Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC X12N 837P

Professional Medicaid Encounter

Integrated Care Organizations (ICOs)

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MDHHS
Michigan Department of Health & Human Services

MSA
MEDICAL SERVICES ADMINISTRATION

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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 engaging in electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Payment System (CHAMPS).

This document is intended as a companion to the 005010X222 • 837P Health Care Claim: Professional Technical Report 3 (TR3) dated May 2006. This document also includes updates appearing in:

- Errata 005010X222E1 • 837 Health Care Claim: Professional dated January 2009
- Errata 005010X222A1 • 837 Health Care Claim: Professional dated June 2010

The 5010 TR3 and related Errata documents can be purchased from the Washington Publishing Company web site at www.wpc-edi.com.

1.1 Scope

This document is expected to be used in conjunction with the Implementation Guides and related Errata for the 837P 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 TR3 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 ICO encounter claims. 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.

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

- Interaction with the MDHHS File Transfer Service (FTS)
- Modes of submission (SSL FTP or HTTPS)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

1.3 References

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 >> 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

This transaction set is used to exchange health care claim and/or encounter information, or both, 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.

2. Getting Started

2.1 Working with MDHHS

An entity (Provider, billing agent, clearinghouse, etc.) who wishes to 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 information on provider and billing agent enrollment:

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

2.2 Certification and Testing Overview

Michigan Medicaid provides test systems for our Trading Partners’ use to verify their transactions are properly generated and submitted to MDHHS. The Michigan Medicaid provider community 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].

[1] CMS ICD-10 Implementation Guide

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 CHAMPS B2B Test system may vary from the actual rates used in the CHAMPS production 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

2.2.2 CHAMPS B2B Testing

Providers and Trading Partners may test claims and encounters using the CHAMPS B2B Test environment. Test claim adjudication reports, encounter processing reports and ETRRs (instead of 277CA) are provided to State Trading Partners for use in their own review and testing functions.

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 to: 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 except for 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 submissions for ANSI ASC X12N 837P 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 requirements 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 with the FTS 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 >> Doing Business with MDHHS >> Health Care Providers
	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 837P Professional 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 TR3 document.
“ ”	Text with “ ” around a value represents the value to be submitted. This may be a TR3 value or a specific value required by MDHHS.
( )	The description of the HIPAA TR3 value in quotes, described above, is provided parenthetically.
Light yellow shading	Light yellow shading indicates items changed in this revision of the Companion Guide

Encounters where Medicare did not pay on the claim should go into the 5777 Medicaid file. Encounters where Medicare paid more than $0 on the claim should go into the 5776 Medicare file. Please do not split claims; encounters should show both Medicare and Medicaid payments on a single encounter transaction.

6.2 Encounter 837P - 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 ISA02])

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present [No Meaningful Information in ISA04])
	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 left justified, followed by spaces. This value must also appear in the GS02 data element.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces. This value must also appear in the GS03 data element.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID. Use the FTS Username ID This value should always match ISA06 <Interchange Sender ID>.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDHHS. This value should always match ISA08 <Interchange Receiver ID>.

6.3 Encounter 837P - 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 or Encounter Identifier> "RP" (Reporting) for Encounters
1000A			**Loop - Submitter Name**	
1000A	**NM1**		**Segment - Submitter Name**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000A	NM1	NM109	Identification Code	<Submitter Identifier>. Use the FTS Username 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**	
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)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2000B			**Loop - Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment - Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"S" as all ICO beneficiaries are dual eligible
2000B	SBR	SBR09	Claim Filing Indicator Code	"16" Health Maintenance Organization (HMO) Medicare Risk
2010BA			**Loop – Subscriber Name**	
2010BA	**NM1**		**Segment—Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)
2010BA	NM1	NM109	Identification Code	10-digit Medicaid beneficiary ID assigned by MDHHS

