

Outpatient Substance Use Disorder (SUD) Services

Revised: [January 29, 2024](#)

Review [MHCP Billing Policy](#) for general billing requirements and the [Substance Use Disorder \(SUD\) Services](#) section in the MHCP Provider Manual when submitting SUD service claims.

Log in to MN-ITS

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

Submit an 837I Outpatient SUD claim

To submit an 837I outpatient SUD claim, follow the instructions in the following tables 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. Use the [Change of Enrollment Information](#) 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 (Loop: 2010AA, N403)	The ZIP Code for the address in address fields 1 and 2.

Telephone (Loop: 2010AA, PER04)	Telephone number reported on the provider file.
Select Locations	When using a consolidated NPI, a table will display showing the locations and taxonomy codes information on file with MHCP. Select the <i>radio button</i> next to the location where the services were provided.
Screen Action Button	Select: <ul style="list-style-type: none"> • Cancel to cancel the claim entry • Continue to proceed to the next screen

Subscriber

Use the Subscriber (member) screen to report the member who received the services reported on this claim.

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

Field Name* (X12 Loop and element)	Field Instruction
Subscriber ID (Loop: 2010BA, NM109)	Enter the 8-digit MHCP ID for the subscriber (member) indicated on the MHCP member identification card.
Birth Date (Loop: 2010BA, DMG02)	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 (Loop: 2010BA, NM104)	The first name of the subscriber.
Middle Initial (Loop: 2010BA, NM105)	The middle initial of the subscriber.
Last Name (Loop: 2010BA, NM103)	The last name of the subscriber.
Gender (Loop: 2010BA, DMG03)	The gender of the subscriber. Select Delete to remove the subscriber information if incorrect.
Screen Action Button	Select: <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

Claim Information

Use the Claim Information screens to report claim (header) 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* (X12 Loop and element)	Field Instruction
TOB (Loop: 2300, CLM05)	Enter Type of Bill 89X or 13X.

Payer Claim Control Number <i>(Loop: 2300, REF02)</i>	<p>The Payer Claim Control Number (PCN) field will display when the TOB frequency code 7 (Replacement), or 8 (Void), is entered.</p> <p>Enter the 17-digit PCN to identify the previously paid claim to be replaced or voided.</p> <p>If the claim has been retrieved from a submit response, or the request status feature, the payer claim number will display.</p>
Statement Date (From) <i>(Loop: 2300, DTP03)</i>	<p>Enter the service start date.</p>
Statement Date (To) <i>(Loop: 2300, DTP03)</i>	<p>Enter the service end date.</p>
Patient Control Number <i>(Loop: 2300, CLM01)</i>	<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>
Assignment/Plan Participation <i>(Loop: 2300, CLM07)</i>	<p>Code indicating whether the provider accepts payment from MHCP.</p> <p>Default is Assigned</p> <p>Select the correct response if different than the default.</p>
Benefits Assignment <i>(Loop: 2300, CLM08)</i>	<p>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>Default is Yes</p> <p>Select the correct response if different than the default.</p>
Release of Information <i>(Loop: 2300, CLM09)</i>	<p>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>Default is Yes</p> <p>Select the correct response if different than the default.</p>
Admission Type <i>(Loop: 2300, CL101)</i>	<p>Select the appropriate response from the drop-down menu to identify the admission or visit.</p>
Admission Source <i>(Loop: 2300, CL102)</i>	<p>Select the appropriate admission source from the drop-down menu options.</p>
Patient Status <i>(Loop: 2300, CL103)</i>	<p>Select the appropriate patient status from the drop-down menu options.</p>
Diagnosis Type Code <i>(Loop: 2300, HI01-1)</i>	<p>From the drop-down menu, select whether the diagnosis code reported on this claim is in the ICD-10 classification.</p>
Principal Diagnosis Code <i>(Loop: 2300, HI01-2)</i>	<p>Enter the highest level of ICD or other industry-accepted codes that best describe the condition or reason the member needed the services.</p>
Other Diagnosis Code <i>(Loop: 2300, HI01-2)</i>	<p>Enter the ICD or other industry-accepted codes that best describe the additional condition or reason the member needed the services and select Add. Repeat this process to add all other diagnosis codes.</p> <p>To delete the entered codes, select Delete.</p>
Situational Claim Information - Select the situational claim information accordion screen to report situational information when required.	

