

**MICHIGAN DEPARTMENT OF  
COMMUNITY HEALTH**

**COMPANION GUIDE  
FOR THE HIPAA  
837 DENTAL CLAIM ADDENDA  
VERSION 4010A1**

**October 1, 2007**

**Effective for Claims Submitted On or After  
October 1, 2007**

*Michigan Department  
of Community Health*



***MSA***

**MEDICAL  
SERVICES  
ADMINISTRATION**



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This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim Addenda, ASC X12N 837 (004010X097A1)**, dated October 2002 and the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental Claim, ASC X12N 837 (004010X097)**, dated May 2000. This document should be used in conjunction with all MDCH claim submission and claim processing guidelines. The document follows guidelines authorized in the Final Rule by the Department of Health and Human Services on September 17, 2001. The clarifications described herein include:

- Identifiers to use when a national standard has not been adopted [and]
- Parameters in the implementation guide that provide options

(The Addenda implementation guide can be found at [http://www.wpc-edi.com/hipaa/hipaa\\_40.asp](http://www.wpc-edi.com/hipaa/hipaa_40.asp). HHS guidance on data clarifications can be found at <http://aspe.os.dhhs.gov/admsimp/q0321.htm>).



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Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	<b>ISA</b>		<b>INTERCHANGE CONTROL HEADER</b>	
	ISA	<b>ISA01</b>	Authorization Information Qualifier	Please use '00'.
	ISA	<b>ISA02</b>	Authorization Information	Please use 10 spaces.
	ISA	<b>ISA03</b>	Security Information Qualifier	Please use '00'.
	ISA	<b>ISA04</b>	Security Information	Please use 10 spaces.
	ISA	<b>ISA05</b>	Interchange ID Qualifier	Please use 'ZZ'.
	ISA	<b>ISA06</b>	Interchange Sender ID	Please use the 4-character Billing Agent ID, followed by spaces.
	ISA	<b>ISA07</b>	Interchange ID Qualifier	Please use 'ZZ'.
	ISA	<b>ISA08</b>	Interchange Receiver ID	Please use "D00111" followed by spaces.
	ISA	<b>ISA09</b>	Interchange Date	Please use Interchange Date in YYMMDD format.
	ISA	<b>ISA10</b>	Interchange Time	Please use Interchange Time in HHMM format.
	ISA	<b>ISA11</b>	Interchange Control Standards Identifier	Please use "U"
	ISA	<b>ISA12</b>	Interchange Control Version Number	Please use "00401"
	ISA	<b>ISA13</b>	Interchange Control Number	MDCH will transmit identical interchange control numbers in ISA13 and IEA02 for a single interchange envelope.
	ISA	<b>ISA14</b>	Acknowledgment Requested	Please use "0"
	ISA	<b>ISA15</b>	Usage Indicator	Please use 'T' when submitting a Test file. Please use 'P' when submitting a Production file.
	ISA	<b>ISA16</b>	Component Element Separator	<:>
	<b>GS</b>		<b>FUNCTIONAL GROUP HEADER</b>	
	GS	<b>GS01</b>	Functional Identifier Code	HC



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	GS	<b>GS02</b>	Application Sender's Code	Please use the 4-character Billing Agent ID provided during the enrollment process.
	GS	<b>GS04</b>	Date	Please use the functional group creation date, in CCYYMMDD format.
	GS	<b>GS05</b>	Time	Please use the functional group creation time, in HHMM format.
	GS	<b>GS06</b>	Group Control Number	MDCH will transmit identical data interchange control numbers in GS06 and GE02 for a single functional group.
	GS	<b>GS07</b>	Responsible Agency Code	"X" (Accredited Standards Committee X12)
	GS	<b>GS08</b>	Version / Release / Industry Identifier Code	004010X097A1
	<b>ST</b>		<b>Transaction Set Header</b>	MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE), as recommended by the HIPAA-mandated implementation guide. Submission with greater than 5,000 CLM segments in a single transaction (ST-SE) will be rejected.
	ST	<b>ST01</b>	Transaction set identifier code	837
	<b>BHT</b>		<b>Beginning of Hierarchical Transaction</b>	
	BHT	<b>BHT06</b>	Transaction Type Code	Please use 'CH' for Fee for Service claims (ECC, adjustments, or reversal).
	<b>REF</b>		<b>Transmission Type Identification</b>	
	REF	<b>REF01</b>	Reference Identification Qualifier	87
	REF	<b>REF02</b>	Reference Identification	When this draft is used to send the transaction set in a production mode, this value is '004010X097A1'.
<b>1000A</b>	<b>NM1</b>		<b>Submitter Name</b>	
1000A	NM1	<b>NM109</b>	Identification Code	Use the 4-character Billing Agent ID assigned by MDCH. This value should match GS02 (Application Sender's Code).
<b>1000B</b>	<b>NM1</b>		<b>Receiver Name</b>	-



