

Financial Reporting Requirements with Coordination of Benefits, Phase 2

PRE-PAID INPATIENT HEALTH PLANS

June 5, 2023.

(Revisions from previous 2022 version in blue)

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

Since calendar year 2013, the Michigan Department of Health and Human Services (MDHHS) has required that prepaid inpatient health plans (PIHPs) report paid amount and provider identifiers for services rendered with each 837 encounter submitted for services and supports provided to public behavioral health recipients. In 2022, MDHHS proposed a timeline for the roll-out of reporting information on coordination of benefits (COB) with charge amounts, paid amounts and adjustments for all payers including third party payers and non-managed care fund source. The roll-out was proposed in three stages, the first of which required the PIHPs start reporting COB for fee-for service arrangements at the start of the 2023 fiscal year (Oct. 1, 2022) The second and third stages would occur at the start of fiscal year 2024 and 2025 and would require the PIHPs report COB for direct-run encounters (FY24) and alternative payment mechanisms (FY25.)

Originally, the FY24 proposal required that the PIHPs report payments by each individual fund source used for that service. After consultation with the field the decision was made to delay the requirement that payments be broken out by individual fund sources. It is still expected that for FY24 the PIHPs will report COB payments for direct-run encounters.

Reporting of coordination of benefits supports MDHHS' goals for: 1) aligning requirements with those for Medicaid Health Plans and providing the necessary data for the T-MSIS (Transformed Medical Statistical Information System) as required by CMS; 2) obtaining accurate information about the rates that are paid to providers in order to understand the variation in rates among PIHPs; 3) obtaining accurate information about the providers in order to understand the variation in rates among PIHPs; and 4) the need to use the rate and provider information to move toward a standard price or price ranges for certain high volume and high expenditure services.

PIHPs will continue reporting the cases, units and costs of each procedure code on the Encounter Quality Initiative (EQI) template for periods 1, 2 and 3. It is not expected that the sum of the EQI-reported costs for each procedure code, or the total costs of all procedure codes will equal the sum of the rates paid and reported in the encounter data by procedure or total.

PIHPs should report encounters with monetary amount and provider information according to the requirements in the MDHHS/PIHP contract 3.1 Project Management Reporting section, Encounter Data Reporting: *Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a contractor whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered.*

The following set of instructions was developed with the assistance of a workgroup made up of representatives from PIHPs, in consultation with the State's actuary, Milliman, Inc., and staff at MDHHS's Behavioral and Physical Health and Aging Services Administration (BPHASA).

I. Definition of terms

- a. Adjusted amount: If the paid amount does not equal the charge amount, adjustment amount must be reported as well as reason code. (See specific information about loops in Section V)
- b. Approved amount: amount that was approved by the PIHP (not required by MDHHS)
- c. Atypical provider: Atypical providers are non-health care providers who are not eligible to obtain an NPI, such as adult foster care facilities and taxi companies.
- d. Billing provider: The organization or agency who employs the provider of services. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity.
- e. Case rate: amount paid for a period (e.g., monthly, quarterly) for each beneficiary authorized to receive services (regardless of the amount of services delivered by a provider).
- f. Charge amount: amount charged by the provider. This is a HIPAA-required field for encounters but \$0 can be reported for non-fee-for-service arrangements.
- g. CMHSP-delivered services: CMHSP employees, including individually contracted employees who are paid a wage or salary and who perform work under the control and direction of the CMHSP. (See PIHP-CMHSP Standard Cost Allocation Methodology 'Determination of employee, CMHSP contractual staff, or network provider').
- h. Network provider: any individual provider, group of providers, or entity that has a provider agreement with a PIHP or CMHSP, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with the PIHP or CMHSP.
- i. Cost settled or net cost contract: payer pays provider a set dollar amount periodically (e.g., monthly, quarterly) based on an anticipated cost, then cost settles at the end of the period based on the actual expenditures incurred by a provider in the current financial period.
- j. EIN: Employer Identification Number
- k. SS number: Social Security Number
- l. NPI number: National Provider Identifier. Used by professionals, organizations and corporations that deliver a service.
- m. Fee-for-service: provider is reimbursed based on a submitted claim for a service rendered.
- n. Most current rate: a calculated rate based on previous year's amount paid to the provider, or on predicted amount that will be paid to the provider
- o. Paid amount: Required reporting with each procedure code
 - i. "Paid amount" through a **fee-for-service** payment model, is the actual amount paid for the procedure to the rendering provider through the adjudication process (primary payers have paid and adjustment reductions have occurred). When billing provider is the rendering provider, the amount paid to the billing provider is reported.
 - ii. "Paid amount" through **non-fee-for service** payment models (e.g., case rate, sub-cap, cost-settled or CMHSP-delivered), is based on the most current rate (e.g., calculated from last year's actual rate + inflation or deflation) for the procedure paid to the billing or rendering provider after primary payers have paid and adjustment reductions processed. When the billing provider is the rendering provider, the amount paid to the billing provider is reported.
 - iii. CMHSP service-related administrative costs **should** be included in the Paid Amount reported for direct run services. However, the CMHSP service-related administrative costs should not be included in the amount that the CMHSP paid a contracted provider. While these service-related administrative costs will not be reported in the encounter data, they will be included in the service line amounts that PIHPs report in the EQI. Managed Care administrative costs are not to be included in any Paid Amounts reported in the encounter data.
- p. Provider: the individual, agency, organization or corporation that provided reportable service to a beneficiary or consumer.
- q. Rendering provider: a provider that is the person or entity who rendered the care.
- r. Sub-capitation arrangement: amount paid for a period (e.g., month) for each group (e.g., Medicaid, Healthy Michigan) of eligibles.

