

837 Professional and Dental Claims Frequently Asked Questions

Q. Where can I find the rules for required and conditional data elements?

A. For this information you should read and follow the rules presented in the HIPAA-mandated 837 version 4010 implementation guide and addenda.

Q. Where can I find information related to Medicaid-specific identifiers?

A. To access this information you should read and follow the rules in the Medicaid 837 companion document.

Q. Where can I locate information on testing claims with Michigan Medicaid?

A. Information on 837 claims testing with Michigan Medicaid can be found in the Medicaid B2B Testing document. This document can be accessed using the following link:
http://www.michigan.gov/documents/B2B_Testing_Instructions_MV_Feb_10_03_pdflinks_57409_7.pdf , or by going to www.michigan.gov/mdch, Providers, HIPAA, HIPAA Implementation Materials.

Q. What does it mean to have an “Invalid HL01”?

A. HL01, Hierarchical ID Numbers, 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.

Q. What is an “Invalid Billing/Pay-to Provider ID”?

A. The Billing Provider Name (2010AA) and Billing Provider Secondary Identification Number (REF02) must be a valid 9-digit value in order for claims to be compliant.

- i. Use the 9-digit provider identifier assigned by MDCH (2-digit provider type, followed by a 7-digit assigned ID).
- ii. No spaces or hyphens.
- iii. ID should pass check digit routine.

Q. Where should I provide Coordination of Benefits (COB) information?

A. COB information must be provided in Loop 2320.
This information is required if:

- i. Other payers are known to potentially be involved in paying on the claim;
- ii. Other payer adjudication information should be provided at the service line level (Loop 2430);

Other payer adjudication information should balance at the service line, claim and transaction level as specified in the 835 Implementation Guide.

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Q. What does it mean to have an “Invalid Sender ID”?

A. Loop 1000A, NM109 must equal the value reported in the Application Sender’s Code (GS02).

Q. What format should be used when entering the Subscriber Primary Identifier (Loop 2010BA, NM109) to avoid submitting an “Invalid Subscriber ID”?

A. The Subscriber Primary Identifier should be the patient’s 8-digit beneficiary ID number assigned by MDCH.

Q. Do I need prior authorization?

A. Missing or invalid prior authorization will result in pended claims.

Q. What do I need to submit for the “Payer Responsibility Sequence Number” SBR01 (Loops 2000B and 2320)?

A. The Payer Responsibility Sequence Number should include the following:

- i. A single “P” (primary) payer;
- ii. A single “S” (secondary) payer (if applicable);
- iii. Only multiples of “T” (tertiary) payers are allowed on a claim, and must be preceded by a single “P” payer and “S” payer;
- iv. MDCH coverage information should be reported in Loop 2000B only. Loop 2320 is reserved for reporting coverage under other payers.

Q. I was told that the information that I provided to my Service Bureau was incomplete, why is this?

A. The information sent on old formats (Example: HCFA 1500, UB 92, or ADA 2000) by providers to their Service Bureaus is insufficient to complete and 837 because they do not collect enough required data. MDCH guidelines for paper claims does not always transfer to the electronic format.

Q. What must be included in “Payer Identification Codes” to be compliant?

A. Payer Identification Codes – Loop 2330B-NM109 must use the carrier code assigned by MDCH (refer to the MDCH website at: www.michigan.gov/mdch for a listing of all carrier codes).

- i. Example values used for this field (BCBSM = “G00210”, Medicare Part A (United Government Services) = “C00452”, and Medicare Part B (Wisconsin Physician Services) = “C00953”).

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- Q. What does it mean to have a “Missing or Invalid Original CRN” on a claim replacement or void/cancelled claims?
- A. Claim frequency type codes (third position of “Type of Bill”) “7” and “8” require a valid 10-digit MDCH assigned CRN for the last approved claim be reported in Loop 2300 REF02-Claim Original Reference Number.
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