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1000B	NM1	<b>NM109</b>	Identification Code	Use "D00111" for MDCH.
<b>2000A</b>	<b>HL</b>		<b>Billing/Pay-To Provider Hierarchical Level</b>	
2000A	HL	<b>HL01</b>	Hierarchical ID Number	HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
<b>2010AA</b>	<b>NM1</b>		<b>Billing Provider Name</b>	
2010AA	NM1	<b>NM108</b>	Identification code qualifier	Use "XX" for the Billing Provider NPI. This ID is mandatory.
2010AA	NM1	<b>NM109</b>	Identification code	Enter the NPI.
<b>2010AA</b>	<b>REF</b>		<b>Billing Provider Secondary Info Identification Number</b>	
2010AA	REF	<b>REF01</b>	Reference Identification Qualifier	Providers must submit "EI" (Employer's Identification Number) or "SY" (SSN).
<b>2000B</b>	<b>SBR</b>		<b>Subscriber Information</b>	
2000B	SBR	<b>SBR01</b>	Payer Responsibility Sequence Number	Use "P" for MDCH if it is the only payer (that is, patient has no other insurance), "S" if there is one other payer, or "T" if there are two or more other payers.
2000B	SBR	<b>SBR09</b>	Claim Filing Indicator Code	Use "MC" for Michigan Medicaid, "11" for CSHCS (Title V) and State Medical Plan (Other Non-Federal). If beneficiary qualifies for more than one program or other MDCH program not listed, use "MC".
<b>2010BA</b>	<b>NM1</b>		<b>Subscriber Name</b>	
2010BA	NM1	<b>NM108</b>	Identification code qualifier	Use "MI" (Member Identification Number).
2010BA	NM1	<b>NM109</b>	Identification code	Use the Beneficiary ID number assigned by MDCH.
<b>2010BA</b>	<b>REF</b>		<b>Subscriber Secondary Identification</b>	
2010BA	REF	<b>REF01</b>	Reference Identification Qualifier	Do not send "1W" if sent in NM108.
<b>2010BB</b>	<b>NM1</b>		<b>Payer Name</b>	-
2010BB	NM1	<b>NM108</b>	Identification Code qualifier	Use "PI" (Payer Identification Number).
2010BB	NM1	<b>NM109</b>	Identification Code	Use "D00111" for MDCH.



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<b>2000C</b>			<b>Loop ID 2000C - Patient Hierarchical Level</b>	MDCH business rules require that the patient is always the subscriber. Therefore, MDCH does not expect health plans to submit any Loop 2000C (Patient Hierarchical Level) in a transaction set. Transaction sets that contain Loop 2000C (Patient Hierarchical Level) information will be rejected.
<b>2300</b>			<b>Loop ID 2300 - Claim Information</b>	Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 Claim Information loop within each Loop 2000B (Subscriber Hierarchical Level). Transaction sets that do not associate Loop 2300 Claim Information with Loop 2000B will be rejected.
2300	CLM	<b>CLM05</b>	Place of service, claim frequency code Health Care Service Location Information	
2300	CLM	<b>CLM05-1</b>	Facility Code Value	Place of service codes are defined by the Center for Medicare and Medicaid Services.
2300	CLM	<b>CLM05-3</b>	Claim Frequency Type Code	Use "1" on original claim submissions; Use "7" for claim replacement, and Use "8" for claim void/cancel. For both "7" and "8", include the original TCN (CRN), as indicated in Loop 2300 REF (Original Reference Number (ICN/DCN).
2300	CLM	<b>CLM11</b>	Accident/employment/related causes (code, code, code, state, country) Related Causes Information	
2300	CLM	<b>CLM11-1</b>	Related Causes Code	If Related Causes Code 1, 2, 3 = "AA", then Auto Accident State (CLM11-4) must be submitted.
2300	CLM	<b>CLM11-2</b>	Related Causes Code	If Related Causes Code 1, 2, 3 = "AA", then Auto Accident State (CLM11-4) must be submitted.



