Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC X12N 837I

Institutional Encounter

Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)

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MDHHS

Michigan Department of Health & Human Services

This document is the property of the Michigan Department of Health and Human Services (MDHHS). The information contained in this document is for the use of Trading Partners exchanging electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS). The content of this document may not be altered by external entities. The information in this document is subject to change. The most recent version will be posted on the MDHHS website at: michigan.gov/tradingpartners

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1. Introduction

This document is the property of the Michigan Department of Health and Human Services (MDHHS). The information contained in this document is for the use of Trading Partners exchanging electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS).

This document is intended as a companion to the 005010X223 • 837I Health Care Claim: Institutional Technical Report 3 (TR3) dated May 2006. This document also includes updates appearing in:

Errata 005010X223A1 • 837I Health Care Claim: Institutional dated October 2007
Errata 005010X223E1 • 837I Health Care Claim: Institutional dated January 2009
Errata 005010X223A2 • 837I Health Care Claim: Institutional dated June 2010

The 5010 Implementation Guide and related Errata documents can be purchased from the Washington Publishing Company web site at: https://x12.org/products/technical-reports

Scope

This document is expected to be used in conjunction with the Implementation Guide and related Errata for the 837I transaction set. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

This document provides MDHHS-specific instructions regarding certain elements within the Implementation Guide but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDHHS rules regarding:

- Identifiers to use when a national standard has not been adopted
- Parameters in the Implementation Guide and related Errata that provide options applicable to Michigan Medicaid.

1.2 Overview

This Companion Guide is intended for use in the electronic submission of health care encounter transactions. Please refer to the MDHHS website for the Companion Guide supporting the submission of health care Fee-For-Service claims. Claims and encounters cannot be sent on the same 837 Transaction file.

Refer to the MDHHS Electronic Submission Manual for information regarding:

- Interaction with the MDHHS File Transfer Service (FTS) (formerly known as the DEG)
- Modes of submission (SSL FTP, HTTPS)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

1.3 References

In order to successfully download HIPAA transactions from the CHAMPS system, it is necessary to comply with the information contained in the MDHHS Electronic Submission Manual. The most current version of this manual can be downloaded from the MDHHS web site at the following location:

michigan.gov/tradingpartners >> HIPAA Companion Guides >> Electronic Submissions Manual

The following reference document will help you perform testing of your encounters with MDHHS:

- ICD-10 837 Test Instructions Encounters, available at: michigan.gov/tradingpartners >> HIPAA ICD-10 >> Testing >> Business-to-Business (B2B) Testing >> 2) CHAMPS ICD-10 B2B Testing

This document provides testing instructions for Billing Agents (e.g., Health Plans) who send 837 encounter transactions to MDHHS. This document includes instructions on ICD-10 testing as well as instructions to be used by prospective Billing Agents seeking approval for production encounter submission to MDHHS.

1.4 Transaction Description

The ANSI ASC X12N 837I is used to submit prepaid inpatient health encounter and mental health care encounter information from providers of health care services to payers, including managed care organizations. This transaction can be submitted either directly or via intermediary billing services and/or claims clearinghouses.

1.5 General Information

All alpha characters must be in UPPER CASE.

Claims and Encounters cannot be sent on the same 837 Transaction file. Refer to the MDHHS website for the Companion Guide supporting the submission of health care Fee-For-Service (FFS) claims.

Fee-For-Service Arrangements referred to below indicates a fee-for-service arrangement between the PIHP or CMHSP and their external, contracted providers.