Prior Authorization Number (Loop: 2300, REF02)	Enter the approved authorization number when appropriate.
Attachment Control Number (Loop: 2400, PWK06)	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)	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. To delete entry, select Delete .
Situational (Continued) Claim Information	
Other Providers (Claim Level) – Select the Other Providers accordion screen when required to report other provider information.	
Patient Responsibility Amt (Loop: 2300, AMT02)	Enter the amount determined to be the member's responsibility for payment.
Rendering Provider	
NPI/UMPI (Loop: 2310B, NM109)	If different than the Attending Provider: <ul style="list-style-type: none"> • Enter the NPI of the Rendering Provider who provided the service • Select Add to add the Rendering Provider NPI • Select the <i>radio button</i> to add the Rendering Provider to the claim • To delete, select Delete
Pay-To Provider	
NPI/UMPI (Loop: 2010AB, NM109)	If different than the Billing Provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who should be paid for the item or service • Select Add to add the other Pay-to Provider NPI • Select the <i>radio button</i> to add the Pay-to Provider to the claim • To delete, select Delete
Referring Provider	
NPI/UMPI (Loop: 2310A, NM109)	If different than the Attending Provider: <ul style="list-style-type: none"> • Enter the NPI of the provider who referred the member for the item or service • Select Add to add the Referring Provider NPI • Select the <i>radio button</i> to add the Referring Provider to the claim • To delete, select Delete
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 <i>radio button</i> to add the Attending Provider to the claim • To delete, select Delete <p>OR</p> <p>If NPI entered is Consolidated:</p> <ul style="list-style-type: none"> • Select Add to add the Attending Provider NPI • Select the location for the Attending Provider

	<ul style="list-style-type: none"> Select the <i>radio button</i> to add the Attending Provider to the claim To delete, select Delete
Operating Provider	
NPI/UMPI (Loop: 2330D, REF02)	Enter the NPI or UMPI of the provider who did the operating for the service: <ul style="list-style-type: none"> Select Add to add the Operating Provider NPI Select the <i>radio button</i> to add the Operating Provider to the claim To delete, select Delete
Service Facility Location	
NPI/UMPI (Loop: 2310E, NM101)	If different than the Billing Provider: <ul style="list-style-type: none"> Enter the NPI of the provider where the services were actually provided Select Add to add the Service Facility Location NPI Select the <i>radio button</i> to add Service Facility Location to the claim To delete, select Delete
Screen Action Buttons	Select: <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 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, click the continue button at the bottom of this screen to proceed to the next screen and skip to the [Services](#) section of this user guide.

You must verify other payers' policy to determine the type of policy the member has when reporting other payers, third party liability (TPL) or Medicare. This supplemental guide [MN-ITS Interactive Field Completion Guide \(PDF\)](#) is to help you determine if the other payers' policy EOB adjustments should be entered at the COB Tab claim (header) level, or the Services Tab (line) level.

Medicare B/HMO Medicare Risk and TPL/Other insurance (non-Medicare) for outpatient claims should be reported on the claim (service/line) level for appropriate claim processing.

Use the following tables to report each type of other payer information at the claim (header) 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 adjustments, payments and denials from Medicare Part B 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 Part B or HMO Medicare Risk Do not use symbols such as slashes, dashes, periods or plus signs.
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	Select the code identifying the type of insurance from the drop-down

(Loop: 2320, SBR09)	menu options. After the claim filing indicator is selected, additional fields will display for reporting Medicare information.
Payer Responsibility (Loop: 2320, SBR01)	Select the code identifying the payer's level of responsibility for payment of a claim from the drop-down menu options.
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)	From the drop-down menu options, select the relationship of the MHCP subscriber (member) to the policy holder.
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: <ul style="list-style-type: none"> • Delete to remove the Medicare's information from the claim level • Save to save the entered Medicare information • Add to add additional prior payer on this claim
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to return to the previous screen • Cancel to the entire claim entry • Continue to proceed to the next screen

TPL and 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 above.

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)	From the drop-down menu options, select the code identifying type of insurance. After the claim filing indicator is selected, additional fields will display for reporting TPL or private insurance.
Payer Responsibility (Loop: 2320, SBR01)	From the drop-down menu options, select the code identifying the insurance carrier's level of responsibility for payment.
Insured ID (Loop: 2330A, NM109)	Enter the policy holder's identification number as assigned by the payer.
Relationship Code (Loop: 2320, SBR02)	From the drop-down menu options, select the relationship of the MHCP subscriber (member) to the policy holder. If reporting adjustments at the claim (header) level for TPL, complete the remaining Claim Level Adjustments. 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 claim (header) 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 other payer adjusted the payment. Refer to the other payer EOB. Refer to the other payer EOB.
Adj Amount (Loop: 2320, CAS03)	Enter the total adjusted dollar amount for this line.
Payer Paid Amount (Loop: 2320, AMT02)	When reporting TPL adjustments at the claim (header level), enter the prior payer paid amount.
Non-Covered Charge Amount (Loop: 2320, AMT02)	When reporting TPL at the claim (header level), enter the non-covered 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: <ul style="list-style-type: none"> • Delete to remove this payer from the claim level • Save to include this TPL/private insurance information on the claim • Add to add additional prior payer on this claim
Screen Action Buttons	Select: <ul style="list-style-type: none"> • Back to return to the previous screen • Cancel to cancel the entire claim entry • Continue to proceed to the next screen

