MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INSTRUCTIONS FOR 837 ENCOUNTER AND QUALITY IMPROVEMENT (QI) DATA SUBMISSION

FOR

MENTAL HEALTH PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICE PROGRAMS

October 2005

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1.0   Introduction

The Michigan Department of Community Health (MDCH) requires that Community Mental Health Prepaid Inpatient Health Plans (PIHPs) report encounters and quality improvement (QI) data for every consumer served by the PIHP or affiliate Community Mental Health Service Program (CMHSP).

Encounters include services delivered either directly or via contract. 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.

MDCH is meeting the mandates set forth under the Health Insurance Portability and Accountability Act (HIPAA). As a result MDCH has implemented a standardized format for encounter (activity) data reporting. MDCH requires that encounters be submitted in the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837, version 4010A1, Professional, Institutional, and Dental Healthcare Claim format. In addition, PIHPs and CMHSPs will be required to report demographic, or quality improvement (QI) data, using a MDCH proprietary format and process.

The purpose of these instructions is to provide guidelines to PIHPs and CMHSPs 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   Encounter Data

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 had an effective date of October 2002.

2.2   Encounter Data Reporting Format

MDCH has implemented the ASC X12N 837 version 4010 format for encounters effective with dates of service on or after October 1, 2002. Effective April 1, 2005, the ASC X12N 837 version 4010A1 has been required. Contracted entities are required to meet these requirements as outlined in their contracts with MDCH.

The provider-to-payer-to-payer coordination of benefits (COB) data model outlined in the 837 implementation guides is required. In the COB model, the provider originates the transaction and sends claim or encounter information to the PIHP or CMHSP. If the provider first submits the transaction to a CMHSP affiliated with a PIHP, the CMHSP will reformat the 837 transaction and send the encounter to their PIHP hub, then the PIHP will reformat the transaction and send it to MDCH. The PIHP 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 PIHP or CMHSP. The PIHP or CMHSP must

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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 implementation guides may also be ordered on line at http://www.wpc-edi.com/hipaa/HIPAA_40.asp

The implementation guides are the primary source of information on how to implement the 837 encounter data model.

MDCH has published Companion Guides for the 837 Institutional, Professional and Dental Encounter, Version 4010A1. 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 Companion Guides will be helpful to the PIHP and CMHSP as they develop outbound 837 encounter transactions. These Companion Guides can be found at http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The titles of these documents are:

837 v4010A1 Institutional Encounter for Mental Health PIHPs and CMHSPs
837 v4010A1 Professional Encounter for Mental Health PIHPs and CMHSPs

 PIHPs and CMHSPs should check the web site regularly for updates or changes to these documents.

2.3   Reporting Requirements

MDCH requires PIHPs to report encounters for all services provided on or after October 1, 2002 to Medicaid, non-Medicaid, and MIChild enrollees. PIHPs 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),
- room and board reimbursed through State Disability Assistance (SDA) funds, and
- mental health services paid by the Medicaid Health Plan (MHP), formerly known as Qualified Health

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Plan (QHP).

PIHPs are required to report on each consumer who received a service from the PIHP or its CMHSP affiliate, regardless of funding stream. When a PIHP, CMHSP, or Medicaid Health Plan contracts with another PIHP or CMHSP to provide mental health services, it is the PIHP, CMHSP or MHP who pays the provider of services that is responsible for submitting the encounter. The PIHP or CMHSP that delivers the service under contract does not report the encounter.

In situations where the client has dual eligibility, i.e., Medicare/Medicaid, the PIHP is required to submit encounter data for the services provided. Services provided to clients that have dual-eligibility must also be reported in the annual sub-element cost report.

2.4 837 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 PIHPs.

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.

2.4.1.   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. PIHPs and CMHSPs must code this data element to a value of "RP" for all encounter data reporting. The value of "RP" should be reported whether the PIHP or CMHSP reimburses the provider on a fee-for-service, per diem, case rate or other payment basis.

