FY'13 REPORTING OF FINANCIAL FIELDS
PRE-PAID INPATIENT HEALTH PLANS
Final Instructions
January 1, 2013

I. Purpose and intents of reporting monetary amount with 837 v.5010 Encounters

The Michigan Department of Community Health (MDCH) is requiring that prepaid inpatient health plans (PIHPs) begin to report paid amount and provider identifiers for services rendered January 1, 2013 and thereafter with each 837 encounter submitted for services and supports provided to public mental health recipients. The rationale for this new requirement is based on: 1) aligning requirements with those for Medicaid Health Plans; 2) obtaining accurate information about the *rates* that are paid to providers in order to understand the variation in rates among PIHPs; 3) obtaining accurate information about the *providers* in order to understand the variation in rates among PIHPs; and 4) the need to use the rate and provider information to move toward a standard price or price ranges for certain high volume and high expenditure services.

PIHPs will continue reporting the cases, units and costs of each procedure code on the annual Medicaid Utilization and Net Cost Report (MUNC). It is not expected that the sum of the MUNC-reported *costs* for each procedure code, or the total *costs* of all procedure codes will equal the sum of the *rates paid* and reported in the encounter data by procedure or total.

PIHPs should report encounters with monetary amount and provider information according to the requirements in MDCH/PIHP Contract Attachment 6.5.1.1: Encounter data is reported within 30 days after the claim for the service is adjudicated, or in cases where claims payment is not part of the PIHP's business practice, within 30 days following the end of the month in which services were delivered.

The following set of instructions was developed with the assistance of a workgroup made up of representatives from PIHPs, in consultation with the State's actuary, Milliman, Inc., and staff at MDCH's Medical Services Administration.

II. Definition of terms

a. **Adjusted amount: If the paid amount does not equal the charge amount, adjustment amount must be reported as well as reason code. Required reporting with each procedure code that has a date of service beginning January 1, 2013 (See specific information about loops in Section V)**
b. Approved amount: amount that was approved by the PIHP (not required by MDCH)
c. Atypical provider: Atypical providers are non-health care providers who are not eligible to obtain an NPI, such as adult foster care facilities and taxi companies (See list of non-health care procedure codes and services in Section IV))
d. **Billing provider: The organization or agency who employs the provider of services. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.**
e. Case rate: amount paid for a period (e.g., monthly, quarterly) for each beneficiary authorized to receive services (regardless of the amount of services delivered by a provider).
f. Charge amount: amount charged by the provider. This is a HIPAA-required field for encounters but $0 can be reported for non-fee-for-service arrangements.

g. CMHSP-delivered services: CMHSP employees, including individually-contracted employees who are paid a wage or salary, deliver a covered service that results in a claim or encounter.
h. Cost settled or net cost contract: payer pays provider a set dollar amount periodically (e.g., monthly, quarterly) based on an anticipated costs, then costs settles at the end of the period based on the actual expenditures incurred by a provider in the current financial period.
i. EIN: Employer Identification Number used by employers who deliver atypical services and thus are not required to have an NPI number
j. Fee-for-service: provider is reimbursed based on a submitted claim for a service rendered
k. Most current rate: a calculated rate based on previous year's amount paid to the provider, or on predicted amount that will be paid to the provider
l. NPI number: National Provider Identifier. Used by professionals, organizations and corporations that deliver a service.
m. Paid amount: Required reporting with each procedure code for dates of service that begin with January 1, 2013
    i. "*Paid amount*" through a **fee-for-service** payment model, is the actual amount paid for the procedure to the rendering provider through the adjudication process (primary payers have paid and adjustment reductions have occurred). When billing provider is the rendering provider, the amount paid to the billing provider is reported.
    ii. "*Paid amount"* through non-fee-for service payment models (e.g., case rate, sub-cap, cost-settled or CMHSP-delivered), is based on the most current rate (e.g., calculated from last year's actual rate + inflation or deflation) for the procedure paid to the billing or rendering provider after primary payers have paid and adjustment reductions processed. When the billing provider is the rendering provider, the amount paid to the billing provider is reported.
n. **Provider: the individual, agency, organization or corporation that provided a reportable service to a beneficiary or consumer.**
o. **Rendering provider: a provider that is the person or entity who rendered the care.**
p. SS number: Social Security Number used by single providers who deliver atypical services and do not have an EIN or NPI.
q. Sub-capitation arrangement: amount paid for a period (e.g., month) for each group (e.g., Medicaid, ABW) of eligibles.

