MARYLAND
Department of Health

MARYLAND DEPARTMENT OF HEALTH

MEDICAL CARE PROGRAM

COMPANION GUIDE FOR
837 HEALTH CARE CLAIM INSTITUTIONAL ENCOUNTERS
VERSION 005010X223A2

January 01, 2020

Version 2.5

Version Control

Version Number	Date	Details
1.0	February 14, 2011	005010 Version Update
2.1	November 01, 2011	NDC Paid Amount and Date mappings
2.2	May 01, 2017	Provider Paid Amount and Date mappings
2.3	December 03, 2018	CN1 Segment and Provider Paid Amount details
2.4	May 01, 2019	REF Segment for Provider Location in Provider loops Corrected Provider Paid Amounts and Date Paid Examples
2.5	August 01, 2019	Added NonPar mappings Release as Live effective date: 01/01/2020

Health Care Claim Institutional Encounter - 837

Introduction:

This Companion Guide contains a subset of the data content established for the Health Care Claim Transaction Set (837). This transaction can be used to submit health care claim / encounter billing information from providers of health care services to Maryland Medicaid, either directly or through an intermediary (i.e., clearinghouses, etc.).

This Companion Guide governs electronic billing of institutional services on an ASC X12 837- Institutional (005010X223A2) transaction. Please refer to Maryland Medicaid Billing Instructions for specific services to be billed using this transaction.

This guide is not to be used as a substitution for the 837 Health Care Claim Implementation Guide. The objective of this document is to clarify what information is needed by a Maryland Medicaid Trading Partner where multiple values exist and/or specific values are needed.

All alpha characters must be in upper case. Data must be in ASCII format. Leading zeros for data elements such as Provider Number, Recipient ID, must not be suppressed. These data fields should be handled as alphanumeric. Transactions not complying with ASC X12N formatting or data compliance will be rejected prior to adjudication. An ASC X12N 997 or 999 transaction set will be used to convey the rejection and may include an associated reason. The Trading Partner will have the choice of receiving either a 997 or 999 Functional Acknowledgment transaction.

Always use the 2000B Subscriber Loop (Subscriber Hierarchical Level), since for Maryland Medicaid, the Patient is always the Subscriber.

Please note that the maximum number of service lines per claim is 50. Encounters containing up to and including 50 line items will be adjudicated. Encounters containing more than 50 line items will be accepted but denied before adjudication.

HI Segment Mapping Clarification

The following provides clarification for mapping HI segments where the occurrence is 2 (or more). In instances where the HI segment occurs 2 (or more) times, it is required that all Data Elements (DEs) of the first occurrence of the HI will be used. In most cases, this provides up to 12 DEs to use to convey the appropriate information for that HI instance. For example:

Correct Mapping: `HI*BH:42:D8:20041123*BH:25:D8:20020719`

Incorrect Mapping: `HI*BH:42:D8:20041123`
`HI*BH:25:D8:20020719`

MDH will only map DEs within the first HI segment and requests that any needed information to adjudicate a claim is made available in the first HI segment instance.

Provider Paid Amounts and Date Paid
Effective January 1, 2018, MDH is required to capture Provider paid amounts and date paid from all MDH MCOs. Below is explanation of the mappings and scenarios for the MCO to follow when conveying this information in the 837.

The 2430 Line Adjudication loop will be used to send the amount paid to the provider by the MCO and the date paid. See specific segments and data elements below. In addition, to convey zero dollar amounts where the MCO cannot send a paid amount for the following conditions:

1) Denied Claim
2) Sub-capitated Arrangement
3) Service Line Billed Amount = 0

The MCO will use the following Segments and data elements for each scenario.

Denied Claim

a. CN1 Segment will be used to identify sub-capitated arrangement when CN101 = 09
   Example: CN1*09~
   i. When CN101 = 09, Provider Paid Amount data in the 2430 SVD segment must not be sent. If Provider Paid Amount > 0, encounter to be set to deny.

Sub-capitated Arrangement

b. CN1 Segment will be used to identify encounters submitted by the MCO where the claim was denied by the MCO from the provider when CN101 = 05
   Example: CN1*05~
   i. When CN101 = 05, Provider Paid Amount data in the 2430 SVD segment must not be sent. If Paid amount > 0, encounter to be set to deny.