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2010BB			**Loop - Payer Name**	
2010BB	**NM1**		**Segment - Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDHHS.
2010BB	**REF**		**Segment – Payer Secondary Identification**	
2010BB	REF	REF01	Billing Provider Secondary Code Qualifier	Report “G2” qualifier when the billing provider is an atypical provider. **Note**: NM103 (Last Name) loop 2010AA is mandatory when an atypical provider is reported.
2010BB	REF	REF02	Billing Provider Secondary Code	Report MMIS Provider ID (9-digit CHAMPS provider ID) when the billing provider is an atypical provider.
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.**
2300			**Loop - Claim Information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 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**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300	**CLM**		**Segment - Claim Information**	
2300	CLM	CLM01	Plan internal claim number	Must be the same as 2330B REF02
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).
2310B			**Loop - Rendering Provider Name**	
2310B	**PRV**		**Segment - Rendering Provider Specialty Information**	
2310B	PRV	PRV01	Provider Code	"PE" (Performing)
2310B	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310B	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
2310B	**REF**		**Segment – Rendering Provider Name**	
2310B	REF	REF01	Rendering Provider Secondary ID Code Qualifier	Report the "G2" qualifier when the rendering provider is an atypical provider.
2310B	REF	REF02	Rendering Provider Secondary ID	Report the MMIS Provider ID (9-digit CHAMPS provider ID) when the rendering provider is an atypical provider.
2320			**Loop - Other Subscriber Information**	**MDHHS does require the health plan to report Loop - 2320 Other Subscriber Information. The health plan 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. Other payers such as Medicare or other commercial carriers 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.**
2320	**SBR**		**Segment - Other Subscriber Information**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	For ICO beneficiaries, there will be at least two iterations of this loop: one with Medicare (generally “P”), one with Medicaid (generally “T”). If the patient has other insurance besides the Medicare and Medicaid benefits, then assign Other Insurance codes “P”, “T”, or “A” as appropriate.
2320	SBR	SBR09	Claim Filing Indicator Code	“MC” (Medicaid ICO) “TV” (Title V) for CSHCS “OF” (Other Federal) for MIChild “MA” or “MB” for Medicare as appropriate (Cannot be applied to the 2330B loop with the CHAMPS-assigned PlanID)
2320	**CAS**		**Segment - Claim Level Adjustments**	**MDHHS requires all COB adjudication to be submitted in the service line level Loop/Segment - 2430 CAS.**
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> 10-digit beneficiary ID number assigned by MDHHS.

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 plan (MHPs, ICO) is required to report themselves as an Other Payer. In the event that there are other payers identified as having financial responsibility for the services being reported, the health plan would report them in subsequent iterations of Loop - 2330B.**
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. For Medicare, use the plan ID assigned by CMS that begins with “H”. For Other payers use the payer ID submitted on the claim.
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. Submit the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a replacement or void. This value must be equal to the value in Loop 2300 CLM01.
2400			**Loop - Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 99 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV1**		**Segment - Professional Service**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2400	SV1	SV102	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 Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or the service(s) is/are recognized by MDHHS as having no associated charge(s), for example, vaccines.
2400	**NTE**		**Segment – Line Note**	
2400	NTE	NTE01	Note Reference Code	"ADD" (Additional information)
2400	NTE	NTE02	Description	Four-digit code identifying personal service.
2420A			**Loop – Line Rendering Provider Name**	
2420A	**PRV**		**Segment – Line Rendering Provider Specialty Information**	
2420A	PRV	PRV01	Provider Code	"PE" (Performing)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2420A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2420A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2420A	**REF**		**Segment – Line Rendering Provider Secondary Identification**	
2420A	REF	REF01	Reference Identification Qualifier	Report the “G2” qualifier when the rendering provider is an atypical provider.
2420A	REF	REF02	Reference Identification	Report the MMIS Provider ID (9-digit CHAMPS provider ID) when the rendering provider is an atypical provider.
2430			**Loop - Line Adjudication Information**	
2430	**CAS**		**Segment - Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**
2430	**SVD**		**Segment – Line Adjudication Information**	
2430	SVD	SVD05	Quantity – Paid Service Unit Count	MDHHS requires paid units be submitted in the SVD05 data element. If a claim line is denied SVD05 should be 0. If a claim line is bundled, billed units should be submitted in SVD05.
2430	SVD	SVD06	Assigned Number	MDHHS requires SVD06 when the service has been bundled. This data element should contain the line number that the service was bundled into.

7. Revision Log

Version Date	Effective Date	Revision Description
January 6, 2015	March 1, 2015	Initial version of Medicaid ICO-specific Professional Companion Guide.
July 23, 2018	June 25, 2018	New file format
May 10, 2024	June 28, 2024	Updated MDHHS requirements as it relates to the SVD05 data element and paid units.
March 12, 2025		Updated guide to reflect where an Atypical Provider ID would be reported if submitted.