2.4.2   Insured Group Name (Loop 2000B, SBR04)

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

2.4.3   Subscriber Primary Identifier (Loop2010BA, NM109)

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

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2.4.4   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 PIHPs and CMHSPs 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. PIHPs and CMHSPs should not ignore the V-series codes identified by IDC-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 is under 18 years of age, a diagnosis has not yet been developed and no other ICD-9-CM code, including the V-Codes, accurately describes the client's signs or symptoms or reason for the encounter.
- Children of consumers receiving services when the child has an assigned identification number and is also receiving services, however the child has no mental health diagnosis.

Level I OBRA/PASSAR assessments are not reported. Level II OPBRA/PASSAR assessments are reported using an assessment procedure code. Level II assessments can be reported with a diagnosis code of V701 – general psychiatric examination requested by the authority. There are other appropriate codes to consider as well.

2.4.5   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. Please refer to the Michigan Uniform Billing Manual (UB-92) which is an enhanced version of the National Uniform Billing Manual for Michigan-specific billing information. This document is available from the Michigan Health and Hospital Association.

2.4.6   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. PIHPs and CMHSPs 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.

PIHPs and CMHSPs should use caution when using the place of service code value "53" – Community Mental Health Center (CMHC). CMHC refers to a facility-based provider. When the PIHP or CMHSP is the direct care provider, the appropriate facility type code to report is often "11" – Office.

2.4.7   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

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four diagnosis codes. Following is an example for a professional service transaction:

Claim Diagnosis Codes

1 =   296.33 Major depressive disorder, recurrent episode w/o mention of psychotic behavior
2 =   300.3   Obsessive-Compulsive Disorders
3 =   301.6   Dependent Personality Disorder

Service Line Procedures and Diagnosis Pointers
Line 1 Procedure = 90801   Psychiatric evaluation
Diagnosis Pointers: Primary = 2, Secondary = 1, Tertiary = 3

Line 2 Procedure = T1017   Targeted Case Management
Diagnosis Pointers: Primary = 1, Secondary = 3, Tertiary = 2

Line 3 Procedure = 90782   Medication Administration
Diagnosis Pointers: Primary = 2

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

With the implementation of the 837 transaction, PIHPs and CMHSPs 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.

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

Secondary identifiers are carried in the REF segment and MDCH requires PIHPs or CMHSPs to report either the Medicaid ID or State License Number for all in-state providers. If the PIHP or CMHSP is the direct care provider, their PT 77 number would be reported in the Professional 837 encounter. The PIHP or CMHSP would not be providing a dental service. The dentist providing the service would be reported in this data element in the 837 dental encounter. The 837 institutional encounter requires the identification of the service facility where services were provided.

The hospital type and identifier must be reported for inpatient claims. There are four types of hospitals that may be reported.

Type   Hospital
22   State Psychiatric Hospital-Inpt (State Hospital)
65   State mental retardation facility – inpatient (ICF/MR)
68   Private mental hospital – inpatient (IMD)
73   Hospital - inpatient psychiatric unit (Community Hospital)

The directions for reporting the Provider Type and Provider ID are as follows:

If the Billing Provider is also the Rendering Provider, the Provider Type and Provider ID (2 character Provider Type + 7 character unique Medicaid provider ID) must be reported in the Billing Provider Segment, Loop 2010AA REF02 - Billing Provider Additional Identifier. The Reference Identification Qualifier, Loop 2010AA REF01 must be "1D" for Medicaid Provider Number.

If the Rendering Provider is different from the Billing Provider, the Provider Type and Provider ID (2 character Provider Type + 7 character unique Medicaid provider ID) must be reported in the Service Facility Name Segment, Loop 2310E REF02 - Laboratory or Facility Secondary Identifier. The Reference Identification
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Qualifier, Loop 2310E REF01 must be "1D" for Medicaid Provider Number.

2.4.10   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 PIHP, and where applicable the CMHSP affiliate, are other payers 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.

