MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INSTRUCTIONS TO SUBSTANCE ABUSE COORDINATING AGENCIES FOR 837 ENCOUNTER DATA SUBMISSION

Fiscal Year 2008

Table of Contents

1.0 Introduction

The Michigan Department of Community Health (MDCH) requires that Substance Abuse Coordinating Agencies (CAs) report encounters and quality improvement (QI) data for every consumer served by the CA. The Reporting Requirements can be found in Appendix A. Encounter reporting is required no matter what the payment arrangement with the provider (i.e., fee-for-service, per diem, case rate, sub-capitation, net cost contract, etc.).

Historically CAs have been submitting activity and demographic data using a proprietary format. As MDCH moves towards meeting the mandates set forth under the Health Insurance Portability and Accountability Act (HIPAA), many national standards for health care transactions are being adopted. As a result MDCH is implementing a standardized format for encounter (activity) data reporting. MDCH will require that encounters be submitted in the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837, version 4010, Professional, Institutional, and Dental Healthcare Claim formats. MDCH will use the provider-to-payer-to-payer coordination of benefits (COB) data model for encounter reporting. In addition, CAs will be required to continue to report demographic, or quality improvement (QI) data, using essentially the same format and process they have been.

The purpose of these instructions is to provide guidelines to CAs for submitting both encounter and QI data. The information provided in this manual that is specific to encounter data reporting is intended to supplement information contained in the ANSI ASC X12N 837 Implementation Guides. The Implementation Guides must be adhered to for creating 837 encounter transactions.

2.0 837 Encounter Data Reporting

2.1 HIPAA Background

In August 1996, the United States Congress adopted the Health Insurance Portability and Accountability Act (HIPAA). The Act includes Administrative Simplification components with provisions to improve the efficiency and effectiveness of the health care system by establishing standards for the electronic exchange of certain administrative and financial transactions and to protect the security and privacy of transmitted health information.

A federal regulation pertaining to transaction standards and code sets was adopted in August 2000. This regulation mandates the use of electronic data interchange (EDI) standard transactions for many of the more common communications used in health care administration, as well as the use of standard code sets. The transaction standards and code sets regulation has an effective date of October 2002. Subsequent legislation allows the effective date to be extended to provide more time to covered entities to be fully compliant. Entities that request extensions to the effective date for transactions and code sets will have until October 2003 to implement the regulation**.**

It is important to note that while an extension allows the CA increased time to meet the transaction and code set mandates set forth by HIPAA, MDCH is implementing the new ASC X12N 837 version 4010 format for encounters effective with dates of service on or after October 1, 2002. Contracted entities will be required to meet these requirements as outlined in their contracts with MDCH.

2.2 Encounter Data Reporting Format

Beginning with services incurred on or after October 1, 2002, CAs will report encounters to MDCH using the transaction sets developed by the ANSI ASC for EDI. Many EDI transaction sets are identified by numeric designations, such as the 837 healthcare claim and encounter transaction. There may also be numerous versions of an EDI transaction and the version required by MDCH for 837 encounter reporting is version 4010. Therefore, CAs reporting encounters to MDCH must use the implementation standards of the ANSI ASC X12N 837, version 4010 transactions.

In addition, the CAs are required to follow the provider-to-payer-to-payer coordination of benefits (COB) data model outlined in the implementation guides. This means the provider originates the transaction and sends claim or encounter information to the CA. The CA will reformat the transaction and send it to MDCH. The CA has ultimate responsibility for sending 837 encounter information on to MDCH. The 837 provider-to-payer-to-payer COB model promotes the handling of coordination of benefits data. It is important to note that if there is another payer identified as primary, such as Medicare or another Commercial carrier, the provider must send the claim to the primary payer for adjudication prior to sending the claim or encounter information on to the CA. The CA must include the primary payer's adjudication information, as well as their own, in the 837 transaction being sent to MDCH. Implementation guides contain notes on each COB-related data element specifying when it is used. This manual will provide guidelines for those data elements identified as most important to MDCH.

Depending on the type of service provided, encounter transactions may need to be submitted using either the Institutional (X096), Dental (X097) or Professional (X098) Industry Identifier of the 837 Encounter Transaction. As a general rule, if the service provided is billed using the Health Care Financing Administration Common Procedural Coding System (HCPCS) codes, including the American Medical Association's (AMA's) Current Procedural Terminology (CPT) codes, it is billed as an 837 professional claim and reported as an 837 professional encounter. If billing rules require the service to be billed using a National Uniform Billing Committee (NUBC) Revenue Code, or Revenue Code and HCPCS code, the format for the claim and encounter would be the 837 institutional. When billing for the service requires the American Dental Association's (ADA's) Code on Dental Procedure and Nomenclature, contained in the Current Dental Terminology (CDT-3) user guide, the claim and encounter would be the 837 dental transaction.

Implementation instructions are contained in detailed manuals known as implementation guides. The implementation guides provide specific instructions on how each loop, segment, and data element in the specified transaction sets should be used. These guides are available from the Washington Publishing Company. You can order these guides by contacting:

Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116
Phone (301) 949-9740

The guides may also be ordered on line or downloaded at no charge at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Note that the guides are quite large and could take some time to download.

The implementation guides are the primary source of information on how to implement the 837 encounter, provider-to-payer-to-payer COB data model.

MDCH has published Data Clarifications for the 837 Institutional, Professional and Dental Encounter, Version 4010. These documents are companion documents to the implementation guides; they supplement and clarify parameters when the implementation guide provides options or "situations". They also provide identifiers to be used when a national standard has not been adopted.

The information in the Data Clarification documents will be helpful to the CAs as they develop outbound 837 encounter transactions. These clarification documents can be found at http://www.michigan.gov/mdch. Once you have reached the web site, click Providers, HIPAA, Health Plan Materials-Reporting/Reimbursements. There are Data Clarifications for 837 Claims and for 837 Encounters available. The CAs should make certain they are using the Data Clarifications for encounters when developing their 837 encounter transaction. In addition, CAs should check the web site regularly for updates or changes to these documents.

2.3 Data Submission Process

Encounter data submitted in the 837 format will be submitted through the MDCH Data Exchange Gateway (DEG) on a monthly basis, at a minimum. CAs may submit encounter data more frequently if necessary.

In order to communicate electronically with MDCH, the CA must first obtain an Identification Number and password from the MDCH Automated Billing Unit. For general instructions on how to obtain that Identification Number and password, please refer to the "MDCH Electronic Submission Manual", which can be found on the web at www.michigan.gov/mdch. Once you have reached the web site, click Providers, Information for Medicaid Providers, Electronic Billing.

Before an encounter file can be submitted to MDCH for processing, the file must be prepared. Instructions can be found in the MDCH Electronic Submission Manual, Section 4, Preparing Electronic Claim Files. It is important to note that all ANSI X12 files have header and trailer data built into them.

Professional, institutional and dental encounters may be combined in one file, or may be transmitted in separate files. Each file must include an Interchange Envelope, containing various ISA elements as specified in the implementation guide. The encounter file must specify **ENCOUNTER** in the Interchange Receiver ID (ISA08) element and **P** in the Usage Indicator (ISA15) element.

The Interchange Envelope may contain one or more Functional Groups. Each Functional Group will specify whether that Functional Group contains Institutional, Dental or Professional encounter transactions. In the Application Receiver's Code (GS03) element of each Functional Group, you must specify **ENCOUNTER**. The Version/Release/Industry Identifier Code (GS08) element of each Functional Group must contain **004010X096**, **004010X097**, or **004010X098**, indicating whether that group contains institutional, dental, or professional encounter transactions, respectively.

To submit the 837 v 4010 encounter file, log onto the DEG (Data Exchange Gateway), using the instructions outlined in the MDCH Electronic Submission Manual, Section 5, Using the Data Exchange Gateway.

When you send an Encounter file to the DEG, take the following steps.

1. Type:

   Put<space> <volume>\<directory>\<file> <space> <file number>@<location>
   For example, **put<space>c:\dos\4951@dchedi**, where **c** is the hard drive, **DOS** is the directory, **4951** is the file for the CA encounter, followed by a space, the @ sign, and a location of **dchedi** (**dch** indicates the Department of Community Health, and **edi** indicates the American National Standards Institute X12 837 transaction format). The submitter would type:

   PUT C:\DOS\4951 4951@DCHEDI

2. Once the file is transferred to **dchedi**, translation begins immediately and an ANSI X12 997 Functional Acknowledgement is produced and moved to the sender's mailbox.

