Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC x12N/005010X222 837P (Professional)
ANSI ASC x12N/005010X223 837I (Institutional)
ANSI ASC x12N/005010X224 837D (Dental)

Applicable to Medicaid Managed Care Programs including but not limited to
CHCP, MHL, MICH, HKD, and MI Choice

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This document is the property of the Michigan Department of Health and Human Services (MDHHS). The information contained in this document is for the use of Trading Partners exchanging electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS). The content of this document may not be altered by external entities. The information in this document is subject to change. The most recent version will be posted on the Michigan Department of Health and Human Services (MDHHS) website at: HIPAA - Companion Guides

Table of Contents

Contents

1. Introduction 2
   1.1 Scope 2
   1.2 Reference: Electronic Submission Manual 2
   1.3 Reference: Testing 2
   1.4 Transaction Description 3
   1.5 General Information 3
2. Getting Started 3
   2.1 Working with MDHHS 3
   2.2 Certification and Testing Overview 3
      2.2.1 Ramp Manager Testing 4
      2.2.2 CHAMPS B2B Testing 4
3. Testing with Michigan Medicaid 4
4. Connectivity with Michigan Medicaid/Communications 4
   4.1 Process Flows 5
   4.2 Transmission Administrative Procedures 5
      4.2.1 Structure Requirements 5
      4.2.2 Response Times 5
      4.2.3 Interchange Acknowledgements 5
   4.3 Communication Protocols 5
5. Contacts 5
6. Michigan Medicaid Specific Business Rules and Limitations 6
   6.1 Supported Service Types 6
6.2 Trading Partner Agreements 6

An EDI Trading Partner is defined as any MDHHS customer (Provider, billing service, software vendor, employer group,

financial institution, etc.) that transmits directly to, or receives electronic data directly from, MDHHS. 6
7. Control Segments / Envelopes 6
8. HIPAA 5010 ANSI ASC X12 837P Implementation Guide 8
8.1 Encounter 837P - Interchange Control Header and Functional Group Header 8
8.2 Encounter 837P – Transaction Set 9
9. HIPAA 5010 ANSI ASC X12N 837I Implementation Guide 23
9.1 Encounter 837I - Interchange Control Header and Functional Group Header 23
9.2 837I Transaction Set 24
10. HIPAA 5010 ANSI ASC X12N 837D Implementation Guide 38
10.1 Encounter 837D - Interchange Control Header and Functional Group Header 38
10.2 837D Transaction Set 39
11. Revision Log 50

1. Introduction

MDHHS requires encounters to be submitted according to EDI standards described by ASC X12N Version 5, Release 1. The 5010 Implementation Guides and related Errata documents can be purchased from the X12 web site at: Products | X12. In this document, when an implementation guide is referred to, that is specifically The Technical Report Type 3 (TR3) document.

This document is intended as a companion to the ASC X12 Standards for Electronic Data Interchange, describing rules and interpretations that are specific to MDHHS encounter standards. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009.

1.1 Scope

This document provides MDHHS-specific instructions regarding certain elements within the Implementation Guides but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDHHS rules regarding:

- Identifiers to use when a national standard has not been adopted.
- Parameters in the Implementation Guide and related Errata that provide options applicable to Michigan Medicaid.

1.2 Reference: Electronic Submission Manual

Please refer to the MDHHS Electronic Submission Manual (HIPAA - Companion Guides > Electronic Submissions Manual) for information regarding:

- Interaction with the MDHHS Data Exchange Gateway (DEG)
- Modes of submission (SSL FTP, or HTTPS)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction
- Download HIPAA transactions from the CHAMPS system

1.3 Reference: Testing

Please refer to the testing instructions available at : How to Become An E-Biller >> 5010 837 Encounter Test Instructions

This document provides testing instructions for Billing Agents (e.g., Health Plans) who send 837 encounter transactions to MDHHS. This document includes instructions to be used by prospective Billing Agents seeking approval for production encounter submission to MDHHS.

1.4 Transaction Description

The ANSI ASC X12N 837P/I/D format is used to submit claim information from providers of health care services to payers, including managed care organizations. These transactions can be submitted either directly or via intermediary billing services and/or claims clearinghouses.

1.5 General Information

The term “Encounter” is used in throughout this document to describe claims generated from Encounters of Managed Care beneficiaries that are applicable to Managed Care Programs. These Encounters may be also referred to as “Encounter Claims”.

All alpha characters must be in UPPER CASE.

FFS Claims and Managed Care Encounters cannot be sent on the same 837 Transaction file. Refer to the MDHHS website for the Companion Guide supporting the submission of health care Fee-For-Service (FFS) claims.

For HIDE-SNP encounter submissions:

Encounters where Medicare did not pay on the claim should go into the 6500 Medicaid file. Encounters where Medicare paid more than $0 on the claim should go into the 6501 Medicare file. Please do not split claims; encounters should show both Medicare and Medicaid payments on a single encounter transaction.

