

# Encounter Reporting

ANSI ASC X12 837 v.4010A1

Requirement for Reporting

Financial Data

Michigan Department of Community Health

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*Michigan Department  
of Community Health*



# Goals

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- Ability to identify which financial data elements MDCH expects to be reported in 837 v4010A1 encounter transactions.
- Understanding of where MDCH expects financial data to be reported within the 837 v4010A1 encounter transactions.
- Knowledge of acceptable values for financial data elements.
- Identification of Edit Errors generated when financial data is missing or values are unacceptable.

# 837 Encounter Financial Data

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- ❁ MDCH expects capitated health plans to submit the following financial data for 837 v. 4010A1 encounters:
  - ❁ Submitted Charge Amount
  - ❁ Approved/Allowed Amount
  - ❁ Paid Amount
  - ❁ Adjusted Amount (when applicable)

# Health Plan Provider Contracts

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- ❁ Requirements for financial data is dependent on health plan provider contract arrangements
  - ❁ Fee-for-service vs. subcapitated arrangements
- ❁ Subcapitated contract arrangement with provider requires reporting Contract Type Code
  - ❁ Loop 2300 CN101, or
  - ❁ Loop 2400 CN101

# Submitted Charge Amount

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- **Submitted Charge Amount** – Provider’s usual and customary fee/amount billed by Provider
  - Reported at the claim and service line level
  - Professional Encounter:
    - Loop 2300 CLM02 (Total submitted charge amount)
    - Loop 2400 SV102 (Line item charge amount)
  - Institutional Encounter:
    - Loop 2300 CLM02 (Total submitted charge amount)
    - Loop 2400 SV203 (Line item charge amount)
  - A value of zero (0) may be reported if:
    - Health plan subcapitated contract arrangement with provider permits zero as a charged amount
    - Service is recognized by MDCH as having no associated charges, for example, vaccines

# Associated Edit Errors

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- **Associated Edit Errors for Submitted Charge Amount**
  - 20558
    - Total submitted charge amount missing **or zero** and health plan provider contract is FFS
  - 20559
    - Total submitted charge amount is missing and health plan provider contract is other than FFS (subcapitated)
  - 20560
    - Line item charge amount is missing **or zero** and health plan provider contract is FFS
  - 20561
    - Line item charge amount is missing and health plan provider contract is other than FFS (subcapitated)

# Approved/Allowed Amount

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- ❁ **Approved/Allowed Amount** – Capitated health plan fee screen or maximum allowable amount for services reported
  - ❁ Professional Encounter:
    - Loop 2400 AMT02 (Approved Amount)
  - ❁ Institutional Encounter:
    - Loop 2320 AMT02 (Allowed Amount)
  - ❁ Not expected to be reported if health plan contract with provider is other than FFS (subcapitated)

# Associated Edit Errors

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## ❁ Associated Edit Errors for Approved/Allowed Amount

### ❁ 20566

- Other Payer Allowed Amount is missing for 837 Institutional encounter and health plan provider contract is FFS

### ❁ 20568

- Service Level Approved Amount is missing for 837 Professional or 837 Dental encounter and health plan provider contract is FFS

# Paid Amount

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- **Paid Amount** – The amount paid to the provider for the service that was billed
  - Reported at the claim and service line level
  - Professional Encounter:
    - Loop 2320 AMT02 (COB Payer Paid Amount)
    - Loop 2430 SVD02 (Service Line Paid Amount)
  - Institutional Encounter:
    - Loop 2320 AMT02 (COB Payer Prior Payment)
    - Loop 2430 SVD02 (Service Line Paid Amount)
  - A value of zero (0) may be reported if:
    - Service was covered under a subcapitated contract arrangement with the provider
    - Service was not covered by the health plan

# Associated Edit Errors

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## ❁ Associated Edit Errors for Paid Amount

### ❁ 20562

- Total paid amount is missing for 837 Professional or 837 Dental encounter

### ❁ 20563

- Service line paid amount is missing for 837 Professional or 837 Dental encounter

### ❁ 20564

- Payer paid amount is missing for 837 Institutional encounter

# Adjustment Amount

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- **Adjustment Amount** – The amount subtracted (or added) from (or to) the amount originally charged by the provider
  - Professional Encounter:
    - Loop 2430 CAS Segment (Claims Adjustment)
  - Institutional Encounter:
    - Loop 2320 CAS Segment (Claims Adjustment)
    - Loop 2430 CAS Segment (Claims Adjustment)
  - Requires reporting a Claim Adjustment Group Code when amount paid differs from amount billed
  - Requires reporting a Claim Adjustment Reason Code when amount paid differs from amount billed
    - [www.wpc-edi.com](http://www.wpc-edi.com)

# Associated Edit Errors

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## ❁ Associated Edit Errors for Adjustment Amount

### ❁ 20574

- Adjustment amount is missing at the claim and service line level and total paid amount does not equal total submitted charges

# 837 Encounter Financial Data

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Questions?