CM Code book for allowable procedure codes. |

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| 256 – 266 | 2300 – Claim Information | HI – Occurrence Span Information | HI01–2, HI02–2, ..., HI12–2 – Occurrence Span Code | See the National Uniform Billing Manual for allowable codes. |
| 268 – 278 | 2300 – Claim Information | HI – Occurrence Information | HI01–2, HI02–2, ..., HI12–2 – Occurrence Code | See the National Uniform Billing Manual for allowable codes. |
| 281 – 291 | 2300 – Claim Information | HI – Value Information | HI01–2, HI02–2, ..., HI12–2 – Value Code | See the National Uniform Billing Manual for allowable codes. |
| 290 | 2300 – Claim Information | HI – Condition Information | HI01–2, HI02–2, ..., HI12–2 – Condition Code | See the National Uniform Billing Manual for allowable codes. |
| 323 | 2310A – Attending Physician Name | NM1- Attending Physician Primary Identifier | NM108 – Identification Code Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “XX” (NPI) <u>May 23, 2007 and After – Atypical Providers:</u> - Use “24” (EIN) or “34” (SSN). |
| 323 | 2310A – Attending Physician Name | NM1- Attending Physician Primary Identifier | NM109 – Attending Physician Primary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report the NPI value assigned to the provider. <u>May 23, 2007 and After – Atypical Providers</u> - Report the EIN or SSN value assigned to the provider ID identified in Loop 2310A REF02 (Attending Physician Secondary Identifier). |
| 21* | 2310A – Attending Physician Name | PRV – Attending Provider Specialty Information | PRV03 – Provider Taxonomy Code | MDCH requires taxonomy code to identify the provider specialty. MDCH expects the HIPAA-mandated Health Care Provider Taxonomy Code List will be used to identify the specialty code. |
| 326 | 2310A – Attending Physician Name | REF – Attending Physician Secondary Identification | REF01 – Reference Identification Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310A REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number). |
| 327 | 2310A – Attending Physician Name | REF – Attending Physician Secondary Identification | REF02 – Attending Physician Secondary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310A REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Report the Medicaid ID. If the provider does not have a Medicaid ID, report the state license number. |

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| 330 | 2310B – Operating Physician Name | NM1- Operating Physician Primary Identifier | NM108 – Identification Code Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “XX” (NPI) <u>May 23, 2007 and After – Atypical Providers:</u> - Use “24” (EIN) or “34” (SSN). |
| 330 | 2310B – Operating Physician Name | NM1- Operating Physician Primary Identifier | NM109 – Operating Physician Primary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report the NPI value assigned to the provider. <u>May 23, 2007 and After – Atypical Providers</u> - Report the EIN or SSN value assigned to the provider ID identified in Loop 2310B REF02 (Operating Physician Secondary Identifier). |
| 333 | 2310B – Operating Physician Name | REF – Operating Physician Secondary Identification | REF01 – Reference Identification Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310B REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number). |
| 334 | 2310B – Operating Physician Name | REF – Operating Physician Secondary Identification | REF02 – Operating Physician Secondary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310B REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Report the Medicaid ID. If the provider does not have a Medicaid ID, report the state license number. |
| 337 | 2310C – Other Provider Name | NM1 – Other Provider Primary Identification | NM108 – Identification Code Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “XX” (NPI) <u>May 23, 2007 and After – Atypical Providers:</u> - Use “24” (EIN) or “34” (SSN). |
| 337 | 2310C – Other Provider Name | NM1 – Other Provider Primary Identification | NM109 – Other Provider Primary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report the NPI value assigned to the provider. <u>May 23, 2007 and After – Atypical Providers</u> - Report the EIN or SSN value assigned to the provider ID identified in Loop 2310C REF02 (Other Provider Secondary Identifier). |

