

Home Care (Non-PCA) Services

Revised: [February 1, 2024](#)

Review [MHCP Billing Policy](#) for general billing requirements and guidance when submitting claims.

Refer to the [billing](#) chart in the Home Care Services section of the Minnesota Health Care Programs (MHCP) Provider Manual for revenue codes.

Log in to MN-ITS

1. [Log in](#) to MN-ITS
2. From the left menu options:
 - Select **MN-ITS**
 - Select Submit DDE Claims (837)
 - Select Institutional (837I)

Submitting an 837I Outpatient Claim

To submit an 837I Outpatient claim, follow the instructions in the tables in this user manual for each of the following claim screens:

[Billing Provider](#)

[Subscriber](#)

[Claim Information](#)

[Coordination of Benefits \(COB\)](#)

[Services](#)

Billing Provider

The billing provider screen auto-populates with the information in the enrollment profile for the NPI or UMPI used to log in to MN-ITS. Go to [Changes to Enrollment](#) to notify MHCP Provider Eligibility and Compliance if changes are needed.

Refer to the following table for instructions and information about each field on this screen.

Field Name * (X12 Loop and element)	Field Instruction
Organization (Loop: 2010AA, NM103 (last or organization) NM104 (first))	The name of the Billing Provider: This could be an organization, business or the name of an individual provider identified by the NPI used to log in to MN-ITS.
Taxonomy (Loop: 2000A, PRV03)	This field only displays information when a Health care provider specialty/location code has been added to the provider file. If multiple taxonomy codes have been added, additional information will display. Select the radio button to identify appropriate location for this claim.
Address 1 (Loop: 2010AA, N301)	The first address line reported on the provider file.
Address 2 (Loop: 2010AA, N302)	The second address line reported on the provider file.
City (Loop: 2010AA, N401)	The city name for the address in address fields 1 and 2.
State (Loop: 2010AA, N402)	The state name for the address in address fields 1 and 2.
Zip	The ZIP Code for the address in address fields 1 and 2.

<i>(Loop: 2010AA, N403)</i>	
Telephone <i>(Loop: 2010AA, PER04)</i>	Telephone number reported on the provider file.
Select Location	When using a consolidated NPI, a table will display showing the locations and taxonomy codes information on file with MHCP. Select the radio button next to the location where the services were provided.
Screen Action Button	Select one of the following: Continue to proceed to the next screen Cancel to cancel the claim entry

Subscriber

Use the Subscriber screen to report the member who received the services reported on this claim. The following fields auto-populate based on the information entered in the Subscriber ID and Birth Date fields.

Refer to the following table for instructions and information about each field on this screen.

Field Name* <i>(X12 loop and element)</i>	Field Instruction
Subscriber ID <i>(Loop: 2010BA, NM109)</i>	Enter the 8-digit MHCP ID for the subscriber (member) indicated on the MHCP member identification card.
Birth Date <i>(Loop: 2010BA, DMG02)</i>	Enter the birth date of the subscriber. Select Search to have MN-ITS find and display the subscriber associated with the subscriber ID and date of birth entered.
The following fields auto-populate based on the information entered in the Subscriber ID and Birth Date fields:	
Subscriber First Name <i>(Loop: 2010BA, NM104)</i>	The first name of the subscriber
Middle Initial <i>(Loop: 2010BA, NM105)</i>	The middle initial of the subscriber
Last Name <i>(Loop: 2010BA, NM103)</i>	The last name of the subscriber
Gender <i>(Loop: 2010BA, DMG03)</i>	The gender of the subscriber Select Delete to remove the subscriber information if incorrect.
Screen Action Button	Select one of the following: Continue to proceed to the next screen Back to go back to the previous screen Cancel to cancel the claim entry

Claim Information

Use the Claim Information screens to report claim level information that will identify the type of claim and details about the services. Information entered on the claim information screen will apply to all lines of the claim.

Refer to the following table for instructions and information about each field on this screen.