2. Getting Started

2.1 Working with MDHHS

An entity (Provider, Billing Agent, Clearinghouse, etc.) who wishes to submit transactions or retrieve responses, must enroll with MDHHS as a Provider or Billing agent. Please refer to: “HOW TO ENROLL AS A BILLING AGENT” at the location below for enrollment information:

michigan.gov/tradingpartners >> Electronic Submissions Transactions >> How to Enroll

2.2 Certification and Testing Overview

MDHHS provides test systems for our Trading Partners’ use to verify their transactions are properly generated and submitted to MDHHS. Trading Partners may use the test systems to pursue CMS Level II Compliance, to ensure: "an entity covered by HIPAA has completed end-to-end testing with each of its external trading partners and is prepared to move into production mode"[1]
All MDHHS Providers, Health Plans, Clearinghouses, and Billing Agents are required to test their ability to send valid electronic transactions and obtain appropriate results. Please review the following information with your transaction submission and IT teams, ensure HIPAA test transactions are appropriately identified as "Test", and verify you are working in the test environment when submitting claim, encounter, or query transactions. Be aware that the rates included in the ICD-10 B2B Test system may vary from the actual rates used in the production CHAMPS system. MDHHS offers the following two types of testing:

2.2.1 Ramp Manager Testing

Ramp Manager testing validates the format and syntax of EDI transactions and is required for each new Trading Partner; this testing is also available to existing electronic submitters; it is not a pre-requisite for subsequent CHAMPS ICD-10 B2B Testing.

2.2.2 CHAMPS ICD-10 B2B Testing

Providers and Trading Partners may test claims and encounters using the CHAMPS ICD-10 B2B Test environment. Test claim adjudication reports, encounter processing reports and 835 remittance advice transactions are provided to Trading Partners for use in their own review and testing functions.

[1] CMS ICD-10 Implementation Guide

3. Testing with Michigan Medicaid

The MDHHS Electronic Submissions Manual contains an overview of the testing process (see: *Section 1.3 References*).
More information on testing is available at:

michigan.gov/tradingpartners >> HIPAA ICD-10 >> Testing >> Business-to-Business (B2B) Testing

In general, the steps to complete testing are as follows:

- Register as an electronic biller
- Obtain authentication credentials appropriate to the mode of electronic billing
- Send an email to: MDHHSEncounterData@michigan.gov and: MDHHS-B2B-Testing@michigan.gov to request testing enrollment and instructions for using the MDHHS test systems
- Perform the required testing in the MDHHS Test Systems
- Request MDHHS review and approve your test submissions to certify your organization as an electronic submitter, prior to sending production electronic transactions to the MDHHS Medicaid system (CHAMPS)

4. Connectivity with Michigan Medicaid / Communications

4.1 System Availability

The MDHHS CHAMPS system is available 24 hours per day, 7 days a week with the exception of a regular monthly maintenance window, which starts at 6:00 p.m. on the second Saturday of each month and ends at 6:00 a.m. on Sunday. For information on unscheduled outages, please check the Biller “B” Aware page at the following location:

michigan.gov/tradingpartners >> Communications and Training >> Medicaid Alerts >> Biller "B" Aware

4.2 Process Flows

MDHHS supports batch submission for ANSI ASC X12N 837I transactions.

4.3 Transmission Administrative Procedures

4.3.1 Structure Requirements

MDHHS complies with the standards established by the HIPAA Implementation Guides.

4.3.2 Response Times

MDHHS complies with the standards established by the HIPAA Implementation Guides.

4.3.3 Interchange Acknowledgements

Please refer to the MDHHS Electronic Submissions Manual for information regarding:

- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

4.4 Communication Protocols

Please see the Electronic Submissions Manual for additional information on using communication protocols (see *Section 1.3 References*).

5. Contacts

EDI Services	EDI Services handles all issues and questions related to the FTS (formerly known as the DEG) or files exchanged with CHAMPS.
	Website: michigan.gov/tradingpartners
	Email: AutomatedBilling@michigan.gov
Provider Support Unit	The Provider Support Unit handles all billing questions related to the 837 and questions regarding provider and billing agent enrollment.
	Website: michigan.gov/tradingpartners >> Communications and Training >> Health Care Providers >> CHAMPS
	Provider Support Line: 1-800-292-2550
	Email: ProviderSupport@michigan.gov

6. Control Segments / Envelopes

This document uses several text conventions to distinguish MDHHS data elements from the Implementation Guide data elements.