2. Getting Started

2.1 Working with MDHHS

An entity (Provider, billing agent, clearinghouse, etc.) who wishes to retrieve responses, must enroll with MDHHS as a provider or billing agent. Please refer to: “HOW TO ENROLL AS A BILLING AGENT” at the location below for information on provider and billing agent enrollment:

Trading Partners >> Electronic Submissions Transactions >> New Billing Agents

2.2 Certification and Testing Overview

Michigan Medicaid provides test systems for our Trading Partners’ use to verify their transactions are properly generated and submitted to MDHHS. The Michigan Medicaid provider community may use the test systems to pursue CMS Level II Compliance, to ensure: "an entity covered by HIPAA has completed end-to-end testing with each of its external trading partners and is prepared to move into production mode"[1].

All MDHHS Providers, Health Plans, Clearinghouses, and Billing Agents are required to test their ability to send valid electronic transactions and obtain appropriate results. Please review the following information with your transaction submission and IT teams, ensure HIPAA test transactions are appropriately identified as "Test", and verify you are working in the test environment when submitting claim, encounter, or query transactions. Be aware that the rates included in the CHAMPS B2B Test system may vary from the actual rates used in the CHAMPS production system. MDHHS offers the following two types of testing:

2.2.1 Ramp Manager Testing

Ramp Manager testing validates the format and syntax of EDI transactions and is required for each new Trading Partner. This testing is also available to existing electronic submitters; it is not a pre-requisite for subsequent CHAMPS B2B Testing.

2.2.2 CHAMPS B2B Testing

Providers and Trading Partners may test claims and encounters using the CHAMPS B2B Test environment. Test claim adjudication reports, encounter processing reports and ETRRs (instead of 277CA) are provided to State Trading Partners for use in their own review and testing functions.

3. Testing with Michigan Medicaid

The MDHHS Electronic Submissions Manual contains an overview of the testing process (see: *Section 1.3 Reference*). More information on testing is available at: How to Become An E-Biller >> B2B Testing >> 5010 837 Encounter Test Instructions

In general, the steps to complete testing are as follows:

- Register as an electronic biller
- Obtain authentication credentials appropriate to the mode of electronic billing
- Send an email to: MDHHSEncounterData@michigan.gov and to: MDHHS-B2B-Testing@michigan.gov to request testing enrollment and instructions for using the MDHHS test systems
- Perform the required testing in the MDHHS Test Systems
- Request MDHHS review and approve your test submissions to certify your organization as an electronic submitter, prior to sending production electronic transactions to the MDHHS Medicaid system (CHAMPS).

4. Connectivity with Michigan Medicaid/Communications

The MDHHS CHAMPS system is available 24 hours per day, 7 days a week with the exception of a regular monthly maintenance window, which starts at 6:00 p.m. on the second Saturday of each month and ends at 6:00 a.m. on Sunday. For information on unscheduled outages, please check the Provider Alerts page at the following location: Medicaid Provider Alerts & Resources

4.1 Process Flows

MDHHS supports batch submissions for ANSI ASC X12N 837P/I/D transactions.

4.2 Transmission Administrative Procedures

4.2.1 Structure Requirements

MDHHS complies with the standards established by the HIPAA Implementation Guides.

4.2.2 Response Times

MDHHS complies with the requirements established by the HIPAA Implementation Guides.

4.2.3 Interchange Acknowledgements

Please refer to the MDHHS Electronic Submissions Manual for information regarding:

- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

4.3 Communication Protocols

Please see the Electronic Submissions Manual for additional information on using communication protocols (see: *Section 1.2 Reference: Electronic Submission Manual*).

5. Contacts

EDI Services: EDI Services handles all issues and questions with the FTS or files exchanged with CHAMPS.

Website: michigan.gov/tradingpartners >> Electronic Submissions Transactions

Email: AutomatedBilling@michigan.gov and MDHHS-FTS-SUPPORT@michigan.gov

Encounter Support: The encounter team handles all questions related to the 837 submission guidelines.

Website: michigan.gov/tradingpartners >> HIPAA Companion Guides >> Medicaid Encounter Technical Guidance

Email: MDHHSEncounterData@michigan.gov

6. Michigan Medicaid Specific Business Rules and Limitations

6.1 Supported Service Types

MDHHS supports the Service Types required by the HIPAA 5010 ANSI ASC X12N 837P Implementation Guide.

MDHHS supports the Service Types required by the HIPAA 5010 ANSI ASC X12N 837I Implementation Guide.

MDHHS supports the Service Types required by the HIPAA 5010 ANSI ASC X12N 837D Implementation Guide.

6.2 Trading Partner Agreements

An EDI Trading Partner is defined as any MDHHS customer (Provider, billing service, software vendor, employer group, financial institution, etc.) that transmits directly to, or receives electronic data directly from, MDHHS.

If you are not already submitting electronic transactions to MDHHS, you will need to enroll with MDHHS. Please refer to Section 2.1 for information on enrolling with MDHHS as a provider or billing agent. Enrollment and test certification are required to send or retrieve electronic transactions.