Field Name* <i>(X12 Loop and element)</i>	Field Instruction
---	--------------------------

<p>TOB (Loop: 2300, CLM05)</p>	<p>Enter the appropriate Type of Bill (TOB). The TOB is a 3-digit code which defines the type of facility, bill classification, and frequency. The most appropriate coding manual is the NUBC UB-04 (optional resource, subscription required).</p> <p>Home care claims use the 32X and 34X series. Critical Access hospitals must use the 34X TOB.</p> <p>Numeric values for frequency (third digit) are as follows:</p> <ul style="list-style-type: none"> • xx2 - first claim in a series of continuous claims or interim billing. When submitting the first claim, the admission date field must be the same as the statement date • xx3 - continuous claim or interim billing • xx4 - the last claim or discharge claim • xx7 - a replacement claim • xx8 - void
<p>Payer Claim Control Number (Loop: 2300, REF02)</p>	<p>Use only when replacing or voiding a claim (TOB xx7 or xx8) Enter the 17-digit Payer Claim Control Number (PCN) to identify the previously paid claim to be replaced or void.</p> <p>The PCN field will display when the TOB frequency code 7 (Replacement), or 8 (Void), is entered.</p> <p>The payer claim number will display if the claim has been retrieved from a submit response, or the request status feature.</p>
<p>Statement Date (From) (Loop: 2300, DTP03)</p>	<p>Enter the service start date or first date of services that will be entered on this claim.</p>
<p>Statement Date (To) (Loop: 2300, DTP03)</p>	<p>Enter the service end date or last date of services that will be entered on this claim.</p>
<p>Patient Control Number (Loop: 2300, CLM01)</p>	<p>Enter a unique identifier assigned by you, to help identify the claim for this member. The patient control number will be reported on your remittance advice.</p>
<p>Assignment/Plan Participation (Loop: 2300, CLM07)</p>	<p>This is the code indicating whether the provider accepts payment from MHCP.</p> <p>Select the correct response if different than the default.</p> <p>Default is Assigned</p>
<p>Benefits Assignment (Loop: 2300, CLM08)</p>	<p>This is the determination of the policy holder or person authorized to act on their behalf, to give MHCP permission to pay the provider directly.</p> <p>Select the correct response if different than the default.</p> <p>Default is Yes.</p>
<p>Release of Information (Loop: 2300, CLM09)</p>	<p>This is the determination of whether the provider has a signed statement by the member on file, authorizing the release of medical data to other organizations.</p> <p>Select the correct response if different than the default.</p>

	Default is Yes.
Admission Type (Loop: 2300, CL101)	Select the appropriate response from the drop-down menu options, to identify the priority of the admission or visit. (3 - Elective is the most appropriate choice for home care visits)
Admission Source (Loop: 2300, CL102)	Select the appropriate source code from the drop-down menu options, indicating the point of location or origin for this admission or visit. (Enter "1" for new or current patients)
Patient Status (Loop: 2300, CL103)	Select the appropriate code from the drop-down menu options indicating the disposition or discharge status of the member on the date entered in the statement Date (To) field. The most appropriate coding manual is the NUBC UB-04 (optional resource, subscription required).
Diagnosis Type Code (Loop: 2300, HI01-1)	Select from the drop-down menu whether the diagnosis code reported on this claim is in the ICD-9 or ICD-10 classification.
Principal Diagnosis Code (Loop: 2300, HI01-2)	Enter the highest level of ICD or other industry accepted codes that best describe the condition or reason the member needed the services.
Situational Claim Information - Select the situational claim information accordion screen to report situational information when required.	
Prior Authorization Number (Loop: 2300, REF02)	Enter the service authorization (SA) number when appropriate. An authorization number is required when an authorization is already in the system for the member. An authorization number is not required if there is no authorization in the system and the service is a skilled nurse visit. (The first nine skilled nurse visits in a calendar year do not require an authorization unless the member has a current waiver SA.)
Attachment Control Number (Loop: 2400, PWK06)	Use only when submitting a claim with attachment. Enter the Code or number assigned by the provider, identifying an attachment for this claim. Review the Electronic Claim Attachments webpage for MHCP Attachment Criteria and additional information.
Attachment Type (Loop: 2400, PWK01)	Use only when submitting a claim with an attachment. Select the code indicating the type ID and description of the attachment from the drop-down menu options. Select Add to add the attachment Control Number and Type ID to the entire claim. Select Delete to delete the entry.
Situational (Continued) Claim Information	
Occurrence Code (Loop: 2300, HI02-2-HI12)	Use only when you have determined the other payer (Medicare/TPL/Other insurance) will not cover the service, even with an authorization. Determine this based on the other payers' process for determining if a service can be covered. You must have documentation in your files to support the determination. Enter the Occurrence Code defining a significant event relating to this claim. Home care uses the following for each payer: <ul style="list-style-type: none"> • 24 - Third party liability/other insurance • 25 - Medicare
Date (Loop: 2300, HI01-4)	Enter the date associated with the Occurrence Code. (This must be the date the determination was made with the other payer.) Select Add to add the Occurrence Code and Date. Select Delete to delete the entry.