III. Identifying the "Billing and Rendering Providers"

In the chart below are the various types of services provided in the public behavioral health and intellectual/developmental disabilities services system. Since the current system has many ways that it provides and pays for services, this chart is a guide for determining who is the "billing" provider and "rendering" provider. PIHPs will identify in the 837 transaction the billing or rendering provider with the provider's NPI number, unless the provider is "atypical" delivering non-health care services (See list in Section IV), in which case the billing provider's EIN or social security number will be reported.

Note #1: In this chart it is assumed that for Detroit Wayne, CMHSP= MCPN or Managers of Comprehensive Provider Networks.

Note#2: When billing provider and rendering provider are the same, billing provider is reported and rendering provider is null.

Note #3: "Professional" referenced below means a clinician that has the ability to bill Medicare and in doing so would need an NPI number. Professional does not mean case manager or supports coordinator.

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Professional clinician (e.g., physician, MH therapy, OT, PT, RN)	Professional employed by or contracted with CMHSP/MCPN & paid a salary	CMHSP/MCPN	Professional
	CMHSP/MCPN contracts with an organization that employs or contracts with the professional	Organization	Professional
	CMHSP/MCPN contracts directly with individual professional who bills for the service provided	Professional	
Non-professional (e.g., CLS, personal care, skill building, respite, supported employment, peer)	CMHSP/MCPN employees provide the service	CMHSP/MCPN	
	CMHSP/MCPN contracts with an individual who bills for the service	Individual	
	CMHSP/MCPN contracts with an organization or corporation that employs workers who deliver the service	Organization or corporation	
	CMHSP/MCPN contracts with a sole proprietor that employees workers who deliver the service	Sole proprietor	
	CMHSP/MPCN contracts with an organization or corporation (#1) that subcontracts with another organization, corporation (#2), that subcontracts with another organization or corporation or sole proprietor (#3)	Organization, corporation #1	Organization, corporation or sole proprietor #3
Self-directed services (e.g., community	Employer of record in which the beneficiary (or	Fiscal intermediary	

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
living supports and skill building delivered by aide-level workers, independent supports coordination and psychiatry delivered by professionals)	guardian on behalf of) hires and pays worker through a fiscal intermediary.		
	Purchase of service in which the CMHSP/MCPN pays a fiscal intermediary who pays an organization who employs the worker	Fiscal intermediary	Organization
	Agency with choice in which the CMHSP/MCPN pays the agency that employs the workers who the beneficiary chooses	The agency	
Team-based services (ACT, home-based, wraparound)	CMHSP/MCPN or provider staff perform service individually or as a team	Refer to Professional above	
Treatment Planning	CMHSP/MCPN or provider professional staff participate in the planning and report separately	Refer to Professional above	Refer to Professional above
Behavior Treatment Plan Review Committee	CMHSP/MCPN or provider professional staff participate on the committee but only one event is reported	Refer to Professional above	Refer to Professional above
Adaptive equipment and enhanced pharmacy items	CMHSP/MCPN or a provider purchases from a vendor	CMHSP/MCPN or the provider	
Housing assistance and good and services	CMHSP/MCPN reports a monthly total that may include multiple items from multiple vendors	CMHSP/MCPN or the provider	
Respite care or CLS provided in a day or overnight camp	CMHSP/MCPN or a provider pays camp	CMHSP/MCPN or a provider	
Institutional services delivered in a hospital	CMHSP/MCPN contracts with and pays hospital	Hospital	
Transportation	CMHSP/MCPN or provider	CMHSP/MCPN or	

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Services are delivered by provider staff, or by local taxis, ambulance or transit authorities	pays taxi, ambulance or transit authority	provider	

IV. Atypical providers

Atypical providers deliver the non-health care services listed below. Some providers deliver a mix of health care and non-health care services so will have an NPI number that should be reported with the encounter even if the service is on this list. If all the services a provider delivers are non-health care services from the list below, the provider will not have an NPI number, and thus either an EIN or social security number will be reported with the encounter.