II. Scope of encounter reporting

PIHPs are expected to report encounters for services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the contractor. Encounter date is collected and reported for every individual for which a claim was adjudicated, or service rendered during the month by the Contractor (directly or via contract) regardless of payment source or funding stream. (MDHHS/PIH contract 3.1 Project Management Reporting section, Encounter Date Reporting; MDHHS/CMHSP contract C6.5.1.1.) . MDHHS providers additional guidance for CMHSP direct-run services that the scope of encounter reporting includes both encounters for which third party covers 100% of the cost and as well as encounters for which non-MDHHS dollars pay for the service. Currently this guidance does not apply to providers external to the PIHP or CMHSP as MDHHS recognizes that collecting information from external providers when the CMHSP or PIHP as \$0 liability to pay may be unduly burdensome.

III. Expectations for corrections to financial and supporting information.

CMHSP/PIHPs are required to ensure that all encounter data is complete and accurate for purposes of rate calculation (MDHHS/PIHP contract, Health Information Systems 2.b) As guidance, MDHHS recommends that PIHPs give special attention to the accuracy and completeness of the following elements that are necessary for the EQI/encounter reconciliation and rate setting process.

Client	Service	Provider ID	Funding
PIHP Person ID Medicaid ID Gender DOB Claim-level Diagnosis codes	DOS Adjudication Date Procedure code Revenue code Modifiers reported on EQI Service Code Set Units Charge Amount	Billing Rendering Service Facility	CMHSP Paid Amount COB Paid amount Adjustments

IV. Identifying the “Billing and Rendering Providers”

In the chart below are the various types of services provided in the public behavioral health and intellectual/developmental disabilities services system. Since the current system has many ways that it provides and pays for services, this chart is a guide for determining who is the “billing” provider and “rendering” provider. PIHPs will identify in the 837 transaction the billing or rendering provider with the provider’s NPI number along with the provider’s EIN or social security number (SSN). If the provider is “atypical” delivering non-healthcare services, only the Billing Provider’s EIN or social security number will be reported.

Note #1: When billing provider and rendering provider are the same, billing provider is reported and rendering provider is null.

Note #2: “Professional” referenced below means a provider whose scope of practice and licensure requires an NPI for third-party reimbursement.

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Professional clinician(e.g., physician, MH therapy, OT, PT, RN)	CMHSP delivered service. Professional employed by or contracted with CMHSP & paid a salary.	CMHSP	Professional
	Network provider. CMHSP contracts with an organization that employs or contracts with the professional.	Organization	Professional
	Network provider. CMHSP contracts directly with individual professional who bills for the service provided.	Professional	
Non-professional (e.g., CLS, personal care, skill building, respite, supported employment, peer)	CMHSP delivered service. CMHSP employees provide the service	CMHSP	
	Network provider. CMHSP contracts with an individual who bills for the service	Individual	
	Network provider. CMHSP contracts with an organization or corporation that employs workers who deliver the service	Organization or corporation	
	Network provider. CMHSP contracts with a sole proprietor that employs workers who deliver the service	Sole proprietor	
	Network provider. CMHSP contracts with an organization or corporation (#1) that subcontracts with another organization, corporation (#2), that subcontracts with another organization or corporation or sole proprietor (#3)	Organization, corporation #1	Organization, corporation or sole proprietor #3