Other Providers (Claim Level) – Select the Other Providers accordion screen when required to report other provider information	
Attending Provider	
NPI/UMPI (Loop: 2310A, NM101)	Enter the NPI or UMPI of the provider who is attending the service: <ul style="list-style-type: none"> • Select Add to add the Attending Provider NPI • Select the radio button to add the Attending Provider to the claim Select Delete to delete.
Screen Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Back to go back to the previous screen • Cancel to cancel the claim entry • Continue to proceed to the next screen

Coordination of Benefits (COB)

Use only if reporting payments or denials by another payer source. Use the COB screen to report other payers, private insurance (TPL) or Medicare’s financial responsibility for all or a portion of the claim. If no other payers are involved with this claim, select the action button at the bottom of this screen to proceed to the next screen and skip to the [Services](#) section of this user guide.

Use the following tables to report each type of other payer information at the header (claim) level:

[Medicare Part B/HMO Medicare Risk](#)

[Third Party Liability \(TPL\)/Other insurance \(non-Medicare\)](#)

Medicare Part B and HMO Medicare Risk

Complete the following fields to report adjustment, payments and denials from Medicare or an HMO Medicare Risk plan.

Field Name* (X12 Loop and element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Enter the name of the Medicare or Medicare Advantage Plan.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter the NPI listed on the Explanation of Medicare Benefits (EOMB) used to submit the claim to Medicare.
Claim Filing Indicator (Loop: 2320, SBR09)	Select the code from the drop-down menu options identifying the type of insurance. Additional fields will display for reporting Medicare information after the claim filing indicator is selected.
Payer Responsibility (Loop: 2320, SBR01)	Select the code from the drop-down menu options identifying the payer’s level of responsibility for payment of a claim.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder’s identification number as assigned by the payer. For Medicare, this would be the Medicare health insurance claim number (HICN) or the Medicare beneficiary identifier (MBI) number.
Relationship Code (Loop: 2320, SBR02)	Select the relationship of the MHCP subscriber (member) to the policy holder from the drop-down menu options.
Other Payers Claim Control Number (Loop: 2330B, REF02)	Enter the claim number reported on the Medicare EOMB.

Benefits Assignment (Loop: 2320, O103)	The determination of the policy holder or person authorized to act on their behalf, to give the other payer permission to pay the provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information (Loop: 2320, O106)	The determination of whether the provider has a signed statement by the member authorizing the release of medical data to other organizations on file. Default is Yes. Select the correct response if different than the default.
Outpatient Adjudication Information (MOA)	
Remark Code (Loop: 2320, MOA03-MOA07)	Enter the Medicare remark codes from the Medicare EOMB. Select Add to add the code to the claim.
Section Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Add to add additional prior payer on this claim • Save to save the entered Medicare information • Delete to remove Medicare information from the claim level
Screen Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Continue to proceed to the next screen • Back to return to the previous screen • Cancel to cancel the entire claim entry

TPL/Private Insurance

Complete the following fields to report adjustment, payments and denials from the private insurance (Non-Medicare) carrier.