2.4.11   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 there is Medicare, or a commercial carrier, with financial responsibility, they would always be the primary payer and therefore "P" would be reported for them. In this case, the PIHP or CMHSP affiliate could be reported as the secondary payer, "S". Whether it is the PIHP or the CMHSP identified as secondary is dependent on which one actually is responsible for payment to the provider. All remaining payers are then reported with a value of "T", tertiary. If there is a commercial payer and Medicare, the commercial payer would be reported as the primary payer "P", Medicare secondary "S", and the PIHP, and if applicable the CMHSP, as "T" tertiary. Tertiary can be reported multiple times if needed.

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

All mental health encounters require the reporting of the Consumer Identification Number (CONID) in Loop 2330A, NM109. This element is intended to report the unique member number assigned by the plan or other payer (PIHP or CMHSP). The CONID must be reported here even when it was used as the subscriber primary identifier in Loop 2010BA, NM109. The CONID must be 11-characters in length. Right justify and zero fill to the left if required to create an 11-character CONID. The CONID can be alphanumeric.

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

The contract between MDCH and the PIHPs for capitated mental health services places responsibility on the PIHP for the management of client services and payment for services rendered directly or by contracted providers. The PIHP is reported as an Other Payer (Loop 2330B), as well as any CMHSP affiliate responsible for the services being reported in the encounter transaction. A Payer Identification (PI) number is required in Loop 2330B, NM109 of the 837 to identify the Other Payer(s). MDCH will enroll PIHPs and CMHSPs as payers. They will receive a nine-character number (for example 17XXXXXXX) that identifies them as an MDCH mental 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 PIHP, and CMHSP Affiliate (when applicable), 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. It should not be used to identify the provider of services, even when the PIHP or CMHSP is a direct provider.

To report other commercial payers, the PIHP or CMHSP 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

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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"

2.4.14   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 mental health services. The code list developed by MDCH will be used for reporting revenue codes and procedure codes on 837 encounters. The code list for mental health services is posted on the MDCH website which should be checked regularly for updates. The code list for mental health services can be found at http://www.michigan.gov/mdch, then click Providers, HIPAA, Health Plan Materials, "Mental Health HCPCS and Revenue codes".

2.4.15   Financial/Adjudication Data Elements

The provider-to-payer-to-payer COB data model of the 837 will provide MDCH with expanded financial information on encounter records. The loops in the 837 HIPAA implementations that can be used to convey information regarding adjudication are the 2320 (Other Subscriber Information) and 2430 (Service Line Adjudication Information). Reporting of financial data is voluntary. PIHPs and CMHSPs choosing to report financial data should use the following guidelines.

The financial, or adjudication fields that MDCH requests the PIHPs and CMHSPs to report include:

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

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

MDCH requests PIHPs and CMHSPs to report the provider's 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 mental health services would not have a charge. Therefore, the amount coded in the Submitted Charge Amount data element should not be '0'.

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

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

PIHPs and CMHSPs would 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. These amounts must be present and not equal to zero.

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

If the PIHP or CMHSP paid the provider for the service, the Paid Amount should reflect the amount paid.

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2.4.15.4   *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.

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

This data element identifies the general category of payment adjusted. The PIHP and CMHSP 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.

2.4.15.6   *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. PIHPs and CMHSPs must use the standard Claim Adjustment Reason Codes available at www.wpc-edi.com.

Example A: PIHP "A" pays a contracted provider on a fee-for-service basis for all services. The PIHP 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 PIHP "A". PIHP "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: PIHP "B" has a per diem contract arrangement with a local facility to provide inpatient psychiatric hospital services. The per diem rate is $450 per day. John Doe spends four inpatient days in their facility. There is no other payer. PIHP "B" submits the encounter to MDCH.

Submitted Charge	Approved / Allowed Amount	Paid Amount	Adjustment Reason	Adjustment Amount
$2500	$1800	$1800	A2 – contract adjustment	$700

Example C: PIHP "C" has a capitated case rate contract arrangement with a local provider for case management services. The case rate is $800 per client per month. His case manager sees John Doe five times during the month. There is no other payer. PIHP "C" submits an encounter to MDCH.