6.1 ANSI ASC X12 837I Institutional Encounter Companion Guide Rules

The following table lists the text conventions used in this document:

Convention used	Explanation
< >	Text included within < > is the “Implementation Name” field from the Implementation Guide document.
“ ”	Text with “ ” around a value represents the value to be submitted. This may be an Implementation Guide value or a specific value required by MDHHS.
( )	The HIPAA Implementation Guide description of the value in quotes, described above, is provided parenthetically.
Light yellow shading	Light yellow shading indicates items changed in this revision of the Companion Guide

6.2 Encounter 837I - Interchange Control Header and Functional Group Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present [No Meaningful Information in I02])
	ISA	ISA02	Authorization Information	10 Spaces

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present [No Meaningful Information in I04])
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID Use the FTS Username ID (formerly known as the DEG ID) left justified, followed by spaces. This value should always match GS02 <Application Sender's Code>
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces. This value should always match GS03 <Application Receiver's Code>
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID. Use the FTS Username ID (formerly known as the DEG ID). This value should always match ISA06 <Interchange Sender ID>
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDHHS. This value should always match ISA08 <Interchange Receiver ID>

6.3 Encounter 837I - Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	**MDHHS accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment - Beginning of Hierarchical Transaction**	
	BHT	BHT03	Reference Identification	<Originator Application Transaction Identifier> MDHHS requires this number to always be unique. This number may not be used again even if the prior batch is rejected.
	BHT	BHT06	Transaction Type Code	<Claim Identifier> "'RP" (Reporting) for Encounters.
1000A			**Loop - Submitter Name**	
1000A	**NM1**		**Segment - Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
1000A	NM1	NM109	Identification Code	<Submitter Identifier>. Use the FTS Username ID (formerly known as the DEG ID). This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>
1000B			**Loop - Receiver Name**	
1000B	**NM1**		**Segment - Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name>. "Michigan Department of Health and Human Services" or "MDHHS".
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDHHS.
2000A			**Loop - Billing Provider Hierarchical Level**	
2000A	**PRV**		**Segment - Billing Provider Specialty Information**	
2000A	PRV	PRV01	Provider Code	"BI" (Billing)
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code>. MDHHS requires taxonomy code to always be submitted to identify the provider specialty.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2000B			**Loop - Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment - Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	Order of payer at this location is based on priority of other payers. See Appendix B.
2000B	SBR	SBR09	Claim Filing Indicator Code	"MC" (Medicaid and Healthy MI) "11" (Other Non-Federal) ~~for State Medical Plan or~~ for persons not enrolled in Medicaid. If recipient qualifies for more than one program, or other MDHHS program not listed, use "MC" (Medicaid). Use SBR09 to indicate Medicaid enrollment, not to indicate the capitated funding source of payment. Value should correspond with 2010BA NM109 - if a Medicaid ID is reported in 2010BA NM109, value of this element is 'MC', else the value is '11'. If have enrollment not listed above, use value found in the standard X12 list.
2010AA			**Loop – Billing Provider Name**	

2010AA	REF		**Segment – Billing Provider Tax Identification**	Use when Billing Provider is other than a hospital. MDHHS requires this segment for all providers. Example: REF*EI*123456789~
2010AA	REF	REF01	**Reference Identification Qualifier**	"EI" Employer's Identification Number "SY" Social Security Number
2010BA			**Loop - Subscriber Name**	
2010BA	**NM1**		**Segment - Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> Medicaid and Healthy MI and MIChild plans use the 10-digit beneficiary ID number assigned by MDHHS. 10-digit beneficiary ID should **always** be reported when know, even if person does not have Medicaid eligibility on the date of service. Use the 11-digit Consumer Unique ID (CONID) assigned to the patient by Mental Health Prepaid Inpatient Health Plans (PIHP) **only** when the person is not enrolled in Medicaid, Healthy MI or MIChild
2010BB			**Loop - Payer Name**	
2010BB	**NM1**		**Segment - Payer Name**	Example: NM1*PR*2*MDHHS*****PI*D00111~
2010BB	NM1	NM103	Payer Name	"MDHHS"
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDHHS.