Procedure Code	Description
A0080	Non-emergency transportation per mile – vehicle provided by volunteer (individual or organization) with no vested interest
A0090	Non-emergency transportation per mile – vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation: Taxi
A0110	Non-emergency transportation and bus: Intra- or interstate carrier
A0120	Non-emergency transportation: Mini bus, mountain area transports, or other transportation systems
A0130	Non-emergency transportation: Wheel chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or interstate
A0160	Non-emergency transportation: per mile- case worker or social worker
A0170	Transportation ancillary: parking fees, tolls, other
A0180	Non-emergency transportation: ancillary: lodging-recipient
A0190	Non-emergency transportation: ancillary: meals-recipient
A0200	Non-emergency transportation: ancillary: lodging - escort
A0210	Non-emergency transportation: ancillary: meals - escort
H0023	Drop-in center: 15 minutes
H0025	Prevention education encounter
H0038	Peer specialist services: 15 minutes
H0043	Supported housing: per diem
H0045	Respite care, out of home: per diem
H0046	Peer mentor services: 15 minutes
H2014	Skill-building, out-of-home voc rehab: 15 min
H2015	Comprehensive community support services: per 15 minutes
H2016	Comprehensive community support services: per diem
H2023	Supported employment: 15 min
H2030	Psycho-social rehab, Club House: 15 min
S5111	Home care, family training: encounter
S5140	Foster care, adult: per diem
S5145	Foster care, therapeutic, child: per diem
S5150	Respite care, unskilled: 15 min

Procedure Code	Description
S5151	Respite care, in-home: per diem
S9976	Lodging, per diem, not otherwise classified
T1005	Respite care: 15 minutes
T1012	Recovery services:
T1016	Supports Coordination
T1017	Targeted Case Management
T1020	Personal care: per diem
T2015	HSW, Prevocational service: hour
T2025	Waiver service: not otherwise classified (used for fiscal intermediary)
T2036	Therapeutic camping, overnight, waiver: each session
T2037	Therapeutic camping, day, waiver: each session
T2038	Community transition, waiver: per service
T5999	Wraparound – supply: item

V. Loops and segments

Attached is a chart with the location of loops and segments from the 837 Implementation Guide

Financial Loops – Professional

-Information Taken from Health Care Claim: Professional (837) Implementation Guide ASC X12N/005010X222-

Loop	Field	Name	Description	Balancing Rules
2300	CLM02	Total Claim Charge Amount	CLM02 is the total amount of all submitted charges of service segments in this claim	For 5010, the total claim charge amount reported in Loop ID-2300 CLM02 must balance to the sum of all the service line charge amounts reported in Loop ID-2400 SV102
2320	AMT02	Total Payment Amount, Payer Paid Amount		Balancing of claim payment information is done payer to payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loops ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02)
2320	CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)	Claim Adjustment Amounts	The adjustment amounts at the claim level (e.g., patient deductible). Adjustment amounts within the CAS segment **decrease** the payment amount when the adjustment amount is **positive,** and **increase** the payment amount when the adjustment is **negative**	There are two different ways the claim information must balance. They are as follows: 1) Claim Charge Amounts The total claim charge amount reported in Loop ID-2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop ID-2400 SV102. 2) Claim Payment Amounts Balancing of claim payment information is done payer by payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02).
2320	CAS (CAS01, CAS02, CAS04, CAS05…)	Claim Adjustment Group Code & Reason Code		
2400	SV102	Line Item Charge Amount	Total charge amount for the service line	
2430	SVD02	Service Line Paid Amount	The amount paid to the provider	Line level balancing occurs independently for each individual Line Adjudication Information Loop. In order to balance, the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information loop must balance to the provider's charge for that line (Loop ID-2400 SV102)
2430	CAS (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18)	Line Adjustment Amounts	The adjustment amount for the submitted charge for the line. Adjustment Amounts within the CAS segment **increase** the payment amount when the adjustment amount is **positive**, and **decrease** the payment amount when the adjustment is **negative**	In order to balance the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information loop must balance to the provider's charge for that line (Loop ID-2400 SV102).
2430	CAS (CAS01, CAS02, CAS04, CAS05…)	Line Adjustment Group Code & Reason Code		

The payer for each line payment is identified in Loop ID-2430 SVD01.This identifier must match the identifier of the corresponding payer identifier reported in Loop ID-2330B NM109.