3. Enter the **dir** command to see the ANSI X12 997 Functional Acknowledgement with the name of the file sent.

4. Download the ANSI X12 997 Functional Acknowledgement by entering a get command, being careful to change the file name for the destination system so the file sent is not written over. For example, adding an "a" to the file name would indicate that it has been acknowledged.

After you have issued the PUT command and the file has been transferred, you can do a "DIR" (Directory Command) to see if the 4951 file exists in your Mailbox.

CAs should copy transferred files immediately as a back up for their site. It is the agent's responsibility to retain back-up files until the party at the final destination has verified and backed up the files. Should the file not be received in its entirety, it may have to be resent using the back up.

As mentioned, after the file has been received by MDCH, a 997 Functional Acknowledgement transaction will be generated and submitted to the CA's mailbox. It can be retrieved via the DEG. The Functional Acknowledgment contains segments that can identify the acceptance or rejection of the functional group, transaction sets or segments. It is important that the CA retrieve the 997 acknowledgements to determine if MDCH has received the ASC X12 837 transaction sets, and identify transmissions that have not been acknowledged.

2.4 Implementation Timeline

For all services incurred on or after October 1, 2002, the CA is required to send data monthly on post-adjudicated encounters in the new 837 format. Encounter data is required to be submitted by the last day of the month following the month in which it was adjudicated.

To assist in the transition MDCH will allow encounters for claims adjudicated in the months of October, November, and December 2002 and January 2003 to be submitted by March 3, 2003. Submission is due by 5:00 p.m. on the last day of the month following the month it was adjudicated. Services that have been provided but for some reason are still in the adjudication process will be reported using a year-end reconciliation process. The year-end reconciliation process is described in Section 2.5 below.

MDCH will be retiring its current proprietary encounter format November 2002. CAs must have all FY2002 data or updates submitted by November 15, 2002.

2.5 Year-End Reconciliation Process

Substance abuse encounters are required to be submitted by the last day of the month following the month it was adjudicated. Any encounter that has not been reported by the end of the fiscal year because the adjudication process is incomplete, must be reconciled within 90 days of the last month of the fiscal year. That means the CA will have 90 days following the end of the fiscal year to submit the encounter data. For example, if the date of service is January 20, 2003 and by September 30, 2003 still has not been adjudicated by the primary payer, the CA is required to submit an encounter reporting the services provided with $0 reported in the approved and paid amount fields by December 31, 2003. The claim or service line adjudication date, whichever is applicable to the encounter being submitted, should be reported with a date value of 99999999. This will allow the transaction to be processed without indicating adjudication has taken place.

The CA will then be required to submit a replacement encounter by the last day of the month following the month it was adjudicated, once it is finally adjudicated.

2.6 Reporting Requirements

MDCH requires CAs to report encounters for all consumers whose services are paid for in whole or in part with MDCH administered funds. CAs **are not required** to submit encounters in the following instances:

- children's waiver services that are billed fee-for-service directly to Michigan Medicaid, (QI data files are still required to be submitted), and,
- room and board reimbursed through State Disability Assistance (SDA) funds.

In situations where the client has dual eligibility (i.e., Medicare/Medicaid), the CA is required to submit encounter data for the services provided.

2.7 Encounter Data Edits

To ensure the usefulness of the data submitted, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All data currently submitted to MDCH are subjected to an editing process. All 837 encounter data will also be subjected to an editing process. Appendix B, Encounter Error List, lists the 837 encounter edits that correspond to errors identified during the encounter data warehouse editing process.

Encounter data edits can have one of the following results:

1. The data pass all edits and is accepted into the data warehouse,
2. The data contain a minor error(s); an informational edit report is generated and the data is accepted into the data warehouse, or
3. The data contain a fatal error that results in its rejection.

Output from the edit process is an Error Return File that will be available to the CAs at their mailbox through the DEG. The file layout, including header and trailer records, can be found in Appendix C. This report is different than the 997 Functional Acknowledgment discussed earlier. The report will advise of the status of the records submitted in a particular file. If the records result in any errors

being identified in the editing process, the report will specify the records that contain errors and the nature of the errors.

When retrieving the Error Return File from the DEG, you must use the "get" command. Once your logon has been accepted, the prompt **ftp>** appears, type **dir** to select the directory of files available. From the list of files that may be shown, look at the column labeled **APPL**, these are the files ready to be retrieved. The 837 Encounter Error Return File APPL ID is 4950. Therefore, you would type:

get 4950 c:\download\4950

This will move the oldest 4950 file to the sender's PC. The file will downloaded to the C drive, in the "download" directory, to file 4950.

All Error Return Files will reference the data submission number. It is critical that the CA track their data submission number.

2.8 Rejection Criteria

MDCH will reject encounters that fail to meet specified edit criteria. The following outlines situations that will result in the rejection of an entire batch, an individual encounter, or a specific service line.

A. Batch

There are minimal structural requirements that must be met to allow an entire batch to be properly read and interpreted. If a transmitted batch fails to meet any of the following criteria, the entire batch will be rejected:

1. Submitter Identifier (Loop 1000A, NM109) is missing or invalid
2. Submission Number (HDR, BHT03) is missing
3. Submission Number (HDR, BHT03) is not alphanumeric
4. Submission Number (HDR, BHT03) has been used on a previous batch
5. Transaction Type Code (HDR, BHT06) is not "RP", encounters
6. Transmission Type Code (HDR, REF02) is missing or invalid

MDCH will not reject an entire batch based on the contents of individual records within the file.

B. Encounter

Rejections below the batch level may occur for an entire encounter. An encounter is defined as all of the services incurred under the same claim/encounter identifier assigned by the provider or the CA. The following situations will result in rejection of the encounter, including all of the services that are part of the encounter:

1. The data in any of the following fields is missing or invalid:
    a. Other Payer Primary Identifier (Loop 2330B, NM109)
    b. Submitter Primary Identifier (Loop 1000A, NM109) is not valid for the Other Payer Primary Identifier (Loop 2330B, NM109)
    c. Other Payer Secondary Identifier – Encounter Reference Number (Loop 2330B, REF02)

d. Service Line Number - Counter (Loop 2400, LX01)
e. Claim Frequency Type Code - Original, Void, Replacement (Loop 2300, CLM05-3)
f. Subscriber Primary Identifier (Loop 2010BA, NM109)
g. Admission Date (Institutional transactions only) (Loop 2300, DTP03)
h. Principal Diagnosis Code (Institutional transactions only) (Loop 2300, HI01-2)

2. The encounter is a duplicate of a previously submitted encounter.

3. The encounter is a void or replacement of an encounter that does not exist in the data warehouse.

C. Service Line

It is possible MDCH will reject only a service line from a submitted encounter. The reason for this is to keep the data warehouse as complete as possible while awaiting corrected encounters. If an edit fails a service line, only the failing service line will be rejected, all other data will be stored on the warehouse. If there is only one service line on an encounter and that service line is rejected, the entire encounter will be rejected. The following are examples of situations in which a service line will be rejected for missing or invalid values.

1. Service Date (Loop 2400, DTP03)
2. The first Diagnosis Code Pointer "points" to an invalid diagnosis code (Professional Loop 2400, SV107-1)
3. Procedure Code (Professional Loop 2400, SV101-2, Dental Loop 2400, SV301-2, and those Institutional [Loop 2400, SV202-2] transactions where services require both a Revenue Code and a HCPCS code)
4. Revenue Code (Institutional Loop 2400, SV201)
5. Units (Professional Loop 2400, SV104, Dental Loop 2400, SV306, Institutional Loop 2400, SV205)

2.9 Correction Process

Resubmission is the process the CA uses when the encounter has not made it through the translator or processing and there is subsequently no data stored in the data warehouse. The CA will need to resubmit when a 997 Functional Acknowledgement is received indicating the submission was not accepted or if the Error Return File contains messages that result in an action of "Reject Batch" or "Reject Encounter", indicating the submission could not be processed.

Replacement is the process the CA uses when the encounter has made it through the translator and processing system and is stored in the data warehouse, but for some reason needs to have corrections made to the data originally submitted. The CA will need to replace an encounter if the Error Return File contains a message that results in an action of "Reject Line", if there has been a change in the number of units originally reported, if there has been a change in the monetary amounts originally reported, if the claim has been adjudicated since the encounter was reported using the year-end reconciliation process, and if there has been a change in the client's eligibility changing the funding source reported in the original encounter (i.e., General Fund to Medicaid).

Batches, encounters or service lines that were rejected by the system must be corrected and resubmitted within 30 days of the date the Error Return File was created. Refer to Appendix C, 837

Encounter Error Return File, for the "Creation Date" element reported in the Error Return File header and trailer records.