Submitted Charge	Approved / Allowed Amount	Paid Amount	Adjustment Reason	Adjustment Amount
$0	$800	$0	NA	$0

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

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When reporting financial data PIHPs and CMHSPs should heed the balancing requirements outlined in the Implementation Guides.

2.5   Submission Deadlines

A mental health encounter is 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 submitted by December 31. That means the PIHP 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, 2005 and by September 30, 2005 still has not been adjudicated by the primary payer, the PIHP is required to submit an encounter reporting the services provided by December 31, 2005.

2.6   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. PIHPs may submit encounter data more frequently if necessary. Encounter data is required to be submitted by the last day of the month following the month in which it was adjudicated. Claims should not be sent in small batches. Large batches are more efficiently processed. Up to 5000 claims may be sent in one Transaction Set. Multiple transaction sets in an 837 file are preferred.

In order to communicate electronically with MDCH, the PIHP or CMHSP 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, HIPAA and Health Plan Materials. Select the document named "Electronic Submissions Manual - October 4, 2002".

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 004010X096A1, 004010X097A1, or 004010X098A1, indicating whether that group contains institutional, dental, or professional encounter transactions, respectively.

PIHPs should copy transferred files immediately as a backup for their site. It is the agent's responsibility to retain backup 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 backup.

After the file has been received by MDCH, a 997 Functional Acknowledgement transaction will be generated and submitted to the PIHP'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 PIHP retrieve the 997 acknowledgements to determine if MDCH has received the ASC X12 837 transaction sets, and identify transmissions that have not been acknowledged.

2.7   Editing

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Once the encounter data is submitted to the DEG, it is edited and stored on the encounter data warehouse. A process is run prior to the data being stored on the encounter data warehouse, known as editing. This process includes checking data conditions to determine acceptance or rejection of encounters, service lines, and batches or files. Error conditions detected by the edit process are reported in an Error Return File. The PIHPs should check their data after receiving the Error Return File, make any necessary corrections, and submit replacements as necessary.

A complete list of the encounter data warehouse edits that may be reported in the Error Return File can be found on the MDCH website. Go to http://michigan.gov/mdch. Once you have reached the web site, click Providers, HIPAA, Health Plan Materials, "837 Encounter Error Listing".

Acceptance or rejection of data elements, service lines, encounters, or files are based on the 837 Implementation Guides. Electronic data transactions (original or replacement submissions) are accepted if all submission rules and required formats are followed. Once the data are submitted, the submitting PIHP or CMHSP must use the Error Return File to check the rejection status of a data element, service line, encounter, or batch. The PIHP/CMHSP will need to be aware of its data submission number and basic information about its submission.

The CMH encounter data is linked to the QI data using the key elements from each data set. All encounters must have a QI record stored in the encounter data warehouse prior to acceptance of the encounter.

To be able to make those links, the relational rules in the following two tables are applied. Page references refer to the Implementation Guides.

Table 2-1: Professional Encounter Data Relationships

QI Primary Key Data Elements		Sample QI data	Relational Rule	Professional Encounter Foreign Key Relational Elements		Sample 837 Encounter Data
1.	Reporting Period, format CCYYMMDD (REPORTPD)	20021030	Does the Date Time Period fall within the QI Reporting Period? If yes, this part of the relationship is approved.	16.	Date Time Period (Date Time Period - Service Date, 2400, DTP03, Service Date, Pg. 457)	20021011 OR 20021011 - 20021013
2 a.	PIHP Payer Identification Number (PHPID)	174357240	Is the PIHP Payer ID number the same as the QI PHPID? If yes, this part of the relationship is approved.	1a.	PIHP Payer Identification Number (Identification Code- Other Payer Primary Identifier 2330B, NM109, Other Payer Name, Pg. 411, Iteration 1 for the PIHP)	174357240
2 b.	CMHSP Payer Identification Number (CMHID)	174351292	Is the CMHSP Payer ID number the same as the QI CMHID? If yes, this part of the relationship is approved.	1 b.	CMHSP Payer Identification Number (Identification Code- Other Payer Primary Identifier 2330B, NM109, Other Payer Name, Pg. 411, Iteration 2 for the CMHSP)	174351292