2000C			**Loop - Patient Hierarchical Level**	**MDHHS business rules require that the patient is always the subscriber. Therefore, MDHHS does not expect health plans to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set.** **Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300			**Loop - Claim information**	**Note that the HIPAA mandated implementation guide allows a maximum of 5000 repetitions of the Loop - 2300 Claim Information within each Loop - 2000B Subscriber Hierarchical Level.** **Transaction sets that do not associate Loop - 2300 Claim Information with Loop - 2000B will be rejected.**
2300	**CLM**		**Segment - Claim information**	
2300	CLM	CLM05-1	Facility Code Value	<Facility Type Code> First 2 digits of Type of Bill.
2300	CLM	CLM05-3	Claim Frequency Type Code	<Claim Frequency Code> "1" on original encounter submissions "7" for encounter replacement "8" for encounter void/cancel For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number), for both the PIHP/CA loop and the CMHSP loop.
2300	**CN1**		**Segment - Contract Information**	
2300	CN1	CN101	Contract Type Code	MDHHS requires this data element on encounters where the health plan contract arrangement with the provider is other than fee-for-service.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2310A			**Loop - Attending Provider Name**	
2310A	**PRV**		**Segment - Attending Provider Specialty Information**	
2310A	PRV	PRV01	Provider Code	"AT" (Attending)
2310A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to identify the provider specialty.
2310C			**Loop - Service Facility Location Name**	
2310C	**REF**		**Service Facility Location Secondary Identification**	
2310C	REF	REF01	Reference Identification Qualifier	"LU" For psychiatric inpatient services: Use the two-digit inpatient hospital type (68 or 73) as well as the CHAMPS-assigned Hospital ID. This hospital ID is required as of 10/1/2022. Example: REF*LU*731556349~
2320			**Loop - Other Subscriber Information**	**MDHHS does require the health plan to report Loop - 2320 Other Subscriber Information. The health plan (Mental Health Prepaid Inpatient Health Plans (PIHP) as well as any Community Mental Health Service Program (CMH) affiliate responsible for the services being reported in the encounter**

				transaction) will be identified as a payer in Loop - 2330B Other Payer Name. The information reported in this iteration of Loop - 2320 is specific to the subscriber's coverage through the health plan.
				Fee-for-Service Arrangements with network providers **For FY23, other payers such as Medicare, commercial carriers, general fund, and other non-managed care are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name.** **See Appendix A below for comprehensive list of funding sources) -** *If applicable*
				Net Cost Contract and Alternative payment arrangements, (case rate, and all other non-fee-for-service). **No additional iterations of this loop are required.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				Valid combinations are: **Health Prepaid Inpatient Health Plans (PIHP)** - *Required (once)* *and/or* **Health Service Program (CMH) -** *If applicable (once)*
2320	**SBR**		**Segment - Other Subscriber Information**	
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	See Appendix B – Payer Priority
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber's group number (assigned by the health plan or the other payer), not the number that uniquely identifies the subscriber.
2320	SBR	SBR09	Claim Filing Indicator Code	See Appendix A for additional values for SBR09.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				If recipient qualifies for more than one program, or other MDHHS program not listed, use “MC” (Medicaid).
2320	**CAS**		**Segment - Claim Level Adjustments**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**
2320	**AMT**		**Segment – Monetary Amount Information**	(*Note: Based on TR3 this loop is optional and used only if payer billed claim-level payment*). **Fee-for-Service Arrangements with network providers** Beginning FY23, the paid amount will be reported in subsequent iterations of the 2320 loop for each payer “paying” for the service **Net Cost Contract and Alternative payment arrangements, (case rate, and all other non-fee-for-service)** The Paid Amount is reported to the CMHSP (PIHP CA for Substance Abuse) 2320 loop.
2330A			**Loop - Other Subscriber Name**	**Loop - 2330A Other Subscriber Name, segment NM1 is required for all encounters. The subscriber information reported is specific/related to the health plan and/or any other additional other payer information submitted on Loop - 2330B Other Payer Name.**
2330A	**NM1**		**Segment - Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).