When MDCH **rejects an entire batch**, the CA must make the necessary corrections and **resubmit the batch**. The individual transactions in the resubmitted file must have the same Claim Frequency Code (Loop 2300, CLM05-3) designation (i.e., original, void, or replacement) as what was reported on the rejected file. These should not be designated as replacement encounters. Since the contents of a rejected batch are not retained in the data warehouse, there is no record to replace in the warehouse.

When MDCH **rejects the encounter**, the CA must correct the identified error(s) and **resubmit the encounter**. As with a rejected batch, a rejected encounter is not stored in the data warehouse, so the corrected encounter will be submitted with the same Claim Frequency Code designation as was coded on the first submission. If the rejected encounter was an original encounter, the "corrected" encounter should also be an original encounter.

When MDCH **rejects a service line**, the CA must correct the identified error(s) and **replace the entire encounter, including those service lines that were accepted by the data warehouse in the original submission**. The MDCH encounter data warehouse processing system will replace in the warehouse the entire original encounter with the data submitted on the replacement encounter. The Claim Frequency Type Code is a "claim" level code, which means the entire claim/encounter is designated as either original, void, or replacement; this designation cannot be applied to an individual service line.

If MDCH rejects a service line and there are multiple service lines on the encounter, the service lines that pass the edits will be retained in the data warehouse. While MDCH may reject only one service line reported on an encounter that contains multiple service lines, the CA may not correct a single service line on an 837 encounter transaction. The CA has two options:

1. The CA may replace the entire encounter once the errors have been corrected. The entire encounter (the service line that originally contained errors and all associated services) will be completely replaced in the data warehouse. The following information must be included within the 837 encounter:

    a. The Claim Frequency Type Code (Loop 2300, CLM05-3) on the replacement encounter must now be designated as replacement.
    b. The Replacement Claim Number (Loop 2300 REF02 and Loop 2330B REF02) must be the same as the claim number on the original claim.

    Since service line numbers within the 837 encounter must begin at "1" and increment by "1", any attempt to correct a single line in a previously submitted and accepted encounter that contained multiple services would result in the replacement encounter deleting all of the previously accepted services.

2. The CA may leave the original encounter minus the rejected service(s) "as is" in the warehouse and create a new encounter reporting only the corrected service line(s). The new encounter must report a different claim number and should report a Claim Frequency Type Code of "Original". CAs should NOT use this option for correcting a service that is already in the data warehouse, as it would result in the service being duplicated.

If the CA must replace or void a service that has been accepted into the data warehouse, it must do so by replacing or voiding the entire encounter on which the service originally appeared. The claim number for the replacement or void encounter must be the same as the original claim number.

An encounter that was submitted by the CA can only be voided if the CA identifies that the client identified in the original encounter is not correct or if the CA identifies that the CA identified as the "Other Payer" in the encounter is not correct. The CA would never void an encounter to replace an encounter. To replace an encounter follow the steps outlined above. To void an encounter, the CA would change the encounter designation to void (Loop 2300, CLM05-3 value of "8") and the Original Reference Number must be used (Loop 2300, REF02 and 2330B, REF02). When an encounter is voided, the CA must submit a new "original" encounter to report the service requiring reporting.

2.10 837 Encounter Data Elements

The 837 transaction contains a number of required and situational data elements. It is MDCH's intention to use many of these data elements to enhance the information available in the data warehouse. This section outlines many of the data elements that are of particular interest to MDCH, those that may be used in the processing of the 837 encounters, and those that have resulted in many questions from CAs.

These supplemental instructions do not address all of the data elements in the 837 transaction. Note that implementation of the 837 encounter must include all required and applicable situational data elements identified in the implementation guide, not just those mentioned in this section.

2.10.1 Transaction Type Code (HDR, BHT06)

All 837 transactions require the coding of a claim or encounter indicator. Transaction Type Code, which performs this function, appears in the Header Table portion of the transaction set. Specifically the BHT, or Beginning Hierarchical Transaction, segment must include data element BHT06. CAs must code this data element to a value of "RP" for all encounter data reporting. The value of "RP" should be reported whether the CA reimburses the provider on a fee-for-service, per diem, other payment basis.

2.10.2 Insured Group Name (Loop 2000B, SBR04)

To report that the client is enrolled in the MIChild program, the CA must report the value "MICHILD" in SBR04, Insured Group Name.

2.10.3 Subscriber Primary Identifier (Loop2010BA, NM109)

CAs are reporting on a number of clients, many enrolled in various Medicaid programs, many not enrolled in Medicaid at all but whose services are paid through a variety of funding sources, and some enrolled in MIChild. Clients are identified in these programs through the use of different unique identifiers. Since there is no national or MDCH standard subscriber primary identifier, CAs should follow these guidelines:

- If the client is enrolled in Medicaid, report their 8-digit Medicaid ID number
- If the client is enrolled in MIChild, report their 8-character Client Identification Number (CIN) assigned by the enrollment broker
- For persons not enrolled in Medicaid or MIChild, report their 9-digit Social Security Number

- Use the CA's unique identifier (CA Client Identifier) **only** when the person is not enrolled in Medicaid or MIChild, and the Social Security Number is not known. The CA Client Identifier **must** be 11-characters. It may be alphanumeric. If necessary, right justify and zero fill to the left to create an 11-character value.

2.10.4 Contract Information (Loop 2300, Segment CN1 and Loop 2400, Segment CN1)

When the contract arrangement between the CA and their providers is anything other than fee-for-service, MDCH recommends that this situational segment be reported to help explain monetary amounts and adjudication information provided within the 837 transaction. This information is optional at this time, however, if the CA chooses to report contract information the following guidelines should be used.

2.10.4.1 Contract Type Code (Loop 2300, CN101 and Loop 2400, CN101)

Report one of the values as indicated in the standard code list provided. MDCH anticipates that many of the contract type codes reported may fall into the category of "Other", value "09".

2.10.4.2 Contract Amount Code (Loop 2300, CN102 and Loop 2400, CN102)

The CA should report the contract amount as indicated by the instructions in the implementation guide. Report the contract amount for the Contract Type indicated in Loop 2300, CN101 or Loop 2400, CN101. If the Contract Type Code is "Per Diem", the per diem rate would be reported in this element.

2.10.4.3 Contract Percent Code (Loop 2300, CN103 and Loop 2400, CN103)

The CA should report a percent in this element only if the Contract Type Code reported in Loop 2300, CN101 or Loop 2400, CN101 is "Percent". The value represents the contract percentage or charge percent.

2.10.5 Principal Diagnosis (Loop 2300, HI01)

The 837 transaction sets allow a large number of diagnosis codes to be reported – over 14 on institutional encounters and eight on professional encounters. MDCH will collect up to 14 diagnosis codes for institutional encounters (the primary diagnosis, the admitting diagnosis, and twelve additional diagnosis codes) and up to eight diagnosis codes for professional encounters. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the standard code set CAs must use for reporting diagnosis codes. MDCH expects that all encounters will have a diagnosis reported.

The diagnosis represents the reason for the encounter. Therefore it could be signs, symptoms, diagnosis if available, or other reason for the encounter. CAs should not ignore the V-series codes identified by ICD-9-CM. These codes include diagnoses that relate to encounters for various reasons, including administrative.

The ICD-9-CM Diagnosis Code for Other Unknown and Unspecified Cause (799.9) may be used **only** in the following situations:

- The client has a relationship with a client receiving substance abuse services and is receiving services for co-dependency.

2.10.6 Type of Bill (Institutional Loop 2300, CLM05)

For institutional services, Type of Bill is a standard field that has been required on the UB-92 form and that provides several different pieces of information. The first digit of this data element identifies the type of facility (hospital, office, home, etc.). The second digit is referred to as the bill classification and conveys information on the place of service. The third digit is the frequency code and identifies the type of billing (e.g., original, interim, final, adjustment, void). MDCH will be using the components of Type of Bill to identify Record Type (original, void, replacement) and institutional place of service codes.

2.10.7 Facility Type Code (Loop 2300, CLM05-1 and Loop 2400 SV105 Professional and Dental)

The data element identifies the type of facility where services were performed. CAs must refer to the standard code sets from the National Electronic Media Claims National Standard Format available from http://cms.hhs.gov/states/poshome.asp.

2.10.8 Diagnosis Code Pointers (Professional Loop 2400, SV107-1, SV107-2, SV107-3, SV107-4)

Diagnosis codes for both institutional and professional transactions are provided at the claim level in the 837 transactions. For professional services, the 2400 service loop provides segments that contain diagnosis code pointers. These pointer data elements contain a value of one through eight. These values "point to" the diagnoses coded at the claim level that most closely correspond to each service line. Each service line can have up to four diagnosis pointers, or four separate diagnosis codes for each service. Each service may point to a different set of four diagnosis codes.