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Self-directed services (e.g., community living supports, and skill building delivered by aide-level workers, independent supports coordination and psychiatry delivered by professionals)	Employer of record in which the beneficiary (or guardian on behalf of) hires and pays worker through a fiscal intermediary.	Fiscal intermediary	
	Purchase of service in which the CMHSP pays a fiscal intermediary who pays an organization who employs the worker	Fiscal intermediary	Organization
	Agency with choice in which the CMHSP pays the agency that employs the workers who the beneficiary chooses	The agency	
Team-based services (e.g., ACT, home-based, wraparound)	CMHSP or provider staff perform service individually or as a team	Refer to Professional above	
Treatment Planning	CMHSP or provider professional staff participate in the planning and report separately	Refer to Professional above	Refer to Professional above
Behavior Treatment Plan Review Committee	CMHSP or provider professional staff participate on the committee but only one event is reported	Refer to Professional above	Refer to Professional above
Adaptive equipment and enhanced pharmacy item	CMHSP or a provider purchases from a vendor	CMHSP or the provider	

Service Type	Service Delivery Type	Billing Provider	Rendering Provider
Housing assistance and goods and services	CMHSP reports a monthly total that may include multiple items from multiple vendors	CMHSP or the provider	
Respite care or CLS provided in a day or overnight camp	CMHSP or a provider pays camp	CMHSP or a provider	
Institutional services delivered in a hospital	CMHSP contracts with and pays hospital	Hospital	
Transportation Services are delivered by provider staff, or by local taxis, ambulance, or transit authorities	CMHSP or provider pays taxi, ambulance, or transit authority	CMHSP or provider	

v. Financial Loops – Professional

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

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

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

Example 1 – Fee for Service:

Loop **Claim**
2300: CLM*A37YH556*100***11:B:1*Y*A*Y*I*P~
2320: AMT*D*80~
2320: CAS*PR*1*5~
2330B: NM1*PR*2*Payer Name*****PI*11122333~

Notes

Total Claim Charge Amount - CLM02
Total Payment Amount - AMT02
Claim Adjustment Amount - CAS03; Patient Responsibility – CAS01
Payer ID – NM109 - Must match 2430 SVD01

Line 1
2400: SV1*HC:H2016:25*80*UN*1*11***1:2:3***N~
2430: SVD*11122333*70*HC:H2016***3~
2430: CAS*OA*93*10~
2430: DTP*573*D8*20130203~

Line Item Charge Amount - SV102
Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109
Line Adjustment Amount - CAS03, Other Adjustment – CAS01
Remittance Date

Line 2
2400: SV1*HC:T1020:25*20*UN*1*11***1:2:3***N~
2430: SVD*11122333*15*HC:T1020***2~
2430: CAS*OA*93*5~
2430: DTP*573*D8*20130203~

Line Item Charge Amount SV102
Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109
Line Adjustment Amount - CAS03, Other Adjustment – CAS01
Remittance Date

Calculations:

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

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

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

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

Notes:

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

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

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

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

Example 2 – Capitated Arrangement:

Loop Claim
 2300: CLM*A37YH556*0**11:B:1*Y*A*Y*I*P~
 2320: AMT*D*150~
 2320: CAS*PR*1*5~
 2330B: NM1*PR*2*Payer Name*****PI*11122333~

Line 1
 2400: SV1*HC:H2016:25*0*UN*1*11**1:2:3**N~
 2430: SVD*11122333*70*HC:H2016**3~
 2430: CAS*CO*24*-70~
 2430: DTP*573*D8*20130203~

Line 2
 2400: SV1*HC:T1020:25*0*UN*1*11**1:2:3**N~
 2430: SVD*11122333*85*HC:T1020**2~
 2430: CAS*CO*24*-85~

2430: DTP*573*D8*20130203~

Calculations:

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

0 = 0 + 0

Claim Payment Amount = (Line 1 Payment + Line 2 Payment) – Claim Adjustment

150 = (70 + 85) - 5

Line Item 1 Charge Amount = (Line 1 Payment) + (Line 1 Adjustments)

0 = 70 + (-70)

Line Item 2 Charge Amount = (Line 2 Payment) + (Line 2 Adjustments)

0 = 85 + (-85)

Notes

Total Claim Charge Amount - CLM02

Total Payment Amount - AMT02

Claim Adjustment Amount - CAS03; Patient Responsibility – CAS01

Payer ID – NM109 - Must match 2430 SVD01

Line Item Charge Amount - SV102

Service Line Paid Amount - SVD02; Payer ID – SVD01 Must match 2330B NM109

Line Adjustment Amount - CAS03, Contractual Obligation – CAS01

Remittance Date

Line Item Charge Amount SV102

Service Line Paid Amount SVD02; Payer ID – SVD01 Must match 2330B NM109

Line Adjustment Amount - CAS03, Contractual Obligation – CAS01

Claim Adjustment Group Code – CO: Contractual Obligation;

Claim Adjustment Reason Code – 24: Charges are covered under a capitation agreement/managed care plan.