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| 340 | 2310C – Other Provider Name | REF – Other Provider Secondary Identification | REF01 – Reference Identification Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310C REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number). |
| 341 | 2310C – Other Provider Name | REF – Other Provider Secondary Identification | REF02 – Other Provider Secondary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310C REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Report the Medicaid ID. If the provider does not have a Medicaid ID, report the state license number. |
| 350 | 2310E – Service Facility Name | NM1 – Service Facility Primary Identification | NM108 – Identification Code Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Use “XX” (NPI) <u>May 23, 2007 and After – Atypical Providers:</u> - Use “24” (EIN) or “34” (SSN). |
| 350 | 2310E – Service Facility Name | NM1 – Service Facility Primary Identification | NM109 – Laboratory or Facility Primary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Report the NPI value assigned to the provider. <u>May 23, 2007 and After – Atypical Providers</u> - Report the EIN or SSN value assigned to the provider ID identified in Loop 2310E REF02 (Laboratory or Facility Secondary Identifier). |
| 357 | 2310E – Service Facility Name | REF – Service Facility Secondary Identification | REF01 – Reference Identification Qualifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310E REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Use “1D” (Medicaid Provider Number) unless the provider does not have a Medicaid ID, then use “0B” (State License Number). |
| 358 | 2310E – Service Facility Name | REF – Service Facility Secondary Identification | REF02 – Laboratory or Facility Secondary Identifier | <u>May 23, 2007 and After – Covered Healthcare Providers:</u> - Do not submit 2310E REF segment. <u>May 23, 2007 and After – Atypical Providers</u> - Report the Medicaid ID. If the provider does not have a Medicaid ID, report the state license number. |
| 359 | 2320 – Other Subscriber Information | SBR – Subscriber Information | | This loop will be used once for the capitated plan and once for each other payer. |

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| 360 | 2320 – Other Subscriber Information | SBR – Subscriber Information | SBR01 – Payer Responsibility Sequence Number Code | If the patient has Medicare or other insurance, report that coverage with code “P” or “S” as appropriate, and the capitated plan coverage with “S” or “T”, as appropriate. If the patient has no other insurance, report the capitated plan coverage with “P”. |
| 361 | 2320 – Other Subscriber Information | SBR – Subscriber Information | SBR02 – Individual Relationship Code | The code carried in this element is the patient’s relationship to the person who is insured. For example, if a child with Medicaid has coverage under his father’s insurance, use code 19 (Child). |
| 363 | 2320 – Other Subscriber Information | SBR – Subscriber Information | SBR03 – Insured Group or Policy Number | Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits. |
| 363 | 2320 – Other Subscriber Information | SBR – Subscriber Information | SBR09 – Insurance Type Code | Use “MC” (Medicaid) for Medicaid Health Plan, “OF” (Other Federal) for MICHild Health Plan or Adult Benefit Waiver Program Phase I Health Plan. Additional payers should be identified using the appropriate code. |
| 365 | 2320 – Other Subscriber Information | CAS – Claims Adjustment | | MDCH expects claim adjustment information when the health plan paid the provider an amount different than the value reported in Loop 2300 CLM02 (Total Claim Charge). MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference. |
| 372 | 2320 – Other Subscriber Information | AMT – Monetary Amount | AMT02 – Allowed Amount | MDCH requires the health plan’s fee-screen or maximum allowable amount for the service(s) reported when the contract with the provider is fee-for-service. Zero (0) may be an appropriate value if the health plan never covers the service. The health plan is not required to report this data element when the contract arrangement with the provider is subcapitated, as designated in Loop 2300 CN101 (Contract Type Code) or Loop 2400 CN101 (Contract Type Code). |
| 401 – 402 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM103, NM104, NM105 – Other Insured: Last Name, First Name, Middle Name | Use the name of the subscriber as it appears on the files of the capitated plan or other payer. |
| 401 – 402 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM108 – Identification Code Qualifier | Use “MI” (Member Identification Number). |