If reporting MB-Medicare Part B or 16-Health Maintenance Organization, HMO Medicare Risk insurance uses the instructions in the [Medicare/HMO Medicare Risk](#) section of this user manual.

Field Name* (X12 Loop and element)	Field Instruction
Other Payer Name (Loop: 2330B, NM103)	Enter the name of the TPL insurance payer. Do not use symbols such as slashes, dashes, periods or plus signs.
Other Payer Primary ID (Loop: 2330B, NM109)	Enter the identifier of the insurance carrier. (This is available on the member's eligibility response.) Do not use symbols such as slashes, dashes, periods or plus signs.
Claim Filing Indicator (Loop: 2320, SBR09)	Select the code identifying type of insurance from the drop-down menu options. Additional fields will display for reporting TPL or private insurance after the claim filing indicator is selected.
Payer Responsibility (Loop: 2320, SBR01)	Select the code identifying the insurance carrier's level of responsibility for payment from the drop-down menu options.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the payer.
Relationship Code (Loop: 2320, SBR02)	Select the relationship of the MHCP subscriber (member) to the policy holder from the drop-down menu options. Complete the remaining Claim Level Adjustments if reporting adjustments at the claim (header) level for TPL.

	If reporting adjustment at the line level, select the Save action button in this section and then scroll to down to the Other Insurance Information section of this screen.
Claim Adjustment Group Code (Loop: 2320, CAS01)	For header (claim) level adjustment, select the code identifying the general category of the payment adjustment for this line from the drop-down menu options.
Adj Reason Code (Loop: 2320, CAS03)	Enter the code identifying the reason the adjustment was made.
Adj Amount (Loop: 2320, CAS03)	Enter the total adjusted dollar amount for this line.
Payer Paid Amount (Loop: 2320, AMT02)	Enter the prior payer paid amount when reporting TPL adjustments at the claim (header level).
Non-Covered Charge Amount (Loop: 2320, AMT02)	When reporting TPL at the claim (header level), enter the noncovered charge amount.
Benefits Assignment (Loop: 2320, O103)	Other Insurance Information: The determination of the policy holder or person authorized to act on their behalf, to give the other payer permission to pay the provider directly. Default is Yes. Select the correct response if different than the default.
Release of Information (Loop: 2320, O106)	The determination of whether the provider has a signed statement by the member on file, authorizing the release of medical data to other organizations. Default is Yes. Select the correct response if different than the default.
Section Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Save to include this TPL/private insurance information on the claim • Delete to remove this payer from the claim level • Add to add additional prior payer on this claim
Screen Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Continue to proceed to the next screen • Back to return to the previous screen • Cancel to cancel the entire claim entry

Services

Use the Services screen to describe details for each service being billed. Information reported on a service line will override information reported at the header (claim) level for that line.

Refer to the following table for instructions and information about each field on this screen.

Field Name* (X12 Loop and element)	Field Instruction
Date of Service (From) (Loop: 2400, DTP03)	Enter the date the item or service was provided, dispensed or delivered to the member. Dates must be within the statement dates entered in the Claim Information Screen. (Date of Service (To) does not need to be entered and will later auto-populate to match the Date of Service (From) for each line of service.)