Service Line Billed Amount = 0

c. The Service Line Billed Amount = $0 and the SVD Provider Paid Amount = $0
   i. CN1 segment should not be sent
   ii. SVD Date Paid segment must be sent.

Transmission Considerations
Trading Partners are requested to follow the 837 Implementation Guide recommendations to limit the number of CLMs within a transaction (ST-SE envelope) to 5,000. (See section 1.3.2 of the 837 Institutional Implementation Guides) In cases where the Trading Partner needs to transmit several 5000 CLM files, MDH recommends uploading the files one at a time in five minute intervals to avoid file submission problems.

Trading partners are requested to use unique Group Control Numbers (GS06) for all interchanges submitted to MDH. This provides ease of tracking for the Trading Partner for reconciliation, easy identification for MDH support staff for troubleshooting, identifying Functional Acknowledgements and verifying results.

This Companion Guide can be found on the State of Maryland's Department of Health Web site at:
https://health.maryland.gov/HIPAA/Pages/transandcodesets.aspx

Maryland Medicaid Companion Guide - 837 Institutional Encounter

LEGEND:
SHADED rows represent "segments" in the X12N implementation guide
NON-SHADED rows represent "data elements" in the X12N implementation guide

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3			**Interchange Control Header**			
C.4		ISA01	Authorization Information Qualifier	00		
C.4		ISA03	Security Information Qualifier	00		
C.4		ISA05	Interchange ID Qualifier			Agreed upon during trading partner set-up
C.4		ISA06	Interchange Sender ID			Agreed upon during trading partner set-up
C.5		ISA07	Interchange ID Qualifier	ZZ		
C.5		ISA08	Interchange Receiver ID			526002033MCPP - Production 526002033MCPT - Test
C.6		ISA14	Acknowledgment Requested	0		No TA1 returned. Note: A 997 or a 999 will be returned.
C.6		ISA15	Usage Indicator			T for Test Data P for Production Data
C.7			**Functional Group Header**			
C.7		GS02	Application Sender's Code			Agreed upon during trading partner set-up
C.7		GS03	Applications Receiver's Code			MMISENC
C.8		GS08	Version/Release/Industry Identifier Code			005010X223A2