Remittance Date

Example 3 - Fee for Service with Coordination of Benefits

1. MEDICARE – Primary (00105-MB)
2. CHAMPVA – Secondary (00052)
3. SWMBH PIHP – Tertiary (2813562)
4. Branch CMHSP – A (1181825)
5. MDHHS – B (D00111)

Loop 2000B: Subscriber Hierarchical Level - MDHHS – B (D00111)

HL*2*1*22*0~

SBR*B*18*****11~

Loop 2010BA: Subscriber Name

NM1*IL*1*CASH*JOHNNY*A***MI*04000124999~

N3*123 Elm St~

N4*COLDWATER*MI*99999~

DMG*D8*19400101*M~

Loop 2010BB: Payer Name

NM1*PR*2*MDHHS*****PI*D00111~ (MDHHS)

N3*123 Elm St~

N4*COLDWATER*MI*99999~

Loop 2300: Claim Information

CLM*CLM-ALPHA01*122***11:B:7*Y*A*Y*I*P~

HI*ABK:F331*ABF:F411*ABF:F4310~

Loop 2310B: Rendering Provider Name

NM1*82*2*PROVIDER, LAURA*****XX*1174839999~

PRV*PE*PXC*101Y00000X~

Loop 2320: Other Subscriber Information – MEDICARE Part A – Primary (33333333)

SBR*P*18*****MB~

AMT*D*73.24~

OJ***Y***I~

Loop 2330A: Other Subscriber Name

NM1*IL*1*CASH*JOHNNY*****MI*999999999A~

Loop 2330B: Other Payer Name

NM1*PR*2*MEDICARE*****PI*33333333~

REF*F8*CLM-ALPHA01~

Loop 2320: Other Subscriber Information

SBR*S*18***47***CI~

AMT*D*18.68~

OJ***Y***I~

Loop 2330A: Other Subscriber Name

NM1*IL*1*CASH*JOHNNY*****MI*999999999~

Loop 2330B: Other Payer Name

NM1*PR*2*CHAMPVA*****PI*14697005~

REF*F8*CLM-ALPHA01~

Loop 2320: Other Subscriber Information - SWMBH PIHP – Tertiary (2813562)

SBR*T*18*****11~

AMT*D*0.0~

OI***Y***I~

Loop 2330A: Other Subscriber Name

NM1*IL*1*CASH*JOHNNY****MI*04000124999~

Loop 2330B: Other Payer Name

NM1*PR*2*SWMBH*****PI*2813562~

DTP*573*D8*20151217~

REF*F8*CLM-ALPHA01~

Loop 2320: Other Subscriber Information - Branch CMHSP – A (1181825)

SBR*A*18*****11~

AMT*D*30.8~

OI***Y***I~

Loop 2330A: Other Subscriber Name

NM1*IL*1*CASH*JOHNNY****MI*04000124999~

Loop 2330B: Other Payer Name

NM1*PR*2*PINES BEHAVIORAL HEALTH SERVICES*****PI*1181825~

DTP*573*D8*20151217~

REF*F8*CLM-ALPHA01~

Loop 2400: Service Line Number

LX*1~

SV1*HC:H0032*122*UN*1***1:2:3~

DTP*472*D8*20151214~

REF*6R*SVC-ALPHA01~

Loop 2430: Line Adjudication Information - MEDICARE – Primary (33333333)

SVD*33333333*73.24*HC:H0032**1~

CAS*PR*2*48.76~

DTP*573*D8*20160209~

Loop 2430: Line Adjudication Information - CHAMPVA

SVD*14697005*18.68*HC:H0032**1~

CAS*PR*2*30.08~

DTP*573*D8*20160310~

Loop 2430: Line Adjudication Information – Branch CMHSP – B (1181825)

SVD*1181825*30.08*HC:H0032**1~

DTP*573*D8*20160210~

Example 4 – Direct-run service with Coordination of Benefits:**Loop 2300: Claim Information**