2.10.9 Rendering Provider Primary Identifier (Loop 2310B, NM109)

With the implementation of the 837 transaction, CAs will need to report at least two identifiers for servicing (or rendering) providers. The servicing (or rendering) provider is the person or entity that actually provided the service. For rendering providers, the NM1 segment is required and will be used to report either the Employer Identification Number (EIN) or Social Security Number (SSN) of the provider. Note that this will be the case until the National Provider Identifier or NPI is adopted and all NM1 provider segments will then require the use of the NPI.

2.10.10 Rendering Provider Secondary Identifier (Professional Loop 2310B, REF02)

Secondary identifiers are carried in the REF segment and MDCH requires CAs to report either the Medicaid ID or State License Number for all in-state providers. The 837 institutional encounter requires the identification of the service facility where services were provided (Loop 2310E, REF02). The nine-character Payer Identification number should never be used to report the rendering provider secondary identifier.

2.10.11 Other Subscriber Information (Loop 2320) Segment SBR

Loop 2320, Segment SBR reports information primarily about the Other Subscriber. This loop is required when there are known other payers potentially responsible for payment of the services reported. This loop repeats. MDCH will always be the receiver identified in Loop 1000B, therefore, none of the information reported here is specific to MDCH. The CA is an "other payer" and information specific to their responsibility and the subscriber's relationship to them would be reported in the SBR segment. Any other commercial payer or Medicare would be reported in an iteration of this loop as well.

2.10.12 Payer Responsibility Sequence Number Code (Loop 2320, SBR01)

This element identifies the level of financial responsibility all other payers have with respect to the services reported. Appropriate values to report are "P" for primary, "S" for secondary, and "T" for tertiary. The transaction must always have one payer identified as primary. If there are multiple payers, the level of responsibility for each must be determined. If the consumer has Medicare **or** a commercial carrier with financial responsibility, the commercial carrier **or** Medicare would be the primary payer and therefore "P" would be reported for them. In this example, the CA would be reported as the secondary payer, "S". If there is Medicare **and** a commercial payer, the commercial carrier would be identified as primary, "P", and Medicare secondary, "S". The CA would then be reported with a value of "T", tertiary. Tertiary can be reported multiple times if needed.

2.10.13 Other Insured Identifier (Loop 2330A Other Subscriber Name – NM109 Other Insured Identifier)

All substance abuse encounters will require the reporting of the CA Client Identifier in Loop 2330A, NM109. This element is intended to report the unique member number assigned by the plan or other payer (CA). The CA Client Identifier **must** be reported here even when it was used as the subscriber primary identifier in Loop 2010BA, NM109. The CA Client Identifier must be 11-characters in length. Right justify and zero fill to the left if required to create an 11-character CA Client Identifier.

2.10.14 Other Payer Primary Identifier (Loop 2330B Other Payer Name – NM109 Other Payer Primary Identifier)

The contract between MDCH and the CAs for capitated substance abuse services places responsibility on the CA for the management of client services and payment for services rendered by contracted providers. The CA is reported as an Other Payer (Loop 2330B). A Payer Identification (PI) number is required in Loop 2330B, NM109 of the 837 to identify the Other Payer(s). MDCH will enroll CAs as payers. They will receive a nine-character number (for example, 17XXXXXXX) that identifies them as an MDCH health plan. This number will be required to be reported as their Payer ID until such time as the national standard Plan ID is implemented. MDCH will use this identifier to identify the CA within the encounter transaction. This number is also used to link the 837 Encounter with the client's corresponding QI data file. This number is different than the Provider Identifier used to identify the direct care provider.

To report other commercial payers, the CA should use the carrier code assigned by MDCH. The carrier codes can be found in a listing posted on the MDCH website, www.michigan.gov/mdch. Click Providers, Information for Medicaid Providers, then Third Party Liability. Medicare does not have an MDCH assigned carrier code. When reporting Medicare as an Other Payer, the following numbers should be used to report the Other Payer Primary Identifier:

- Medicare Part A (United Government Services), use "00452"
- Medicare Part B (Wisconsin Physician Services), use "00953"

2.10.15 Procedure Code (Professional Loop 2400, SV101-2, Dental Loop 2400, SV301-2, and Institutional Loop 2400, SV201 for Revenue Code and SV202-2 for Service Line)

MDCH has developed a list of procedure and revenue codes to be used when submitting 837 encounter and claims data for substance abuse services. The Centers for Medicare and Medicaid Services (CMS) has not yet approved all the codes for substance abuse that the states have requested. The requested codes will not be approved and available for use in time for implementation of the ASC X12N 837 version 4010 encounter format. Therefore the code crosswalk developed by MDCH will be used for reporting revenue codes and procedure codes on 837 encounters and claims until otherwise notified. The code crosswalk for substance abuse services is posted on the MDCH website which should be checked regularly for updates. The code crosswalk can be found at the following address:

http://www.michigan.gov/documents/SubAbuseCodeChart8-15-03_71938_7.pdf

2.10.16 Financial/Adjudication Data Elements

The provider-to-payer-to-payer COB data model of the 837 is being used and will provide MDCH with expanded financial information on encounter records. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information) and 2430 (Service Line Adjudication Information). **Reporting of financial data is voluntary through September 2003. If CAs choose to report financial data for FY03 encounters, the following guidelines should be followed.**

The financial, or adjudication fields that MDCH requests the CAs to report include:

- Submitted Line Item Charge Amount (Provider Billed Amount)
- Approved Amount (Allowable Amount)
- Paid Amount
- Adjustment Amounts
- Adjustment Group and Reason Codes

2.10.16.1 Submitted Line Item Charge Amount (Professional Loop 2400, SV102, Institutional Loop 2400, SV203)

MDCH expects CAs to report the provider submitted charge amount or billed amount. This charge generally represents the provider's usual and customary amount for the service. There have been no situations identified where substance abuse services would not have a charge. Therefore, the amount coded in the Submitted Charge Amount data element should not be "0" (zero).

Institutional encounters also accommodate reporting total submitted charges (COB Total Submitted Charges) within Loop 2320, AMT02.

2.10.16.2 COB Approved (Allowed) Amount (Professional Loop 2320, AMT02 and Loop 2400, AMT02, Institutional Loop 2320, AMT02 [COB Total Allowed Amount])

CAs should report their fee schedule amount, or what they would have paid for the service (maximum allowable amount), whether or not the service was covered with the provider on a per diem, case rate, prepaid or other payment basis. If the CA never covers the specific service reported, the Approved Amount may be "0" (zero).

2.10.16.3 COB Payer Paid Amount (Loop 2320, AMT02 and Loop 2430, SVD02)

If the CA paid the provider for the service, the Paid Amount should reflect the amount paid. If the service was not covered by the CA, or was covered under a contract payment methodology such as prepaid or per diem, "0" (zero dollars) may be an appropriate Paid Amount.

2.10.16.4 Other Payer Adjustment Amount (Loop 2320, CAS03, CAS06…CAS18 and Loop 2430, CAS03, CAS06…CAS18)

If the Paid Amount reflects any adjustment to the billed amounts, the adjustment amount, as well as adjustment reasons must be reported.

2.10.16.5 Other Payer Adjustment Group Code (Loop 2320, CAS01 and Loop 2430, CAS01)

This data element identifies the general category of payment adjusted. The CA must use the values identified in the implementation guide. Code values include, "CO" for contractual obligation, "OA" for Other Adjustments, and "PR" for patient responsibility.

2.10.16.6 Other Payer Adjustment Reason Code (Loop 2320, CAS02, CAS05…CAS17 and Loop 2430, CAS02, CAS05…CAS17)

This element is required to report the detailed reason for any adjustment to the submitted line item charge amount. CAs must use the standard Claim Adjustment Reason Codes available at www.wpc-edi.com.

Example A: CA "A" pays a contracted provider on a fee-for-service basis for all services. The CA uses a fee schedule to determine its approved (allowed) amount. John Doe is seen for Individual Therapy, adult or child, 45-50 minutes and the provider submits a claim to CA "A". CA "A" adjudicates the claim and then reformats and sends an 837 encounter to MDCH.

Submitted Charge	Approved Amount	Paid Amount	Adjustment Reason	Adjustment Amount
$100	$55	$55	42 - charges exceed our fee-schedule or maximum allowable amount	$45

Example B: CA "B" has a per diem contract arrangement with a local facility to provide intensive outpatient (IOP) services. The per diem rate is $100 per day. John Doe receives 13 days of IOP services. There is no other payer. CA "B" submits the encounter to MDCH.