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| 5. | Consumer Identification Number (CONID) | 00000456789 | Is the CONID data in the Identification Code the same as the QI CONID? If yes, this part of the relationship is approved. | 2. | Identification Code/Other Subscriber Primary Identifier (Identification Code - Other Insured Identifier 2330A, NM109, Other Subscriber Primary Identifier, Pg. 403) | 00000456789 |

Table 2-2: Institutional Encounter Data Relationships

QI Primary Key Data Elements	Sample QI data	Relational Rule	Institutional Encounter Foreign Key Relational Elements		Sample 837 Encounter Data
1. Reporting Period, format CCYYMMDD (REPORTPD)	20021030	Does the Date Time Period fall within the QI Reporting Period? If yes, this part of the relationship is approved.	1 6.	Date Time Period (Date Time Period - Service Date, 2400, DTP03, Service Date, Pg. 436	20021011 OR 20021011 - 20021013
2 a. PHP Payer Identification Number (PHPID)	174357240	Is the PHP Payer ID number the same as the QI PHPID? If yes, this part of the relationship is approved.	1a.	PHP Payer Identification Number (Identification Code- Other Payer Primary Identifier 2330B, NM109, Other Payer Name, Pg. 361, Iteration 1)	174357240
2 b. CMHSP Payer Identification Number (CMHID)	174351292	Is the CMHSP Payer ID number the same as the QI CMHID? If yes, this part of the relationship is approved.	1 b.	CMHSP Payer Identification Number (Identification Code- Other Payer Primary Identifier 2330B, NM109, Other Payer Name, Pg. 361, Iteration 2)	174351292
5. Consumer Identification Number (CONID)	00000456789	Is the CONID data the same as the QI CONID? If yes, this part of the relationship is approved.	2.	CONID (Identification Code - Other Insured Identifier 2330A, NM109, Other Subscriber Primary Identifier, Pg. 352)	00000456789

2.8   4950 Error Return File

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.

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 the rejection of a line or the entire claim.

Output from the edit process is a 4950 Error Return File that will be available to the PIHPs at their mailbox

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through the DEG. 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.

All Error Return Files will reference the data submission number. The PIHP should keep track of their data submission numbers.

The list of edits will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The list of edits for the 837 is called "837 Encounter Error Listing".

2.9   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.

2.9.1   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. Version Identifier Code is not equal to "A1"
2. Submitter Identifier (ISA06, GS02, Loop 1000A, NM109) is missing or invalid
3. Submission Number (HDR, BHT03) is missing
4. Submission Number (HDR, BHT03) is not alphanumeric
5. Submission Number (HDR, BHT03) has been used on a previous batch
6. Transaction Type Code (HDR, BHT06) is not "RP", encounters
7. 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.

2.9.2   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 PIHP. 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. MICHILD encounter but no MICHILD identification number
    h. Admission Date (Institutional transactions only) (Loop 2300, DTP03)
    i. Statement through date for an admission for room and board to a facility (instutional)
    j. Statement through date is less than the admission date (institutional)
    k. Statement from date (institutional)
    l. Diagnosis Code(s) (Institutional transactions only) (Loop 2300, HI01-2)

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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.
4. Subscriber SSN ID is present but not numeric
5. All service lines rejected.
6. No match on a QI record.

2.9.3   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. A Diagnosis Code Pointer "points" to an invalid diagnosis code (Professional Loop 2400, SV107-1)
3. Revenue Code (Institutional Loop 2400, SV201)
4. Service Line Procedure Code (Professional loop 2400, SV101-2)
5. Units (Professional Loop 2400, SV104, Dental Loop 2400, SV306, Institutional Loop 2400, SV205)
6. Rendering provider identification (Dental or Professional, 2010AA, NM109 or 2010AB, NM109 or 2310B, NM109 or 2420A, NM109)
7. Service level Approved Amount not > 0 (Loop 2400, AMT02 where AMT01 ="AAE")

2.10   4950 Error Return File Format

The 837 error return file header, detail, and trailer record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the 837 error return file format is called "837 Error File Layout (4950)".