Revenue Code (Loop: 2400, SV201)	Enter the appropriate revenue code used to specify the service line item detail for a health care institution. Use the codes in the table under billing in the Home Care Services section of the MHCP Provider Manual to determine the revenue code used for MHCP home care services.
Line Item Charge Amount (Loop: 2400, SV102)	Enter the total charge for the service.
Unit Code (Loop: 2400, SV204)	Enter the units or manner in which a measurement has been taken.
Service Unit Count (Loop: 2400, SV104)	Enter the quantity of units, time, days, visits, services or treatments for the service.
Procedure Code (Loop: 2400, SV101-2)	Enter the HCPCS code identifying the product or service. This code must match the HCPCS code entered on your service authorization (SA).
Procedure Code Modifier(s) (Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)	Use only when a modifier is listed on the service authorization (SA) or when a claim for private duty nursing shared services. Enter the modifier that clarifies or further identifies the service indicated in the procedure code field.
Other Payer – Use this accordion screen when reporting COB at the line level for either Medicare Part B or TPL.	
Other Payer Primary Identifier (Loop: 2430, SVD01)	Select the identifier of other payer entered on the COB screen from the drop-down menu options.
Service Line Paid Amount (Loop: 2430, SVD02)	Enter the total dollar amount the other payer paid for this service line.
Adjudication - Payment Date (Loop: 2430, DTP03)	Enter the date of payment or denial determination by the Medicare payer for this service line. This field is not required for TPL or private insurance reporting.
Paid Unit Count (Loop: 2430, SVD05)	Enter the number of units identified as being paid from the other payer's EOB or EOMB.
Claim Adjustment Group Code (Loop: 2430, CAS01)	Enter the code identifying the general category of the payment adjustment for this line.
Adjustment Reason Code (Loop: 2430, CAS02)	Enter the code identifying the reason the adjustment was made.
Adjustment Amount (Loop: 2430, CAS03)	Enter the total dollar amount of the specific adjustment for the reason code entered on this service line.
Other Providers - Select the Other Providers accordion panel when required to report other provider information on the service line, if different than what was reported at the claim level.	
Referring Provider	
NPI/UMPI (Loop: 2420D, NM109)	If different than the provider reported on the claim information screen: <ul style="list-style-type: none"> • Enter the NPI of the provider who provided the service • Select the Add action button in this section to add the other provider information • Select the radio button to add the other provider to the claim
Section Action Buttons	Select one of the following: <ul style="list-style-type: none"> • Add to add the specific adjustment to this line • Save after all adjustment entries for the specific line has

	<ul style="list-style-type: none"> • been added • Delete (next to the save button) to cancel all the line item adjustment entries for this line <p>Repeat the Other Payer COB Line Adjustment Entries to report all adjustments for this line as noted on the EOB/EOMB.</p> <p>Report adjustments to additional lines when entering service information for that other line.</p>
Screen Action Button	<p>Select one of the following screen action buttons:</p> <ul style="list-style-type: none"> • Save/View Line(s) to save and view all entered lines in the service line table • Edit to return and edit a particular line • Copy to save and copy the entire line information (including other payer information) to an additional service line • Delete to delete the the entire service line information (including other payer information) • Add to add a new blank service line <p>Note: You must always select Save/View Lines(s) after entering all lines to see the Validate and Submit action buttons.</p>
Claim Action Button	<p>Select Validate to determine if the claim has met the HIPAA-compliant and certain basic requirements at both the claim and line level information.</p> <p>Use the X12 External Codes Lists to identify the claim status category and claim status odes displayed on the validate and submit claim response.</p>
Claim Action Button	<p>Select Submit to identify if the claim will be paid, denied, or suspended for review at the claim and service line level of the claim.</p> <p>Use the X12 External Codes Lists to identify the claim status category and claim status codes displayed on the validate and submit claim response.</p>

Copy, Replace or Void the Claim

The Copy, Replace, or Void action buttons will appear at the bottom of the claim response screen after submitting the claim and receiving a claim response. Use each of these features to do the following:

Copy – Copy this exact claim. You may want to do this if you have to resubmit your claim with corrections.

Replace – If the claim paid incorrectly (including zero pay) and you want to resubmit to replace the previously paid claim. The original paid claim will be taken back and replaced with the new claim submission.

Void – If the claim was submitted in error. This deletes the claim and takes the payment back.

Review the [Copy, Replace or Void](#) user guide for step-by-step instructions when completing these transactions.