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| 403 | 2330A – Other Subscriber Name | NM1 – Other Subscriber Name | NM109 – Other Insured Identifier | Use the unique member number assigned to the subscriber by the capitated plan or other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits. |
| 408 | 2330A – Other Subscriber Name | REF – Other Subscriber Secondary Identification | REF01 – Reference Identification Qualifier | Do not use “1W” (Member Identification Number). |
| 411 | 2330B – Other Payer Name | NM1 – Other Payer Name | NM108 – Identification Code Qualifier | Use “PI” (Payor Identification). |
| 411 | 2330B – Other Payer Name | NM1 – Other Payer Name | NM109 – Other Payer Primary Identifier | For the capitated plan, use the 7-digit Payer ID assigned by champs for example 1234567. For other payers, use the 8-digit carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) carried in this element would be “00029005”. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”. |
| 416 | 2330B – Other Payer Name | REF – Other Payer Secondary Identification | REF01 – Reference Identification Qualifier | For the capitated plan, use “F8” (Original Reference Number). |
| 417 | 2330B – Other Payer Name | REF – Other Payer Secondary Identification | REF02 – Other Payer Secondary Identifier | For the capitated plan, enter the plan-assigned unique identifier (encounter reference number) for the encounter. |
| 418 | 2330B – Other Payer Name | REF – Other Payer Prior Authorization or Referral Number | REF01 – Reference Identification Qualifier | Use “9F” (Referral Number) or “G1” (Prior Authorization Number). |
| 419 | 2330B – Other Payer Name | REF – Other Payer Prior Authorization or Referral Number | REF02 – Other Payer Prior Authorization or Referral Number | If the capitated plan or other payer pre-authorized services or a referral, enter the authorization number or referral number here. Do not use the Prior Authorization or Referral Number (Loop 2300 REF02 – Prior Authorization or Referral Number), which is specific to the destination payer. |
| 426 | 2330D – Other Payer Attending Provider | REF – Other Payer Attending Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |

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| 430 | 2330E – Other Payer Operating Provider | REF – Other Payer Operating Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 434 | 2330F – Other Payer Other Provider | REF – Other Payer Other Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 438 | 2330G – Other Payer Referring Provider | REF – Other Payer Referring Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 442 | 2330H – Other Payer Service Facility Provider | REF – Other Payer Service Facility Provider Identification | REF01 – Reference Identification Qualifier | Do not use “1D” (Medicaid Provider Number). |
| 444 | 2400 – Service Line | | | The HIPAA implementation guide allows up to 999 repetitions of the 2400 service line loop for each 2300 loop. |
| 446 | 2400 – Service Line | SV2 – Institutional Service Line | SV201 – Service Line Revenue Code | See the National Uniform Billing Manual for allowable codes. |
| 447 | 2400 – Service Line | SV2 – Institutional Service Line | SV202-2 – Procedure Code | See the National Uniform Billing Manual for allowable codes. |
| 448 | 2400 – Service Line | SV2 – Institutional Service Line | SV203 – Line Item Charge Amount | <p>MDCH requires the provider’s usual and customary charge or billed amount. Zero (0) is a valid amount if:</p> <ul style="list-style-type: none"> 3) the health plan has a subcapitated contract arrangement with the provider as designated in Loop 2300 CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 4) the service(s) is/are recognized by MDCH as having no associated charge(s). |
| 35* | 2410 – Drug Identification | LIN – Drug Identification | LIN03 – National Drug Code | <p>This element may be used to report prescribed drugs that may be part of the service(s) described in Loop 2400 SV2 (Institutional Service).</p> <p>MDCH will only process the first iteration of Loop 2410 LIN (Drug Identification). Any additional repeats may be ignored.</p> |

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.



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|------|--|---------------------------------|----------------------------------|--|
| 490 | 2430 – Service Line Adjudication Information | | | MDCH expects this loop to be populated for each payer identified in loop 2320 (Other Subscriber Information), except for when the payer has adjudicated this claim at the claim level. |
| 491 | 2430 – Service Line Adjudication Information | SVD – Service Line Adjudication | SVD02 – Service Line Paid Amount | MDCH requires the amount paid to the provider. Zero (0) is an appropriate value if: <ol style="list-style-type: none"> 1) the service was not covered by the health plan, or 2) the service was covered under a subcapitated contract arrangement. |
| 494 | 2430 – Service Line Adjudication Information | CAS – Claims Adjustment | | MDCH expects claim adjustment information when the value reported in Loop 2430 SVD02 (Service Line Paid Amount) is not equal to the value reported in Loop 2400 SV203 (Service Line Item Charge Amount). MDCH expects health plans to use the HIPAA-mandated Claim Adjustment Reason Codes to report the reason for the difference. |

*Page numbers with asterisks refer to the Addenda (version 4010A1); other page numbers refer to the original implementation guide.