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2300	<b>CLM</b>	<b>CLM11-3</b>	Related Causes Code	If Related Causes Code 1, 2, 3 = "AA", then Auto Accident State (CLM11-4) must be submitted.
<b>2300</b>	<b>DTP</b>		<b>Accident Date</b>	
2300	DTP	<b>DTP02</b>	Accident Date Time Period	Required if CLM11-1, 2, or 3 = "AA"
<b>2300</b>	<b>REF</b>		<b>Original Reference Number (ICN/DCN)</b>	
2300	REF	<b>REF01</b>	Reference Identification Qualifier	When submitting a claim replacement or claim void/cancel, use "F8".
2300	REF	<b>REF02</b>	Reference Identification	Use the 10-digit CRN assigned by MDCH for the last approved claim.
<b>2300</b>	<b>REF</b>		<b>Prior Authorization or Referral Number</b>	
2300	REF	<b>REF01</b>	Reference Identification Qualifier	When submitting a Prior Authorization, use "G1" (Prior Authorization Number).
2300	REF	<b>REF02</b>	Reference Identification	Use the 9-digit PA number assigned by MDCH.
<b>2300</b>	<b>NTE</b>		<b>Claim Note</b>	
2300	NTE	<b>NTE01</b>	Note Reference Code	Use "ADD".
2300	NTE	<b>NTE02</b>	Claim Note Text	Provide free-form text remarks, if needed.
<b>2310A</b>	<b>NM1</b>		<b>Referring Provider Name</b>	
2310A	NM1	<b>NM101</b>	Entity Identifier Code	Use DN for Referring Provider in first loop only. Use if loop is used only once. Use P3 only if loop is used twice. Use only on second iteration of this loop.
2310A	NM1	<b>NM108</b>	Identification code qualifier	Use "XX" for NPI.
2310A	NM1	<b>NM109</b>	Identification code	Enter the NPI.
<b>2310A</b>	<b>REF</b>		<b>Referring Provider Secondary Identification</b>	
2310A	REF	<b>REF01</b>	Reference Identification Qualifier	Submit "EI" (Employer's Identification Number) or "SY" (SSN). For non-enrolled Medicaid providers, use "0B" (State License Number).
2310A	REF	<b>REF02</b>	Reference Identification	Enter EIN or SSN. If the Provider is not a Medicaid provider, use the state license number.
<b>2310B</b>	<b>NM1</b>		<b>Rendering Provider Name</b>	Use this for Rendering Provider information if different than the Billing



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				Provider.
2310B	NM1	<b>NM108</b>	Identification code qualifier	Use "XX" for NPI.
2310B	NM1	<b>NM109</b>	Identification code	Enter the NPI.
<b>2310B</b>	<b>REF</b>		<b>Rendering Provider Secondary Identification</b>	
2310B	REF	<b>REF01</b>	Reference Identification Qualifier	Submit "EI" (Employer's Identification Number) or "SY" (SSN). For non- enrolled Medicaid providers, use "OB" (State License Number).
2310B	REF	<b>REF02</b>	Reference Identification	Enter EIN or SSN. If the Provider is not a Medicaid provider, use the state license number.
<b>2310C</b>	<b>NM1</b>		<b>Service Facility Location</b>	
2310C	NM1	<b>NM108</b>	Identification code qualifier	Use "XX" for NPI.
2310C	NM1	<b>NM109</b>	Identification Code	Enter the NPI.
<b>2310C</b>	<b>REF</b>		<b>Service Facility Location Secondary Identification</b>	
2310C	REF	<b>REF01</b>	Reference Identification Qualifier	Submit "EI" (Employer's Identification Number) or "SY" (SSN). For non- enrolled Medicaid providers, use "OB" (State License Number).
2310C	REF	<b>REF02</b>	Reference Identification	Enter EIN or SSN. If the Provider is not a Medicaid provider, use the state license number.
<b>2320</b>	<b>SBR</b>		<b>Other Subscriber Information</b>	If the patient has other insurance (Medicare, for example), repeat this loop for each other payer. Do not put information about MDCH coverage in this loop.
2320	SBR	<b>SBR01</b>	Payer Responsibility Sequence Number	If the patient has other insurance, report primary payer coverage with code "P" and any other insurance with codes "S" or "T", as appropriate.
2320	SBR	<b>SBR02</b>	Individual Relationship code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid also has coverage under the father's insurance, use code "19" (Child).