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 claim (header) 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.
Date of Service (To) (Loop: 2400, DTP03 * RD8* required in DTP02 when TO date is reported)	Enter the last date of a consecutive date range, the service was provided only when required.
Revenue Code (Loop: 2400, SV201)	Enter the appropriate revenue code used to specify the service line item detail for a health care institution. Refer to the Revenue & Procedure Codes table of the Substance Use Dis section of the MHCP Provider Manual for appropriate codes.
Line Item Charge Amount (Loop: 2400, SV102)	Enter your usual and customary charge for this 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 CPT or HCPCS code identifying the product or service.
Procedure Code Modifier(s) (Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)	Enter the modifier that clarifies or further identifies the service indicated in the procedure code field.
NDC (Loop: 2410, LIN03)	When appropriate, enter the National Drug Code (NDC) required when government regulation mandates that prescribed drugs and biologics are reported with NDC numbers. Drugs and biologics reported in this segment are a further specification of services described in the SV1 segment of this Service Line Loop ID-2400.
NDC Count (Loop: 2410, CPT04)	Enter the National Drug Unit Count – A numeric value used to specify pricing information.
CODE Qualifier (Loop: 2410, CTP05-1)	Enter the code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. When no other payer information is required for this line, skip to the Screen Action Button section.
Other Payer – Use this accordion screen when reporting other payers (Medicare Part B and/or TPL) payments or denials for the line item or service.	
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 <i>(Loop: 2430, DTP03)</i>	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 <i>(Loop: 2430, SVD05)</i>	Enter the number of units identified as being paid from the other payer's EOB/EOMB.
Claim Adjustment Group Code <i>(Loop: 2430, CAS01)</i>	Enter the code identifying the general category of the payment adjustment for this line.
Adjustment Reason Code <i>(Loop: 2430, CAS02)</i>	Enter the code identifying the reason the adjustment was made.
Adjustment Amount <i>(Loop: 2430, CAS03)</i>	Enter the total dollar amount of the specific adjustment for the reason code entered on this service line.
Adjustment Quantity <i>(Loop: 2430, CAS04)</i>	Use this field to enter the number of units not paid when the units paid are different than the number of units submitted on the claim sent to the other payer.
Section Action Buttons	Select: <ul style="list-style-type: none"> • Add to add the specific adjustment to this line • Save after all adjustment entries for the specific line have been added • Delete (next to the save button) to cancel all the line item adjustment entries for this line Repeat the Other Payer COB Line Adjustment Entries to report all adjustments for this line as noted on the EOB /EOMB.
Screen Action Button	Select: <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 entire service line information (including other payer information) • Add to add a new blank service line
Claim Action Button	Select: <ul style="list-style-type: none"> • Save/View Lines(s) after all service lines have been entered • Validate to determine if the claim has met the HIPAA-compliant and certain basic requirements at both the claim and line level information • Submit to identify if the claim will be paid, denied, or suspended for review at the claim and service line level of the claim Use the X12 health care codes lists to identify the claim status category and claim status codes displayed on the validate and submit claim response.

Other Providers

<p>Referring Provider (Loop: 2420D, NM109)</p>	<p>Any provider listed here will override at header level:</p> <ul style="list-style-type: none"> • From the Other Providers accordion, select Referring Provider • Enter NPI of the provider who is not already reported at claim level as the Attending Provider or the Referring provider. <p>When reporting the NPI, use the member for the service associated with that line:</p> <ul style="list-style-type: none"> • Select the Add action button in this section to add the provider information • Select the radio button to add the provider to the claim
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Copy, Replace or Void (take back) the Claim

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

Copy – To correct an error of this denied claim or to copy information from this previously submitted claim.

Replace – To replace the previously paid claim if the claim paid, but paid incorrectly (including zero pay). The user may access the claim, correct the information and resubmit. The original paid claim will be taken back and replaced with the new claim submission.

Void (take back) – If the claim was submitted in error. This reverses the claim and takes the payment back.

Review the [Copy, Replace, Void \(take back\), or Reverse a Claim](#) User Guide for step-by-step instructions when completing these transactions.