Submitted	Approved /	Paid Amount	Adjustment Reason	Adjustment

Charge	Allowed Amount			Amount
$2500	$1300	$0	A2 – contract adjustment	$2500

Any time the charge amount does not equal the paid amount, the CA must report the adjustment amount and the adjustment reason.

When reporting financial data CAs should heed the balancing requirements outlined in the Implementation Guides.

Appendices

Appendix A Encounter Error Listing

Encounter Error Listing As Of 02/19/03

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20000	File contains unreadable characters.	RB	Reject batch	General file edit	D/I/P		
20015	Submitter Identifier is missing (is spaces or blanks).	RB	Reject batch	1000A, NM109	D/I/P	Submitter Name	Submitter Primary Identification Number
20016	Submitter Identifier is not a valid submitter ID.						
20017	Submitter Identifier is inconsistent between ISA06 and 1000A NM109						
20020	Submission Number is missing (is spaces or blanks).	RB	Reject batch	HDR, BHT03	D/I/P	Beginning Of Hierarchical Transaction	Originator Application Transaction ID
20021	Submission Number is not an alphanumeric value.						
20022	Submission Number has already been used on a prior batch.						
20025	Transaction Type Code not for encounters.	RB	Reject batch	HDR, BHT06	D/I/P	Beginning Of Hierarchical Transaction	Claim or Encounter ID (Transaction Type Code)
20030	Transmission Type Code (Record Category) is missing (is spaces or blanks). Cannot edit the remainder of the record.	RB	Reject batch	HDR, REF02	D/I/P	Transmission Type Identification	Transmission Type Code
20031	Transmission Type Code (Record Category) is not equal to 004010X096, 004010X097 or 004010X098 for record category D, I or P. Cannot edit the remainder of the record.						
20050	Other Payer Primary Identifier (e.g., Health Plan ID) is missing (is zero, spaces, blanks, or null) for record category D, I or P.	RE	Reject encounter	2330B, NM109	D/I/P	Other Payer Name	Other Payer Primary Identifier
20051	None of the Other Payer Primary Identifiers are valid Capitated Plans for record category D, I or P.						
20052	There is an invalid combination of Other Payer Primary Identifiers. The valid combinations are: • Exactly one MQHP, CA, or PHP • Exactly one PHP and one CMHSP Any other combination of Other Payer Primary Identifiers (including none or more than two) is ambiguous and will cause this error.						
20053	The Capitated Plan Identifier is not valid for the Submitter Identifier for record category D, I or P.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20055	Other Payer Secondary Identifier (Encounter Reference Number) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2330B, REF02	D/I/P	Other Payer Secondary Identification and Reference Number	Other Payer Secondary Identifier
20056	Other Payer Secondary Identifier (Encounter Reference Number) is not an alphanumeric value for record category D, I or P.						
20057	Service Line Counter (Encounter Detail Line Number) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2400, LX01	D/I/P	Service Line Number	Line Counter
20058	If record category I, Service Line Counter (Encounter Detail Line Number) is not between 01 and 999. If record category D or P Encounter Detail Line Number is not between 01 and 50.						
20059	Service Line Counter(s) [Encounter Detail Line Number(s)] not started with one or not sequentially numbered.						
20060	Claim Frequency Code (Record Type) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2300, CLM05-3	D/I/P	Claim Information	Claim Frequency Code
20061	Claim Frequency Code (Record Type) is invalid for record category D, I or P.						
20100	Subscriber Primary Identifier (Medicaid ID) is missing (is spaces, blanks or zeroes) and MQHP encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109	D/I/P	Subscriber Name	Subscriber Primary Identifier (Medicaid ID)
20101	Subscriber Primary Identifier (Medicaid ID) does not exist in the Medicaid eligibility file and MQHP encounter for record category D, I or P.						
20102	Subscriber Primary Identifier (Medicaid ID) is missing (is spaces, blanks or zeroes) and CMH or SA encounter for record category D, I or P.	IO	Info only				
20103	Subscriber Primary Identifier (Medicaid ID) does not exist in the Medicaid eligibility file and CMH or SA encounter for record category D, I or P.						
20104	Subscriber SSN ID present, not numeric and MQHP encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109 2010BA, REF02	D/I/P	Subscriber Name	Subscriber Primary Identifier/Supplemental Identifier (SSN ID)
20105	Batch is for CMH or SA and Other Insured Identifier (Submitter's Subscriber Unique ID) is missing (is spaces, blanks or zeroes) for record category D, I or P.	RE	Reject encounter	2330A, NM109	D/I/P	Other Subscriber Name	Other Insured Identifier
20106	Batch is for SA and Other Insured Identifier (Submitter's Subscriber Unique ID) present and does not exist in the applicable SA QI file for record category I, D or P.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20107	Batch is for CMH and no match to the applicable CMH QI file for record category D, I or P can be made for the combination of: • Other Insured Identifier (Submitter's Subscriber Unique ID), • Other Payer Primary Identifier equal to the QI PHP identifier, • Other Payer Primary Identifier equal to the QI CMH identifier, and • From Service Date falls within the fiscal year of the last reporting date QI data sent for the applicable fiscal year.						
20108	Subscriber Primary Identifier (Child Identification Number) is missing (is spaces, blanks or zeroes) and MIChild encounter for record category D, I or P.	RE	Reject encounter	2010BA, NM109	D/I/P	Subscriber Name	Subscriber Primary Identifier (Child Identification Number)
20109	Subscriber Primary Identifier (Child Identification Number) does not exist in the MIChild eligibility file and MQHP, BC/BS, or capitated dental MIChild encounter for record category D, I or P.						
20140	Admission Date is missing but yet the revenue code has a Room and Board Designation for record category I for Inpatient Type of Bill.	RE	Reject encounter	2300, DTP03 (P, D and I for inpatient encounters only)	I	Admission Date/Hour	Admission Date and Hour/ Related Hospitalization Admission Date
20141	Admission Date present - Invalid date or date is in an invalid format for record category I for Inpatient Type of Bill.						
20142	Admission Date present and is not less than or equal to the run date of this edit run for record category I for Inpatient Type of Bill.						
20143	Admission Date present and is greater than the Discharge date for record category I for Inpatient Type of Bill.						
20144	Admission date is not equal or less than run date for record category D or P.	IO	Info only		D/ P		
20145	Admission Date present but an invalid date or date is in an invalid format for record category D or P.						
20148	Statement Through Date/Related Hospitalization Discharge Date is missing but yet the Revenue Code indicates an admission with Room and Board charges and the Discharge Status indicates that a discharge occurred for record category I for Inpatient Type of Bill.	RE	Reject encounter	2300, DTP03 (I for inpatient encounters only)	I	Statement Dates	Statement Through Date/ Related Hospitalization Discharge Date
20149	Statement Through Date/ Related Hospitalization Discharge Date exists but yet Admission Date is missing for record category I for Inpatient Type of Bill.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20150	Statement Through Date/ Related Hospitalization Discharge Date is an invalid date for record category I for Inpatient Type of Bill.						
20151	Statement Through Date/ Related Hospitalization Discharge Date is less than the Admission Date for record category I for Inpatient Type of Bill.						
20152	Statement Through Date/ Related Hospitalization Discharge Date is not less than or equal to the run date of this edit run for record category I for Inpatient Type of Bill.						
20155	Patient Status Code (Discharge Status) is not a valid code for record category I for Inpatient Type of Bill.	IO	Info only	2300, CL103 (I only)	I	Institutional Claim Code	Patient Status Code
20156	Patient Status Code (Discharge Status) is missing but yet the revenue code has a Room and Board Designation for record category I for Inpatient Type of Bill.						
20170	Service Date is missing (is spaces, blanks or zeroes) for record category D or P or I for Outpatient Type of Bill.	RL	Reject line	2300, DTP03 (D only) 2400, DTP03	D/I/P	Date - Service (D only) Service Line Date	Service Date
20171	Service Date - Invalid date or date is not in the format CCYYMMDD for record category D or P or I for Outpatient Type of Bill.						
20172	Service Date is not less than or equal to the run date of this Edit Run for record category D or P or I for Outpatient Type of Bill.						
20175	Statement From Date is missing (is spaces, blanks or zeroes) for record category I.	RE	Reject encounter	2300, DTP03 (I only)	I	Statement Dates	Statement From Date
20176	Statement From Date - Invalid date or date is not in the format CCYYMMDD for record category I.						
20177	Statement From Date is not less than or equal to the run date of this Edit Run for record category I.						
20190	Taxonomy Code is not a valid taxonomy code for record category I	IO	Info only	2000A, PRV03 2310E, PRV03 (I only)	I	Servicing Facility Provider Specialty Information	Servicing Facility Provider Taxonomy /Specialty Code
20191	Taxonomy Code is not a valid taxonomy code for record category D or P	IO	Info only	2000A, PRV03 (D and P only) 2310B, PRV03 (D and only) 2420A, PRV03 (D and only)	D/P	Billing/Rendering Provider Specialty Information	Rendering (Servicing) Provider Taxonomy /Specialty Code