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2320	SBR	<b>SBR03</b>	Group or Policy number Reference Identification	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
2320	SBR	<b>SBR09</b>	Claim filing indicator code	Do not use "MC" (Medicaid) in this element.
<b>2320</b>	<b>CAS</b>		<b>Claim Level Adjustment</b>	MDCH expects all COB adjudication to be submitted in the service line level (Loop 2430 CAS) on dental claims.
<b>2330A</b>	<b>NM1</b>		<b>Other Subscriber Name</b>	
2330A	NM1	<b>NM103</b>	Last Name or Organization Name	Use the name of the subscriber as it appears on the files of the other payer.
2330A	NM1	<b>NM104</b>	First Name	Use the name of the subscriber as it appears on the files of the other payer.
2330A	NM1	<b>NM105</b>	Name Middle	Use the name of the subscriber as it appears on the files of the other payer.
2330A	NM1	<b>NM108</b>	Identification code qualifier	Use "MI" (Member Identification Number).
2330A	NM1	<b>NM109</b>	Identification code	Use the unique beneficiary number assigned to the subscriber by the other payer indicated in Loop 2330B (Other Payer Name). For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
<b>2330B</b>	<b>NM1</b>		<b>Other Payer Name</b>	
2330B	NM1	<b>NM109</b>	Identification code	Use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if Delta Dental is the Other Payer, the value (carrier code) carried in this element would be "03085010."
<b>2330B</b>	<b>REF</b>		<b>Other Payer Prior Authorization or Referral Number</b>	
2330B	REF	<b>REF01</b>	Reference Identification Qualifier	Use "9F" (Referral Number) or "G1" (Prior Authorization Number).



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2330B	REF	<b>REF02</b>	Reference Identification	If the other payer preauthorized services or a referral, enter the authorization number or referral number here. Do not use the PA or Referral Number (Loop 2300 REF02), specific to the destination payer.
2330D	REF		<b>Other Payer Referring Provider Identification</b>	
2330D	REF	<b>REF01</b>	Reference Identification Qualifier	Do not use "1D" (Medicaid Provider Number).
2330E	REF		<b>Other Payer Rendering Provider Identification</b>	
2330E	REF	<b>REF01</b>	Reference Identification Qualifier	Do not use "1D" (Medicaid Provider Number).
<b>2400</b>			<b>Line Counter</b>	The HIPAA implementation guide allows up to 50 repetitions of the 2400 service line loop for each 2300 loop.
<b>2400</b>	<b>SV3</b>		<b>Dental Service</b>	
2400	SV3	<b>SV301-1</b>	Product/Service ID Qualifier	Use "AD" for American Dental Association Codes CDT qualifier
2400	SV3	<b>SV301-2</b>	Product/Service ID	MDCH expects American Dental Association Codes CDT = Current Dental Terminology
<b>2400</b>	<b>SV3</b>	<b>SV304</b>	Oral Cavity Designation Code (1-5)	The Oral Cavity Code is required on the claim when applicable. Review the Billing & Reimbursement for Dental Providers Chapter for the required data characters. The dental database on the MDCH website lists the procedure codes that require the Oral Cavity Code designation. The data characters required are two-digit numeric characters. They are: 01 is the Maxillary Arch 02 is the Mandibular Arch 10 is the Upper Right Quadrant 20 is the Upper Left Quadrant 30 is the Lower Left Quadrant 40 is the Lower Right Quadrant
2400	SV3	<b>SV306</b>	Quantity	MDCH requires a quantity of "1". Use a separate service line for each dental



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				service.
<b>2400</b>	<b>TOO</b>		<b>Tooth Information</b>	MDCH will only process one repeat of Loop 2400 TOO (Tooth Information) per service line. Any additional repeats may be ignored.
<b>2400</b>	<b>DTP</b>		<b>Service Date</b>	
2400	DTP	<b>DTP03</b>	Service Date Time Period	MDCH expects service date on every service line.
<b>2420B</b>	<b>REF</b>		<b>Other Payer Prior Authorization or Referral Number</b>	
2420B	REF	<b>REF01</b>	Reference Identification Qualifier	Use "9F" (Referral Number) or "G1" (Prior Authorization Number)
2420B	REF	<b>REF02</b>	Reference Identification	If the other payer preauthorized services or a referral, enter the authorization number or referral number here. Do not use the PA or Referral Number (Loop 2400 REF02), specific to the destination payer.
<b>2430</b>	<b>SVD</b>		<b>Line Adjudication Information</b>	<b>MDCH expects this loop to be populated for each payer identified in Loop 2320 (Other Subscriber Information).</b>