CLM*M0XXXXXXXXXX*68.86***11:B:1*Y*A*Y*Y*P~
HI*ABK:FXXX*ABF:FXXX~

Loop 2310B: Rendering Provider Name

NM1*82*1*XXXXX*XXXXX****XX*1XXXXXXXXXX~

Loop 2320: Other Subscriber Information

SBR*P*18*****MB~

AMT*D*46.15~

OI***Y*P**Y~

Loop 2330A: Other Subscriber Name

NM1*IL*1*XXXXXXXXXXXXXXXXXXXX*MI*XXXXXXXXXXXX~
N3*XXXXX XXXXX~
N4*XXXXXXXXXXXX*MI*4XXXX~

Loop 2330B: Other Payer Name

NM1*PR*2*MEDICARE PART B OF MICHIGAN*****PI*44444444~
REF*F8*M0XXXXXXXXXX~

Loop 2320: Other Subscriber Information – Macomb CMHSP

SBR*S*18*****11~

AMT*D*22.71~

OI***Y*P**Y~

Loop 2330A: Other Subscriber Name

NM1*IL*1*XXXXXXXXXXXXX*MI*000000000~

Loop 2330B: Other Payer Name

NM1*PR*2*MACOMB COUNTY CMH*****PI*339XXX5~
REF*F8*M0XXXXXXXXXX~

Loop 2400: Service Line Number

LX*1~
SV1*HC:99212:AF*68.86*UN*1***1:2~
DTP*472*D8*20221110~
REF*6R*M0XXXXXXXXXX~

Loop 2430: Line Adjudication Information - Medicare

SVD*44444444*46.15*HC:99212:AF**1~
CAS*CO*253*.94*1*45*10*1~
CAS*PR*2*11.77*1~
DTP*573*D8*20221207~

Loop 2430: Line Adjudication Information – Macomb CMHSP

SVD*339XXX5*22.71*HC:99212:AF**1~
CAS*OA*23*46.15~

Provider's Charge Amount- 68.86

Medicare Part B is Primary Payer

\$ Primary Payer Paid Provider-46.15

Macomb CMHSP is secondary payer \$22.71 Macomb CMH Paid Provider

payment from Medicare B (Matches what is in Loop 2320)-46.15

sequestration-reduction in federal payment .94

Coinsurance amount-11.77

Macomb CMH Paid to the Provider-22.71

OA 23 reflecting the primary payer payment-46.15

Provider Reporting Loops:

2010AA — BILLING PROVIDER NAME

NM1 - BILLING PROVIDER NAME

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

85 - Billing Provider

1 – Person or 2 - Non-Person Entity

Name - Last or Organization Name

**XX - Centers for Medicare and Medicaid Services National Provider Identifier
Identification Code - NPI**

REF - BILLING PROVIDER TAX IDENTIFICATION

REF*EI*123456789~

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

2310B — RENDERING PROVIDER NAME – Claim Level

NM1 - RENDERING PROVIDER NAME

NM1*82*1*DOE*JANE*C*XX*1234567804~**

82 - Rendering Provider

1 – Person or 2 - Non-Person Entity

Name - Last or Organization Name

XX - Centers for Medicare and Medicaid Services National Provider Identifier

Identification Code - NPI

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

REF*G2*12345~

G2 - Employer ID Number (EIN)

REFERENCE IDENTIFIER

2420A — RENDERING PROVIDER NAME – Line Level

NM1 - RENDERING PROVIDER NAME

Situational Rule: Required when the Rendering Provider NM1 information is different than that carried in the Loop ID-2310B Rendering Provider.

OR

Required when Loop ID-2310B Rendering Provider is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop ID-2010AA Billing Provider.

NM1*82*1*DOE*JANE*C*XX*1234567804~**

82 - Rendering Provider

1 – Person or 2 - Non-Person Entity

Name - Last or Organization Name

XX - Centers for Medicare and Medicaid Services National Provider Identifier

Identification Code - NPI

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

REF*G2*12345~

G2 - Employer ID Number (EIN)

2310C Loop- Service Facility Location Name- Claim Level

NM1*77 segment – Service Location

NM1*77*2*ABC Home ***XX*1234567890~**

77- Service Location

2- Non-Person Entity

ABC Home – Organization Name

XX – Centers for Medicare and Medicaid Services National Provider Identifier [is in next data element]

1234567890 – Identification Code – NPI (if applicable)

REF

REF-Service Facility Location Secondary Identification

REF*0B* AS55554444~

0B – State License Number AS555544444 – for specialized residential facilities.

0B – State License Number 0080015 – for Substance Use Disorder Facilities.

LU- Hospital type identifier for inpatient services.

In instances in which the facility is not the billing provider, the name, address, NPI (if applicable) will be reported in the Facility Location (2310C loop).