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20200	Primary Diagnosis Code is not a valid diagnosis code for record category I.	RE	Reject encounter	2300, HI01-2	I	Health Care/ Principle, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	Diagnosis Code
20201	Primary Diagnosis Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.	IO	Info only				
20202	Primary Diagnosis Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20203	Primary Diagnosis Code is missing (is zeroes, blanks or spaces) for record category I.	RE	Reject encounter				
20204	Admission Diagnosis Code is present and the Revenue Code indicates an admission with Room and Board charges and admission diagnosis code is not valid for record category I.	IO	Info only	2300, HI02-2 (I only)	I	Principle, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	Diagnosis Code
20205	Admission Diagnosis Code is missing (is zeroes, blanks or spaces) but the Revenue Code indicates an admission with Room and Board charges for record category I.						
20206	Admission Diagnosis Code is not appropriate for the subscriber's age on the applicable QI or Medicaid eligibility file for record category I.						
20207	Admission Diagnosis Code is not a valid diagnosis code for record category I.						
20208	Admission Diagnosis Code is not appropriate for the subscriber's gender for record category I according to the QI or Medicaid eligibility file.						
20209	Other Diagnosis Code 1 exists but yet Primary Diagnosis Code is missing for record category I.	IO	Info only	2300, HI01-2	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 1
20210	Other Diagnosis 1 Code is not a valid diagnosis code for record category I.						
20211	Other Diagnosis Code 1 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20212	Other Diagnosis Code 1 is not appropriate for the subscriber's gender for record category-I according to the applicable Medicaid Eligibility File or QI Files.						
20213	Other Diagnosis Code 2 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI02-2 (I only)	I	Health Care/ Other Diagnosis	Diagnosis Code Other - 2

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20214	Other Diagnosis Code 2 is not a valid diagnosis code for record category I.					Information	
20215	Other Diagnosis Code 2 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20216	Other Diagnosis Code 2 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20217	Other Diagnosis Code 2 exists but yet, Primary Diagnosis Code is missing for record category I						
20218	Other Diagnosis Code 3 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI03-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 3
20219	Other Diagnosis Code 3 is not a valid diagnosis code for record category I.						
20220	Other Diagnosis Code 3 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20221	Other Diagnosis Code 3 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20222	Other Diagnosis Code 3 exists but yet, Primary Diagnosis Code is missing for record category I.						
20223	Other Diagnosis Code 4 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI04-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 4
20224	Other Diagnosis Code 4 is not a valid diagnosis code for record category I.						
20225	Other Diagnosis Code 4 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files e.						
20226	Other Diagnosis Code 4 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20227	Other Diagnosis Code 4 exists but yet, Primary Diagnosis Code is missing for record category I.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20228	Other Diagnosis Code 5 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI05-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 5
20229	Other Diagnosis Code 5 is not a valid diagnosis code for record category I.						
20230	Other Diagnosis Code 5 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20231	Other Diagnosis Code 5 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20232	Other Diagnosis Code 5 exists but yet, Primary Diagnosis Code is missing for record category I.						
20233	Other Diagnosis Code 6 exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI06-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 6
20234	Other Diagnosis Code 6 is not a valid diagnosis code for record category I.						
20235	Other Diagnosis Code 6 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20236	Other Diagnosis Code 6 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20237	Other Diagnosis Code 6 exists but yet, Primary Diagnosis Code is missing for record category I.						
20238	Other Diagnosis Code 7 exists but yet one of the previous Diagnosis is missing for record category I.	IO	Info only	2300, HI07-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 7
20239	Other Diagnosis Code 7 is not a valid diagnosis code for record category I.						
20240	Other Diagnosis Code 7 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20241	Other Diagnosis Code 7 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20242	Other Diagnosis Code 7 exists but yet, Primary Diagnosis Code is missing for record category I.						
20243	Other Diagnosis Code 8 exists but yet one of the previous Diagnosis is missing for record category I.	IO	Info only	2300, HI08-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 8
20244	Other Diagnosis Code 8 is not a valid diagnosis code for record category I.						
20245	Other Diagnosis Code 8 is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20246	Other Diagnosis Code 8 is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20247	Other Diagnosis Code 8 exists but yet, Primary Diagnosis Code is missing for record category I.						
20248	Other Diagnosis 9 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI09-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 9
20249	Other Diagnosis 9 Code is not a valid diagnosis code for record category I.						
20250	Other Diagnosis 9 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20251	Other Diagnosis 9 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20252	Other Diagnosis 9 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20253	Other Diagnosis 10 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI10-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 10
20254	Other Diagnosis 10 Code is not a valid diagnosis code for record category I.						
20255	Other Diagnosis 10 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20256	Other Diagnosis 10 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20257	Other Diagnosis 10 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20260	Other Diagnosis 11 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI11-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 11
20261	Other Diagnosis 11 Code is not a valid diagnosis code for record category I.						
20262	Other Diagnosis 11 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20263	Other Diagnosis 11 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20264	Other Diagnosis 11 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20270	Other Diagnosis 12 Code exists but yet one of the previous Diagnosis Codes are missing for record category I.	IO	Info only	2300, HI12-2 (I only)	I	Health Care/ Other Diagnosis Information	Diagnosis Code Other - 12
20271	Other Diagnosis 12 Code is not a valid diagnosis code for record category I.						
20272	Other Diagnosis 12 Code is not appropriate for the subscriber's age for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20273	Other Diagnosis 12 Code is not appropriate for the subscriber's gender for record category I according to the applicable Medicaid Eligibility File or QI Files.						
20274	Other Diagnosis 12 Code exists but yet, Primary Diagnosis Code is missing for record category I.						
20280	Diagnosis Code Pointer 1 missing or invalid (assumed to be primary diagnosis pointer for the line) for record category P.	RL	Reject line	2400, SV107-1 (P only)	P	Professional Service	Diagnosis Code Pointer 1
20281	Diagnosis Code Pointer 1 valid but points to invalid or missing diagnosis code.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20282	Diagnosis Code Pointer 1 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.	IO	Info only				
20283	Diagnosis Code Pointer 1 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20284	Diagnosis Code Pointer 2 invalid pointer.	IO	Info only	2400, SV107-2 (P only)	P	Professional Service	Diagnosis Code Pointer 2
20285	Diagnosis Code Pointer 2 valid but points to invalid or missing diagnosis codes.						
20286	Diagnosis Code Pointer 2 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20287	Diagnosis Code Pointer 2 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20288	Diagnosis Code Pointer 3 invalid pointer.	IO	Info only	2400, SV107-3 (P only)	P	Professional Service	Diagnosis Code Pointer 3
20289	Diagnosis Code Pointer 3 valid but points to invalid or missing diagnosis codes.						
20290	Diagnosis Code Pointer 3 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20291	Diagnosis Code Pointer 3 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20292	Diagnosis Code Pointer 4 invalid pointer.	IO	Info only	2400, SV107-4 (P only)	P	Professional Service	Diagnosis Code Pointer 4
20293	Diagnosis Code Pointer 4 valid but points to invalid or missing diagnosis codes.						
20294	Diagnosis Code Pointer 4 points to a diagnosis code that is not appropriate for the subscriber's age for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20295	Diagnosis Code Pointer 4 points to a diagnosis code that is not appropriate for the subscriber's gender for record category P according to the applicable Medicaid Eligibility File or QI Files.						
20301	Principal Procedure Code was not yet valid at time of service for record category I.	IO	Info only	2300, HI01-2 (I only)	I	Principal Procedure Information	Principal Procedure Code

