

**Michigan Department of Community Health
Quality Management and Customer Services Administration
Encounter Data Submission
Transition to 837 Format**

Review of Encounter Reporting Changes

Changed Data Elements

- Some values used in the proprietary format will change to standard codes as required under the HIPAA regulations and as specified in the 837 Implementation Guides (IG). Some of the values that will be changing include all of the ID Types (Recipient, Referring Provider, Servicing Provider, etc.) and Record Type.
- All codes used in the 837 transactions should comply with the HIPAA IGs.

Data Element	Description of Change
Submission Number	The submission number will be restricted to five digits. Anything over five digits will be truncated.
Record Category	MDCH will use Transmission Type Code in the Header Table 1 (REF02) to distinguish between Facility (096) and Professional (098) services. LTC services will be mapped from Type of Bill Code (CLM05-1) in the institutional implementation.
Encounter/Claim Line Number	The IG requires that you start with '1' and increment each successive line within a claim by one. If you have intelligence built into your line number (e.g., even line numbers are original records, odd are adjustments, etc.), you will have to include that intelligence in your Encounter/Claim Reference Number. The Encounter/Claim Reference Number is still a maximum of 17 digits.
Quantity	Anesthesia in the proprietary format was reported as number of units. The 837 transactions require that anesthesia be reported as the number of minutes.
Professional and Outpatient Facility Procedure Codes	Select MUPC codes will be allowed until October 2003. The procedure code type reported for MUPC should be "ZZ". All other procedure codes should be designated as "HC" which covers both CPT and HCPCS procedure codes.
Servicing Provider ID	The IGs require that the provider EIN or SSN be submitted. This will change to the NPI once that identifier is implemented. In addition, MDCH requires that Health Plans submit either the servicing provider's Medicaid ID or License Number for all in-state providers.

Changed Data Elements (continued)

Data Element	Description of Change
Servicing Provider Type	MDCH requires that Health Plans submit Taxonomy Codes for servicing providers. These codes are significantly different from the current proprietary values. MDCH will provide a crosswalk showing how the taxonomy codes map to the proprietary values.
Payment Arrangement	This indicator is not available in the 837 transactions and MDCH is considering mapping it using the Adjustment Reason Codes that appear in the CAS segment of the 2430 loops. See Service Line Adjustments under “New Data Elements” below.

New Data Elements

Data Element	Description
Claim/Encounter Indicator	The BHT Segment of header Table 1 (both professional and institutional) contains a data element for Transaction Type Code. The options are “CH” for Chargeable or fee-for-service claims and “RP” for Reporting or encounter services. Default this data element to “RP” for all encounter data reporting whether or not the Health Plan paid for the service. Any fee-for-service bills you may submit to MDCH should not be included with encounter submissions.
Type of Bill (Institutional only)	The first two positions of the UB-92 Type of Bill field will be used to identify LTC claims and place of service for institutional encounters. This data element (CLM05-1 in Loop 2300) will be edited for validity.
Diagnosis Pointers (Professional only)	As with the HCFA 1500 paper form and NSF electronic format, the 837 for professional services has diagnosis codes at the claim level and diagnosis pointers at the service level. MDCH will use the pointers to determine which of the diagnosis codes at the claim level pertain to each service line. Service lines with a diagnosis pointer that points to an invalid primary diagnosis code will be rejected.
Additional diagnosis codes	MDCH will accept up to a total of eight diagnosis codes for both institutional and professional services.
Inpatient Facility Procedure Codes	Inpatient facility ICD-9-CM surgical procedures are reported separately from Revenue Code and Procedure Code in the 837. MDCH will collect these ICD-9-CM surgical procedure codes.
Other New Data Elements	Several are being considered for use in data analysis. Some of the other data elements to be output from the 837 include indicators for EPSDT and family planning services on professional encounters.

New Data Elements (continued)

Data Element	Description
<i>Financial Fields</i>	With the transition to the 837 EDI format, MDCH will begin collecting financial information related to encounter services. Adjudication information should be reported at the service level for professional and outpatient institutional encounters. Inpatient institutional encounters may be reported at the claim level. Note that MDCH will store a maximum of 10 digits – eight whole dollar positions and two “cent” positions.
Submitted Charge Amount	What the provider billed for each service on the claim. Service line charge amount is a required field on the 837 (Loop 2400, SV203) and, as such, should be included on the 837s the health plan receives from its providers, even when that service has been prepaid under a capitation arrangement.
Approved Amount	This is the allowed amount for the service line that was approved by the Health Plan.
Paid Amount	What the Health Plan paid for this service line.
Adjustments	The adjustments reported in the CAS segments of the 2330 (claim) or 2430 (service) loops will allow MDCH to derive Payment Arrangement based on Adjustment Reason Codes. For example, Adjustment Reason Code 62 (among others) denies the service for lack of authorization.

Data Elements Not Used

Process From Date
Process Through Date
PCP ID
PCP ID Type
Servicing Provider Class
Servicing Provider County

Data elements specific to pharmacy and dental services currently on the proprietary format will not be used in the 837 professional or institutional transactions.