2.11   Encounter Correction Process

Resubmission is the process the PIHP 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 PIHP 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 of "Reject Batch" or "Reject Encounter", indicating the submission could not be processed.

Replacement is the process the PIHP 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.

When MDCH rejects an entire batch, the PIHP 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 PIHP 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

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encounter was an original encounter, the "corrected" encounter should also be an original encounter.

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 PIHP may not correct a single service line on an 837 encounter transaction. The PIHP has two options:

1. The PIHP 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 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 PIHP 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". PIHPs 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 PIHP 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.

3.0   Quality Improvement Data

3.1   Overview

MDCH collects and reports Quality Improvement (QI) data for every consumer served during a month by the PIHP, either directly or via contract, or the affiliate CMHSP, either directly or via contract, for whom the PIHP is submitting data, regardless of funding stream. When a PIHP or CMHSP contracts with another PIHP or CMHSP, or a Medicaid Health Plan contracts with a PIHP or CMHSP to provide mental health services, the PIHP or CMHSP that delivers the services does not report the QI data.

QI data is required to be reported monthly for each consumer who received services during the month and for whom an encounter data record or fee-for-service claim (Children's Waiver) is also being submitted. QI data is reported year-to-date, and, because of relationship rules, must be on the encounter data warehouse before the 837 encounter data is processed. The first submission for the fiscal year will contain records for all consumers who received services the first month, the next month's submission will contain records for all consumers who received services in month one and month two, etc. QI data will be submitted to MDCH's data warehouse electronically via a Data Exchange Gateway (DEG).

3.2   Submission Deadlines

For all services incurred on or after October 1, 2002, the PIHP or CMHSP is required to send monthly QI data files. Submission is due by 5:00 p.m. on the last day of the month following the month the claim was 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. Batches and records that were rejected by the system must be

resubmitted within 30 days of the date the Error Return File was created.

3.3   QI Reporting Format

PIHPs and CMHSPs are required to report QI (demographic) data monthly using an ASCII delimited (asterisk) format. Specific header and trailer records will need to be used to prepare the data for submission. The data will be submitted to MDCH via the MDCH Data Exchange Gateway (DEG). The data will be edited to determine acceptance or rejection to the QI Data Warehouse.

3.4   QI File Formats

The CMHSP QI records submitted by the PIHPs must be submitted in a file with a header and trailer. The following three tables define the layout of the header record, the QI records, and the trailer record for each QI file.

The QI header, detail, and trailer input record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the QI 5218 input file format is called "QI Reporting File Layout (5218)".

3.5   QI Data Submission Process

QI data submitted in the ASCII delimited format will be submitted through the MDCH DEG on a monthly basis. The QI data will be year-to-date data as described above. It is important to note that the QI data must be processed and posted to the data warehouse prior to any associated encounter data being processed. Failure of the QI data file being processed and posted to the data warehouse prior to the encounter file may result in rejection of encounter claims. The MDCH processing system will automatically process all submitted QI files prior to processing 837 encounter files that have been submitted. Since successful processing of an 837 encounter is dependent on successful processing of the QI file, the PIHP or CMHSP may wish to submit the QI files first and ensure that transmission and processing is successful.

To communicate electronically with MDCH, the PIHP or CMHSP 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, HIPAA, Health Plan Materials, "Electronic Submissions Manual – October 4, 2002".

PIHPs and CMHSPs should copy transferred files immediately as a backup for their site. It is the agent's responsibility to retain backup 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 backup.

3.6   QI Record Processing

Error conditions detected by the edit process are reported in a 4956 Error Return File. The Error Return File will be available to the PIHPs and CMHSPS at their mailbox through the DEG. 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.

A complete list of the data warehouse QI edits that are reported in the 4956 Error Return File can be found in the "QI Error Listing for FY06 Submissions forward". The QI error listing will be posted on the MDCH website. Go to http://www.michigan.gov/mdch and click Providers, HIPAA, Health Plan Materials, "QI Error Listing for FY06 Submissions Forward".