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20302	Principal Procedure Code was no longer valid at time of service for record category I.						
20310	Service Line Revenue Code is missing (is zeroes, blanks or spaces) for record category I.	RL	Reject line	2400, SV201 (I only)	I	Institutional Service Line	Service Line Revenue Code
20311	Service Line Revenue Code is invalid for record category I.						
20312	Service Line Revenue Code was not yet valid at time of service record category I.						
20313	Service Line Revenue Code was no longer valid at time of service record category I.						
20314	Record category I and hospital outpatient type-of-bill and Procedure Code (HCPCS or local procedure codes for CMH and CA data) not present and valid.	IO	Info only	2400, SV202-2 (I only)	I	Institutional Service Line	Procedure Code (HCPCS)
20315	Record category I and home health services type-of-bill, and Procedure Code (HCPCS or local procedure codes for CMH and CA data) not present and valid.	RL	Reject line				
20316	Procedure Code (HCPCS or local procedure codes for CMH and CA data) was not yet valid at time of service for record category I.	IO	Info only				
20317	Procedure Code (HCPCS or local procedure codes for CMH and CA data) was no longer valid at time of service for record category I.						
20319	Service Line Procedure Code is missing (is zeroes, blanks or spaces) for record category P.	RL	Reject line	2400, SV301-2 (D only) 2400, SV101-2 (P only)	D/P	Dental/Professional Service	Procedure Code
20320	Service Line Procedure Code is invalid for record category D or P.						
20321	Service Line Procedure Code was not yet valid at time of service record category D or P.						
20322	Service Line Procedure Code was no longer valid at time of service record category D or P.						
20330	Procedure Code Modifier 1 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-3 (I only) 2400, SV101-3 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 1
20331	Procedure Code Modifier 1 is not a valid HCPCS procedure code modifier for record category I or P.						
20334	Procedure Code Modifier 2 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-4 (I only) 2400, SV101-4 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 2
20335	Procedure Code Modifier 2 exists but yet Procedure Code Modifier 1 is missing (is zeroes, blanks or spaces) for record category I or P.						

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20336	Procedure Code Modifier 2 is not a valid HCPCS procedure code modifier for record category I or P.						
20340	Procedure Code Modifier 3 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-5 (I only) 2400, SV101-5 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 3
20341	Procedure Code Modifier 3 exists but yet one of the prior Procedure Code Modifiers is missing (is zeroes, blanks or spaces) for record category I or P.						
20342	Procedure Code Modifier 3 is not a valid HCPCS procedure code modifier for record category I or P.						
20345	Procedure Code Modifier 4 exists but yet Procedure Code is missing (is zeroes, blanks or spaces) for record category I or P.	IO	Info only	2400, SV202-6 (I only) 2400, SV101-6 (P only)	I/P	Institutional/Professional Service Line	Procedure Modifier 4
20346	Procedure Code Modifier 4 exists but yet one of the prior Procedure Code Modifiers is missing (is zeroes, blanks or spaces) for record category I or P.						
20347	Procedure Code Modifier 4 is not a valid HCPCS procedure code modifier for record category I or P.						
20350	Product Or Service (Procedure) ID Qualifier missing and there is a procedure code for record category P or D.	IO	Info only	2400, SV202-1 (I only) 2400, SV301-1 (D only) 2400, SV101-1 (P only)	D/I/P	Institutional/Dental/Professional Service	Product/Service ID Qualifier
20351	Product Or Service (Procedure) ID Qualifier missing and there is a HCPCS Procedure Code for record category I.						
20400	Facility Type Code (Place of Service) is missing (is zeroes, blanks or spaces) for record category D or P.	IO	Info only	2300, CLM05-1 (D and P only) 2400, SV303 (D only) 2400, SV105 (P only)	D/P	Claim Information Dental/Professional Service	Facility Type Code
20401	Facility Type Code (First Two Digits of Type of Bill) is not a valid UB place of service code per the UB92 Type of Bill valid values for record category I.	IO	Info only	2300, CLM05-1 (I only) 2300, CLM05-3 (I only)	I	Claim Information	Facility Type Code
20402	Facility Type Code (Place of Service) is not a valid place of service code for record category D or P.	IO	Info only	2300, CLM05-1 (D and P only) 2400, SV303 (D only) 2400, SV105 (P only)	D/P	Claim Information Dental/Professional Service	Facility Type Code
20403	Facility Type Code (First Two Digits of Type of Bill) is missing (is zeros, blanks or spaces) for record category I.	IO	Info only	2300, CLM05-1 (I only) 2300, CLM05-3 (I only)	I	Claim Information	Facility Type Code

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20410	Service Line Units (Quantity) is missing (is zeroes, blanks or spaces) for record category D, I or P.	RL	Reject line	2400, SV205 (I only) 2400, SV306 (D only) 2400, SV104 (P only)	D/I/P	Institutional/Dental/Professional Service Line	Service Line Units/Procedure Count
20411	Service Line Units (Quantity) is less than 0 or not numeric for record category D, I or P.						
20420	Adjudication Date is missing (is spaces, blanks or zeroes) for a payer at both the encounter and service line level for record category D, I or P. Value changed to null.	IO	Info only	2430, DTP03 2330B, DTP03	D/I/P	Service Line Adjudication Date Claim Adjudication Date	Adjudication Or Payment Date
20421	Claim Adjudication Date - Invalid date or date is not in the format CCYYMMDD for record category D, I or P. Value changed to null.			2330B, DTP03		Claim Adjudication Date	Adjudication Or Payment Date
20423	Service Line Adjudication Date - Invalid date or date is not in the format CCYYMMDD for record category D, I or P. Value changed to null.			2430, DTP03		Service Line Adjudication Date	Adjudication Or Payment Date
20471	Reference Identification/Billing Provider Secondary ID Number (Medicaid ID) is missing and a Medicaid encounter for record category D, I or P.	IO	Info only	2010AA, REF02	D/I/P	Billing Provider Secondary Identification	Reference Identification/Billing Provider Secondary ID Number (Medicaid ID)
20500	Billing Provider Qualifier (Billing Provider SSN or EIN ID) is missing (is spaces, blanks or zeroes) for record category D, I or P for MQHP or SA.	IO	Info only	2010AA, NM108	D/I/P	Billing Provider Name	Identification Code Qualifier
20501	Billing Provider Primary ID Number (SSN or EIN) missing for record category D, I or P for MQHP or SA.	RE	Reject encounter	2010AA, NM109	D/I/P	Billing Provider Name	Billing Provider Primary Identifier
20502	Laboratory or Facility Primary Identifier missing for record category I for MQHP.	RE	Reject encounter	2010AA, NM109 (I only) 2010AB, NM109 (I only) 2310E, NM109 (I only)	I	Service Facility Name	Laboratory or Facility Primary Identifier
20503	Rendering Provider Identification (SSN or EIN) missing for record category D or P for MQHP.	RL	Reject line	2010AA, NM109 (D and P only) 2010AB, NM109 (D and P only) 2310B, NM109 (D and P only) 2420A, NM109 (D and P only)	D/P	Rendering Provider Name	Rendering Provider Primary Identifier

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20530	Rendering Provider Secondary Identification Number (State License Number or Medicaid ID) is missing and a Medicaid encounter for record category D or P.	IO	Info only	2010AA, REF02 (D and P only) 2010AB, REF02 (D and P only) 2310B, REF02 (D and P only) 2420A, REF02 (D and P only)	D/I/P	Billing/Pay-to/Rendering Provider Name	Reference Identification/Billing/Pay-to/Rendering Provider Secondary Identification Number (State License Number ID or Medicaid ID)
20531	Servicing Facility Provider Secondary Identification Number (State License Number or Medicaid ID) is missing and a Medicaid encounter for record category I.			2010AA, REF02 (I only) 2010AB, REF02 (I only) 2310E, REF02 (I only)		Billing/Pay-to Provider or Service Facility Name	Reference Identification/Billing/Pay-To/Service Facility Provider Secondary Identification Number (State License Number ID or Medicaid ID)
20570	Submitted Charge Amount (Monetary Amount) missing - blank or null for record category D or P.	IO	Info only	2400, SV302 (D only) 2400, SV102 (P only)	D/P	Dental/Professional Service	Submitted Charge Amount
20571	Line Item Charge Amount (Monetary Amount) missing - blank or null for record category I.	IO	Info only	2400, SV203 (I only)	I	Institutional Service Line	Line Item Charge Amount
20572	COB Payer Paid Amount and Service Line Paid Amount both missing (blank or null) for record category P or D.	IO	Info only	2320, AMT02 2430, SVD02	D/P	COB Payer Paid Amount Line Adjudication Information	Payer Paid Amount Service Line Paid Amount
20573	Other Payer Allowed Amount missing (blank or null) for record category I, P, or D.	IO	Info only	2320, AMT02	D/I/P	COB Allowed Amount	Allowed Amount
20574	Adjusted Amount missing (blank or null) at both the claim level and the service line level and the Total Submitted Charges do not equal the COB Payer Paid Amount for record category P, or D	IO	Info only	2320, CAS03 2430, CAS03	D/I/P	Claim Level Adjustments Line Adjustment	Adjusted Amount - Claim Level Adjusted Amount - Line Level
20590	Revenue Code equal 100-219 and Service Line Rate Amount (Unit Rate) blank or null for record category I.	IO	Info only	2400, SV206 (I only)	I/P	Institutional Service Line	Service Line Rate Amount
20610	Special Program Code not a valid value, value set to null for record category D or P.	IO	Info only	2300, CLM12 (D and P only)	D/P	Claim Information	Special Program Code
20611	EPSDT Indicator not a valid value (Y or N), value set to null for record category P.	IO	Info only	2400, SV111 (P only)	P	Claim Information	EPSDT Indicator
20612	Oral Cavity Designation Code is missing for record category D.	IO	Info only	2400, SV304	D	Dental Service	Oral Cavity