2330A	NM1	NM109	Identification Code	<Other Insured Identifier> This element is intended to report the unique member number assigned by the health plan or other payer. Community Mental Health Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Service Program (CMH) use the 11-digit Consumer Unique ID (CON ID) assigned by the enrollment broker.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330B			**Loop - Other Payer Name**	**Loop - 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the health plans (Mental Health Prepaid Inpatient Health Plans (PIHP) as well as any Community Mental Health Service Program (CMH) affiliate responsible for the services being reported in the encounter transaction) is required to report themselves as an Other Payer.** **Fee-for-Service Arrangements with network providers** Beginning FY23, subsequent iterations of Loop – 2330B will be required for each payer identified as having financial responsibility for the service. **Net Cost Contract and Alternative payment arrangements, (case rate, and all other non-fee-for-service)** No additional 2330B loops are required.
2330B	**NM1**		**Segment - Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification).
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier>. For health plans use the CHAMPS provider ID assigned by MDHHS. **Fee-for-Service Arrangements with network providers** Refer to Appendix A for complete list of payers and benefit plans

2330B	**REF**		**Segment - Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"'F8" (Original Reference Number)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330B	REF	REF02	Reference Identification	<Payer Claim Control Number> For encounters, MDHHS requires a unique Encounter Reference Number (ERN) to always be submitted. For the health plan, enter the plan assigned unique identifier Encounter Reference Number (ERN) for the encounter. Include the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a replacement or void for both the PIHP/CA loop and the CMHSP loop.
2400			**Loop - Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 999 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV2**		**Segment - Institutional Service Line**	

2400	SV2	SV203	Monetary Amount	<Line Item Charge Amount> MDHHS requires the provider's usual and customary charge or billed amount. Zero (0) is a valid amount if: 1) The health plan has a subcapitated contract arrangement with the provider as designated in Loop - 2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop - 2400

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 2) The service(s) is/are recognized by MDHHS as having no associated charge(s), for example, vaccines.
2430			**Loop - Line Adjudication Information**	**MDHHS requires this loop for each payer identified in Loop - 2320 Other Subscriber Information, except when that payer has adjudicated this claim at the claim level only.**
				Fee-for-Service Arrangements with network providers Beginning FY23, a separate 2430 loop will be reported for each payer paying for the service with the corresponding net charge amount, adjustment(s), and paid amount.
				Net Cost Contract and Alternative payment arrangements, (case rate, and all other non-fee-for-service) The net charge amount, adjustment(s), and paid amount are reported to the CMHSP (PIHP CA for Substance Abuse) Service level 2430 loop.
2430	**SVD**		**Segment - Line Adjudication Information**	

2430	SVD	SVD02	Monetary Amount	<Service Line Paid Amount> MDHHS requires the amount paid to the provider. Zero "0" may be reported if: 1) The service was not covered by the health plan, or 2) the service was covered under a subcapitated contract arrangement.
2430	**CAS**		**Segment - Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

7. Michigan Medicaid Specific Business Rules and Limitations

7.1 Supported Service Types

MDHHS supports the Service Types required by the HIPAA 5010 ANSI ASC X12N 837I Implementation Guide.

8. Trading Partner Agreements

An EDI Trading Partner is defined as any MDHHS partner (Provider, billing service, software vendor, employer group, financial institution, etc.) that transmits directly to, or receives electronic data directly from, MDHHS.

If you are not already submitting electronic transactions to MDHHS, you will need to enroll with MDHHS. Please refer to Section 2.1 for information on enrolling with MDHHS as a provider or billing agent. Enrollment and test certification are required to send or retrieve electronic transactions.

Note: Electronic submitters will need to be associated to their Providers (or to themselves) within CHAMPS to be able to submit and receive transactions on the Provider's behalf.