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71	**1000A**		**Submitter Name**			
72		NM109	Submitter Primary Identifier			Same as GS02
76	**1000B**		**Receiver Name**			
77		NM103	Receiver Name			Maryland Medical Care Program
77		NM109	Receiver Primary Identifier			526002033MCP
84	**2010AA**		**Billing Provider Name**			
86		NM108	Identification Code Qualifier	XX	2	
86		NM109	Identification Code		10	National Provider ID
112	**2010BA**		**Subscriber Name**			
113		NM108	Identification Code Qualifier	MI	2	
114		NM109	Subscriber Primary Identifier		11	Patient's Maryland Medical Assistance Number
122	**2010BB**		**Payer Name**			
123		NM103	Payer Name			MCO Organization Name
123		NM108	Payer Qualifier	PI	2	
123		NM109	Payer Identifier			Maryland Medicaid assigned MCO Identifier
125	**2010BB**	**NM4**	**Payer City, State, Zip Code**			
125		NM401	Payer City			Baltimore
125		NM402	Payer State	MD	2	
126		NM403	Payer Zip Code			21201
129	**2010BB**	**REF**	**Billing Provider Secondary Identification**			**This optional segment may be sent to include the 2010AA Pay-to Provider's 9-digit location MA Provider number**
129		REF01	Reference Identification Qualifier	LU	2	Location Number
130		REF02	Reference Identification		9	2010AA Pay-to Provider's 9-digit location MA Provider number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
131	**2000C**		**Patient Hierarchical Level**			**This loop will not be supported by Maryland Medicaid since the subscriber is always the patient**
144	**2300**		**Claim Information**			
158	2300	CN1	Contract Information			Used to identify a Denied Claim between the MCO and the Provider or a sub-capitated agreement between the MCO and Provider.
158		CN101	Contract Type Code	05 09	2	05 – Sub-capitated 09 – Denied
161	2300	REF	Service Authorization Exception Code			Used for submitting NonPar indicator for Billing/Pay-to NPI
161		REF01	Reference Identification qualifier	4N	2	Qualifier for NonPar indicator
161		REF02	Payer Claim Control Number	7	1	Set to 7 to designate NonPar Billing/Pay-to NPI to use legacy crosswalk
166	2300	REF	Payer Claim Control Number			Used for submitting Void and Replace Encounters
166		REF01	Reference Identification qualifier	F8	2	Qualifier for ICN to Credit
166		REF02	Payer Claim Control Number		17	ICN to Credit
170	2300	REF	Claim Identifier For Transmission Intermediaries			
170		REF01	Reference Identification qualifier	D9	2	Use when sending additional account number
171		REF02	Claim Number		30	Use for additional account number (Patient Account Number)
324	2310A	REF	Attending Provider Secondary Identification			This optional segment may be sent to include the Attending Provider's 9-digit location MA Provider number
324		REF01	Reference Identification Qualifier	LU	2	Location Number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
325		REF02	Reference Identification		9	Attending Provider's 9-digit location MA Provider number
329	2310B	REF	Operating Physician Secondary Identification			This optional segment may be sent to include the Operating Physician's 9-digit location MA Provider number
329		REF01	Reference Identification Qualifier	LU	2	Location Number
330		REF02	Reference Identification		9	Operating Physician's 9-digit location MA Provider number
347	2310E	REF	Service Facility Location Secondary Identification			This optional segment may be sent to include the Service Facility Location's 9-digit location MA Provider number
347		REF01	Reference Identification Qualifier	LU	2	Location Number
348		REF02	Reference Identification		9	Service Facility Location's 9-digit location MA Provider number
349	2310F	REF	Referring Provider Secondary Identification			This optional segment may be sent to include the Referring Provider's 9-digit location MA Provider number
349		REF01	Reference Identification Qualifier	G2	2	Location Number
350		REF02	Reference Identification		9	Referring Provider's 9-digit location MA Provider number
449	**2410**		**Drug Identification**			**This loop will be used to convey NDC information: NDC, Qty, UOM, price paid by the MCO.**
449	2410	LIN	Drug Identification			
451		LIN02	Product/Service ID Qualifier	N4	2	Use when sending NDC
451		LIN03	National Drug Code		11	NDC value
452	2410	CTP	Drug Quantity			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
452		CTP04	Quantity		10	Quantity amount of drug used. Precision of 3 decimal positions. (i.e. 1234567.123)
453		CTP05	NDC UOM Code	F2 GR ME ML UN	2	NDC UOM codes (see IG for values)
454	2410	REF	Prescription Or Compound Drug Association Number			Used only for identifying compound drug ingredients in multiple service lines within the claim.
454		REF01	Reference Identification qualifier	VY	2	Code qualifier for link sequence number
455		REF02	Link Sequence Number		50	Use for additional account number (Patient Account Number)
459	2420A	REF	Operating Physician Secondary Identification			This optional segment may be sent to include the Operating Physician's 9-digit location MA Provider number
459		REF01	Reference Identification Qualifier	LU	2	Location Number
460		REF02	Reference Identification		9	Operating Physician's 9-digit location MA Provider number
474	2420D	REF	Referring Provider Secondary Identification			This optional segment may be sent to include the Referring Provider's 9-digit location MA Provider number
474		REF01	Reference Identification Qualifier	G2	2	Location Number
475		REF02	Reference Identification		9	Referring Provider's 9-digit location MA Provider number
476	**2430**		**Line Adjudication Information**			**This loop will be used to convey the paid amount to the provider by the MCO and date paid.**
476	2430	SVD	Service Line Adjudication Information			
476		SVD01	Identification Code			SVD01 data element must = 2010BB data element NM109

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
477		SVD02	Service Line Paid Amount		9	Total amount paid to the provider by the MCO for the associated service line. **For a compound drug**, send the total NDC amount paid for the compound in all NDC service lines that make up the compound.
486	2430	DTP	Drug Quantity			
486		DTP01	Date Time Qualifier	573	3	Date Claim Paid
486		DTP03	Adjudication Date		8	The date the claim was adjudicated by the MCO for payment to the provider for the associated service line. . Format CCYYMMDD