All Error Return Files will reference the data submission number. The PIHP/CMHSP will need to be aware of its data submission number and basic information about the submission.

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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 errors in fields identified as primary key fields and the input record is rejected
3. The data contain errors in the input file header or trailer records causing the batch to be rejected
4. The data contain minor errors resulting in an edit for informational purposes only.

The CMH encounter data will be linked to the QI data using the key elements from each data set.   That means the QI data must be in the data warehouse prior to the corresponding encounter data processing. Because of the adjudication process, it is quite likely that any QI data submission will have records for consumers for which the PIHP has not yet submitted an encounter record. This situation is expected and will not affect QI record acceptance.

3.7　QI 4956 Error Return File

The Error Return File (4956) contains a header record, detail records that indicate which errors were found, and a trailer record. The instructions and formats of each are listed below.

The QI error return file header, detail, and trailer record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the QI error return file format is called "QI Error Return File Layout (4956)".

3.8　QI Correction Process

Resubmission is the process the PIHP or CMHSP uses when the QI data file has not made it through the processing and there is subsequently no data stored in the data warehouse. The PIHP or CMHSP will need to resubmit if the Error Return File contains messages indicating the batch or input record has been rejected.

When MDCH rejects an entire batch, the PIHP or CMHSP must make the necessary corrections and resubmit the batch. 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 input record, the PIHP or CMHSP must correct the identified error(s) and resubmit the record. As with a rejected batch, a rejected input record is not stored in the data warehouse.

Replacement is the process the PIHP or CMHSP uses when the QI data file has made it through processing and data is stored on the data warehouse, but for some reason the PIHP or CMHSP is required to make corrections to the QI data record. There are primary key fields identified in the QI data record that are validated with each submission. Replacement QI data records will be identified through these primary key fields and the original QI record will be replaced.

Batches and records that were rejected through processing must be corrected and resubmitted within 30 days of the Error Return File creation date identified in the Error Return File header and trailer record. Replacement records that are the result of the PIHP identifying necessary corrections must be submitted by December 31, following the end of the fiscal year.

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4.0   Other resources

4.0.1   HIPAA 837 Implementation Manuals
The Federal HIPAA 837 guides may be ordered on line at http://www.wpc-edi.com/hipaa/HIPAA_40.asp

4.0.2   Companion Guides
These Companion Guides can be found at http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The titles of these documents are:

837 v4010A1 Institutional Encounter for Mental Health PIHPs and CMHSPs
837 v4010A1 Professional Encounter for Mental Health PIHPs and CMHSPs

4.0.3   Electronic Submission Manual
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, HIPAA and Health Plan Materials. Select the document named "Electronic Submissions Manual - October 4, 2002".

4.0.4   837 Encounter Error Listing
A complete list of the encounter data warehouse edits that may be reported in the Error Return File can be found on the MDCH website. Go to http://michigan.gov/mdch. Once you have reached the web site, click Providers, HIPAA, Health Plan Materials, "837 Encounter Error Listing".

4.0.5   QI Error Listing for FY06 Submissions Forward
The QI error listing will be posted on the MDCH website. Go to http://www.michigan.gov/mdch . Once you have reached the web site, click Providers, HIPAA, Health Plan Materials, "QI Error Listing for FY06 Submissions Forward".

4.0.6   HCPCS Code List
The code list for mental health services can be found at http://www.michigan.gov/mdch, then click Providers, HIPAA, Health Plan Materials, "Mental Health HCPCS and Revenue Codes".

4.0.7   QI Reporting File Layout (5218)
The QI header, detail, and trailer input record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the QI 5218 input file format is called "QI Reporting File Layout (5218)".

4.0.8   QI Error Return File Layout (4956)
The QI error return file header, detail, and trailer record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the QI error return file format is called "QI Error Return File Layout (4956)".

4.0.9   837 Error File Layout (4950)
The 837 error return file header, detail, and trailer record layouts will be found on the MDCH website. Go to http://www.michigan.gov/mdch. Select Providers, HIPAA and Health Plan Materials. The document containing the QI error return file format is called "837 Error File Layout (4950)".