Appendix A: Funding Source Values for Loops 2320, 2330B, and 2430
Starting FY23: To use for encounters reported for Fee-For-Service arrangements

Funding Source	Value to Report in Loop 2320 SBR09	MDHHS Defined Benefit Identifier 837 Loop 2330B NM109	
		MH and I/DD	SUD
Traditional Medicaid & MIChild	**11**	*Use CMHSP CHAMPS Provider ID*	*Use PIHP SUD CHAMPS Provider ID*
Healthy Michigan Plan	**11**	*Use CMHSP CHAMPS Provider ID*	*Use PIHP SUD CHAMPS Provider ID*
MI Health Link/Medicare (for MIHealth Link encounters that include both ICO Medicare dollars and PIHP Medicaid dollars)	**MA or MB**	D00111-MIHEALTHLINK	D00111-MIHEALTHLINK
Aetna Better Health of Michigan ICO		AETICO	AETICO
AmeriHealth Michigan ICO		AMEICO	AMEICO
HAP Empowered ICO		HAPICO	HAPICO
Meridian Health Plan of Michigan ICO		MERICO	MERICO
MI Complete MI ICO		MICICO	MICICO
Molina Healthcare of Michigan ICO		MOLICO	MOLICO
Upper Peninsula Health Plan ICO		UPPICO	UPPICO
General Fund	**11**	*Use CMHSP CHAMPS Provider ID*	

Appendix A: Funding Source Values for Loops 2320, 2330B, and 2430
Starting FY23: To use for encounters reported for Fee-For-Service arrangements

1st Party - *Not required to report for FY23*		collected at the claim level in the Patient Amount Paid field.	
3rd Party			
Commercial Insurers	**CI**	*Use Payer ID as reported in the CHAMPS Payer ID List* ***Or*** *the original Payer ID used for billing the primary insurance*	*Use Payer ID as reported in the CHAMPS Payer ID List* ***Or*** *the original Payer ID used for billing the primary insurance*
Medicaid Health Plans (for 423 boards)	**MC**		
Aetna Better Health of Michigan		AET	AET
Blue Cross Complete of Michigan		BCC	BCC
HAP Empowered		HAP	HAP
McLaren Health Plan		MCL	MCL
Meridian Health Plan of Michigan, Inc.		MER	MER
Molina Healthcare of Michigan		MOL	MOL
Priority Health Choice		PRI	PRI
UnitedHealthcare Community Plan		UNI	UNI
Upper Peninsula Health Plan		UPP	UPP
Medicare Part A	**MA**	33333333	33333333
Medicare Part B	**MB**	44444444	44444444
Medicare Part C	**MA, MB, or CI**	55555555	55555555

Appendix A: Funding Source Values for Loops 2320, 2330B, and 2430
Starting FY23: To use for encounters reported for Fee-For-Service arrangements

SUD Block Grant	**11**		*Use PIHP SUD CHAMPS Provider ID*
PA2	**11**		*Use PIHP SUD CHAMPS Provider ID*
MH Block Grant	**11**	*Use CMHSP CHAMPS Provider ID*	
CMHSP Local Match, GF 10%	**11**	*Use CMHSP CHAMPS Provider ID*	
Earned Contracts	**11**	*Use CMHSP CHAMPS Provider ID*	*Use PIHP SUD CHAMPS Provider ID*
non-MDHHS Earned Contracts	**11**	*Use CMHSP CHAMPS Provider ID*	*Use PIHP SUD CHAMPS Provider ID*
Local Funds	**11**	*Use CMHSP CHAMPS Provider ID*	*Use PIHP SUD CHAMPS Provider ID*

Appendix B – Payer Priority

Follow the payer priority code rules in the 837 Implementation Guide. For consistency's sake, the recommended order is:

1. Medicare / Commercial Payer(s) (Loop 2320)
2. PIHP / CA (Loop 2320)
3. CMHSP (Loop 2320)
4. MDHHS (Loop 2000B)

Revision Log

Version Date	Effective Date	Revision Description
March 7, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide for the HIPAA 837 Institutional Encounter Addenda Version 4010A1 Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs)* dated June 12, 2009.
November 30, 2011	January 1, 2012	This document includes changes identified as part of business to business testing and reflects the 5010 implementation effective January 1, 2012. Updated location and link for Electronic Submitter's Guide.
January 1, 2016	January 1, 2016	Updated rules for MIChild and other minor rule changes.
June 30, 2022	October 1, 2022	This document includes new requirements for reporting coordination of benefits information for fee-for-service arrangements.