Error Number	Error Description	Msg Type	Msg Type Description	Loop, Data Element	D/I/P	Segment	Description
20613	Oral Cavity Designation Code is not valid for record category D.						Designation Code
20614	Tooth Number is present, but is not a valid value for record category D.	RL	Reject line	2400, TOO02	D	Tooth Information	Tooth Number
20615	Tooth Surface Code is present, but is not a valid value for record category D.	RL	Reject line	2400, TOO03	D	Tooth Information	Tooth Surface Code
20700	Original Other Payer Secondary Identifier (Encounter Reference Number) - encounter already exists for record category D, I or P.	RE	Reject encounter	2330B, REF02	D/I/P	Other Payer Secondary Identification and Reference Number	Other Payer Secondary Identifier (Encounter Reference Number)
20701	Replacement Other Payer Secondary Identifier (Encounter Reference Number) - no encounter exists to replace for record category D, I or P.						
20702	Void Other Payer Secondary Identifier (Encounter Reference Number) - no encounter exists to void for record category D, I or P.						
20703	All service lines for the encounter were rejected; therefore, encounter rejected for record category D, I or P.	RE	Reject encounter	General file edit	D/I/P		
20704	This record was superceded by another input record for record category D, I or P.	IO	Info only				
20801	SA Encounter HCPCS procedure code not compatible with admission service category	RE	Reject encounter	2400, SV202-2 (I only) 2400, SV101-2 (P only)	I/P	Institutional Service Line/ Professional Service	Procedure Code (HCPCS)
20802	SA Encounter reflect HCPCS of assessment and the service date not while subscriber was in an admitted status or within one month after SARF date of admission	RE	Reject encounter	2400, DTP03	I/P	Service Line Date	Service Date
20803	SA Encounter reflect HCPCS other than assessment and the service date not while subscriber was in an admitted status						
20807	Subscriber SSN ID present, not numeric and CMH or SA encounter for record category D, I or P.	IO	Info only	2010BA, NM109 2010BA, REF02	D/I/P	Subscriber Name	Subscriber Primary Identifier/Supplemental Identifier (SSN ID)
99999	This is the last message of your batch transmission.	IO	Info only	General file edit	D/I/P		

Appendix B 837 Encounter Error Return File

B.1 837 Encounter Error Return File Header

This 837 Error Return File EDI Header is a single record that precedes the error report (Error Return File) that gives the entity that submitted data files detail on error detected by the Encounter Data Warehouse edits process.

Table B-1: 837 Encounter Error Return File Header Layout

Field Name	Type	Size	Begin	End	Comments
EDI-HEADER-RECORD					
EDI-TYPE	X(4)	4	1	4	Value “HDDR
EDI-APP	X(4)	2	5	6	Value “MA”
EDI-USER	X(4)	4	7	10	Value “MMIS
EDI-USER-ID	X(4)	4	11	14	Value “00XX” (“XX” = Service Bureau Claim ID
EDI-DATE-CYMD	X(8)	8	15	22	Creation Date (format is YYYYMMDD)
EDI TRANSFER DATE					Transfer date or use creation date
TRANSFER-YYYY	X(4)	4	23	26	
TRANSFER-MM	X(2)	2	27	28	
TRANSFER-DD	X(2)	2	29	30	
TRANSFER-HH	X(2)	2	31	32	
TRANSFER-MINUTE	X(2)	2	33	34	
EDI-FILE					
EDI-FILE-BEG	X(4)	4	35	38	Value "4950"
EDI-RUN-TYPE	X(1)	1	39	39	Value “P” for production or “T” for test
EDI-BATCH	X(3)	3	40	42	Unique batch identifier
FILLER	9(10)	10	43	52	
FILLER	X(101)	101	53	152	

B.2 837 Encounter Error Return File Detail Record

The following defines the 837 Error Return File that reflects the errors detected by the Encounter Data Warehouse edit process. Information on each error is included in the fields that are part of a record that describes the error.

Table B-2: CA 837 Encounter Error Return File Detail Record Layout

Field Name	Type	Size	Begin	End	Comments
ENCOUNTER-ERROR-RETURN-RECORD					
SUBMITTER-ID	X(4)	4	1	4	Also called “autobiller ID” or “service bureau” - identifier of the organization that physically transmits the data.

Field Name	Type	Size	Begin	End	Comments
CAPITATED-PLAN-ID	X(20)	20	5	24	Also called "Health Plan ID" or "Primary Payer ID", this is the ID of the Qualified Health Plan, Community Mental Health Services Provider or Coordinating Agency, etc.
RELATED-PLAN-ID	X(20)	20	25	44	Plan ID of a related plan, if any (e.g. the Prepaid Health Plan corresponding to a CMHSP.)
SUBMISSION-NUMBER	X(20)	20	45	64	Number identifying a batch - may not be reused by the same capitated health plan.
ENCOUNTER-REFERENCE-NUMBER	X(30)	30	65	94	The Encounter Reference Number assigned by the capitated health plan.
ENCOUNTER-LINE-NUMBER	X(3)	3	95	97	The Encounter Line Number assigned by the capitated health plan.
RECORD-TYPE	X(1)	1	98	98	Values are: "O" = Original "R" = Replacement "V" = Void
RECORD-CATEGORY	X(1)	1	99	99	Values are: "P" = Professional "I" = Institutional "D" = Dental
ERROR-NUMBER	X(5)	5	100	104	Format is "20nnn". Reference Section Refer to Appendix B for Edit Error List.
ERROR-SEVERITY	X(2)	2	105	106	Values are: "RB" = Reject batch "RE" = Reject encounter "RL" = Reject line "IO" = Information only
ERROR-FIELD	X(20)	20	107	126	First 20 positions of erroneous field
BATCH-SEQUENCE-NUMBER	X(8)	8	127	134	An internally generated number indicating the relative position of a batch within an input file
ASSIGNED-SEQ-ERN	X(13)	13	135	147	ASSIGNED-SEQ-ERN, ASSIGNED-SEQ-TYPE and ASSIGNED-SEQ-ELN are internal Encounter Reference Numbers, Types and Line Numbers assigned by the edit program for its own use. However, the ASSIGNED-SEQ-ERN values will be assigned sequentially in the order in which the encounters appear in the input file, so it can also be used as a sequence number to sort the error results in that order.

Field Name	Type	Size	Begin	End	Comments
ASSIGNED-SEQ-TYPE	X(2)	2	148	149	Type field indicating source of encounter: "60" = CMH "61" = SA "62" = MIChild "63" = Medicaid "64" = Delta Dental
ASSIGNED-SEQ-ELN	X(3)	3	150	152	Internal ELN assigned to this encounter line by the system

B.3 837 Encounter Error Return File Trailer Record

This 837 Error Return File EDI Trailer record follows the errors detected by the Encounter Data Warehouse edit process.

Table B-3: CA 837 Encounter Error Return File Trailer Record Layout

Field Name	Type	Size	Begin	End	Comments
EDI-HEADER-RECORD					
EDI-TYPE	X(4)	4	1	4	Value "TRLR"
EDI-APP	X(4)	2	5	6	Value "MA"
EDI-USER	X(4)	4	7	10	Value "MMIS"
EDI-USER-ID	X(4)	4	11	14	Value "00XX" ("XX" = Service Bureau Claim ID
EDI-DATE-CYMD	X(8)	8	15	22	Creation Date (format is YYYYMMDD)
EDI TRANSFER DATE					Transfer date or use creation date
TRANSFER-YYYY	X(4)	4	23	26	
TRANSFER-MM	X(2)	2	27	28	
TRANSFER-DD	X(2)	2	29	30	
TRANSFER-HH	X(2)	2	31	32	
TRANSFER-MINUTE	X(2)	2	33	34	
EDI-FILE					
EDI-FILE-BEG	X(4)	4	35	38	Value "4950"
EDI-RUN-TYPE	X(1)	1	39	39	Value "P" for production or "T" for test
EDI-BATCH	X(3)	3	40	42	Unique batch identifier
FILLER	9(10)	10	43	52	
FILLER	X(101)	101	53	152	