Example 1 – Fee for Service:

Loop	Claim	Notes
2300:	CLM✻A37YH556✻100✻✻✻11:B:1✻Y✻A✻Y✻I✻P~	Total Claim Charge Amount - CLM02
2320:	AMT✻D✻80~	Total Payment Amount - AMT02
2320:	CAS✻PR✻1✻5~	Claim Adjustment Amount - CAS03; Patient Responsibility – CAS01
2330B:	NM1✻PR✻2✻**Payer Name**✻✻✻✻✻PI✻11122333~	Payer ID – NM109 - Must match 2430 SVD01
	Line 1	
2400:	SV1✻HC:H2016:25✻80✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻70✻HC:H2016✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻10~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
	Line 2	
2400:	SV1✻HC:T1020:25✻20✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount SV102
2430:	SVD✻11122333✻15✻HC:T1020✻✻2~	Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻OA✻93✻5~	Line Adjustment Amount - CAS03, Other Adjustment – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date

Calculations:

Claim Charge Amount = (Line 1 Charge Amount + Line 2 Charge Amount)
100 = 80 + 20 = 100

Claim Payment Amount = (Line 1 Payment + Line 2 Payment) – Claim Adjustment Amount
80 = (70 + 15) - 5

Line Item 1 Charge Amount = (Line 1 Payment) + (Line 1 Adjustments)
80 = 70 + 10

Line Item 2 Charge Amount = (Line 2 Payment) + (Line 2 Adjustments) =
20 = 15 + 5

Notes:

Loop 2300 CLM02: The Total Claim Charge Amount must be greater than or equal to zero.

Loop 2320 AMT02 (Claim Payment Amount): It is acceptable to show “0” as the amount paid.

Loop 2400 SV102 (Line Charge Amount): Zero “0” is an acceptable value for this element.

Loop 2430 SVD02 (Line Payment Amount): Zero “0” is an acceptable value for this element.

Example 2 – Capitated Arrangement:

Loop	Claim	Notes
2300:	CLM✻A37YH556✻0✻✻✻11:B:1✻Y✻A✻Y✻I✻P~	Total Claim Charge Amount - CLM02
2320:	AMT✻D✻150~	Total Payment Amount - AMT02
2320:	CAS✻PR✻1✻5~	Claim Adjustment Amount - CAS03; Patient Responsibility – CAS01
2330B:	NM1✻PR✻2✻**Payer Name**✻✻✻✻✻PI✻11122333~	Payer ID – NM109 - Must match 2430 SVD01
	Line 1	
2400:	SV1✻HC:H2016:25✻0✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount - SV102
2430:	SVD✻11122333✻70✻HC:H2016✻✻3~	Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻CO ✻24✻-70~	Line Adjustment Amount - CAS03, Contractual Obligation – CAS01
2430:	DTP✻573✻D8✻20130203~	Remittance Date
	Line 2	
2400:	SV1✻HC:T1020:25✻0✻UN✻1✻11✻✻1:2:3✻✻N~	Line Item Charge Amount SV102
2430:	SVD✻11122333✻85✻HC:T1020✻✻2~	Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
2430:	CAS✻CO✻24 ✻-85~	Line Adjustment Amount - CAS03, Contractual Obligation – CAS01 Claim Adjustment Group Code – CO: Contractual Obligation; Claim Adjustment Reason Code – 24: Charges are covered under a capitation agreement/managed care plan.
2430:	DTP✻573✻D8✻20130203~	Remittance Date

Calculations:

Claim Charge Amount = (Line 1 Charge Amount + Line 2 Charge Amount)
0 = 0 + 0

Claim Payment Amount = (Line 1 Payment + Line 2 Payment) – Claim Adjustment
150 = (70 + 85) - 5

Line Item 1 Charge Amount = (Line 1 Payment) + (Line 1 Adjustments)
0 = 70 + (-70)

Line Item 2 Charge Amount = (Line 2 Payment) + (Line 2 Adjustments)
0 = 85 + (-85)

Provider Reporting Loops:

2010AA — BILLING PROVIDER NAME

NM1 - BILLING PROVIDER NAME

NM1✻85✻2✻ABC Group Practice✻✻✻✻✻XX✻1234567890~

85 - Billing Provider
1 – Person or 2 - Non-Person Entity
Name - Last or Organization Name
XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI

REF - BILLING PROVIDER TAX IDENTIFICATION (Atypical Provider)

REF✻EI✻123456789~

EI - Employer's Identification Number or SY - Social Security Number
Billing Provider Tax Identification Number

2310B — RENDERING PROVIDER NAME

NM1 - RENDERING PROVIDER NAME

NM1✻82✻1✻DOE✻JANE✻C✻✻✻XX✻1234567804~

82 - Rendering Provider
1 – Person or 2 - Non-Person Entity
Name - Last or Organization Name
XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

REF✻G2✻12345~

0B - State License Number, 1G - Provider UPIN Number, G2 - Provider Commercial Number or LU Location Number

REFERENCE IDENTIFIER