Note: Electronic submitters will need to be associated to their Providers (or to themselves) within CHAMPS to be able to submit and receive transactions on the Provider's behalf.

7. Control Segments / Envelopes

This document uses several text conventions to distinguish MDHHS data elements from the Implementation Guide data elements. The following table lists the text conventions used in this document:

<> - Text included within < > is the "Implementation Name" field from the TR3 document.

“” - Text with " " around a value represents the value to be submitted. This may be an Implementation Guide value or a specific value required by MDHHS.

() - The description of the HIPAA Implementation Guide value in quotes, described above, is provided parenthetically.

Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC x12N/005010X222 837P (Professional)

Applicable to Medicaid Managed Care Programs including but not limited to CHCP, MICH, HKD, and MI Choice

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8. HIPAA 5010 ANSI ASC X12 837P Implementation Guide

8.1 Encounter 837P - Interchange Control Header and Functional Group Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment – Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present [No Meaningful Information in ISA02])
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present [No Meaningful Information in ISA04])
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID. Use the FTS Username ID (formerly DEG ID) left justified, followed by spaces. This value must also appear in the GS02 data element.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces. This value must also appear in the GS03 data element.
			Functional Group Header	
	GS		**Segment – Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID. Use the FTS ID (formerly DEG ID). This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDHHS. This value should always match ISA08 <Interchange Receiver ID>.

8.2 Encounter 837P – Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment – Transaction Set Header**	**MDHHS accepts a maximum of 5,000 CLM segments in a single transaction (ST - SE) as recommended by the HIPAA mandated implementation guide.** **Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment – Beginning of Hierarchical Transaction**	
	BHT	BHT03	Reference Identification	<Originator Application Transaction Identifier> MDHHS requires this number to always be unique. This number may not be used again even if the prior batch is rejected.
	BHT	BHT06	Transaction Type Code	<Claim or Encounter Identifier> "RP" (Reporting) for Encounters
1000A			**Loop – Submitter Name**	
1000A	**NM1**		**Segment – Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000A	NM1	NM109	Identification Code	<Submitter Identifier>. Use the FTS Username ID (formerly DEG ID). This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>
1000B			**Loop – Receiver Name**	
1000B	**NM1**		**Segment – Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name>. "Michigan Department of Health and Human Services" or "MDHHS"
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDHHS.
2000A			**Loop – Billing Provider Hierarchical**	
2000A	**PRV**		**Segment – Billing Provider Specialty Information**	

2000A	PRV	PRV01	Provider Code	"BI" (Billing)
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2000B			**Loop – Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment – Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"P" if MDHHS is the only payer (patient has no Medicare or other insurance). “S” on ICO and MICH encounters as beneficiaries are dual eligible
2000B	SBR	SBR09	Claim Filing Indicator Code	“MC” (Medicaid including MIChoice, Healthy Michigan, and NEMT) “TV” (Title V) for CSHCS “OF” (Other Federal) for MIChild “11” (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. HIDE-SNPs: “16” Health Maintenance Organization (HMO) Medicare Risk If recipient qualifies for more than one program, or other MDHHS program not listed, use “MC” (Medicaid).
2010BA			**Loop – Subscriber Name**	
2010BA	**NM1**		**Segment – Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> Use the 10-digit beneficiary ID number assigned by MDHHS. MIChild plans: 1) Use the Client Identification Number (CIN) with a value of 'D00111-MIChild' in 2100A Loop NM109 for dates prior to January 1, 2016; and

				2) Use the Beneficiary Identification Number with a value of "D00111' in 2100A Loop NM109 for dates on or after January 1, 2016
2010BB			**Loop – Payer Name**	
2010BB	**NM1**		**Segment – Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDHHS.
2010BB	**REF**		**Segment – Payer Secondary Identification**	
2010BB	REF	REF01	Billing Provider Secondary Code Qualifier	Report the "G2" qualifier when the billing provider is an atypical provider. **Note:** NM103 (Last Name) loop 2010AA is mandatory when an atypical provider is reported.
2010BB	REF	REF02	Billing Provider Secondary Code	Report the MMIS Provider ID (7-digit CHAMPS provider ID) when the billing provider is an atypical provider.
2000C			**Loop – Patient Hierarchical Level**	**MDHHS business rules require that the patient is always the subscriber. Therefore, MDHHS does not expect health plans to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set.** **Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**
2300			**Loop – Claim Information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 repetitions of the Loop - 2300 Claim Information 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**		**Segment – Claim Information**	
2300	CLM	CLM01	Plan internal claim number	Must be the same as 2330B REF02. This number should match what is sent back to providers on their 835 in CLP07
2300	CLM	CLM05-3	Claim Frequency Type Code	<Claim Frequency Code> "1" on original encounter submissions

				"7" for replacement/adjustment "8" for void/cancel For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number).
2300	**DTP**		**Segment – Admission Date**	**MDHHS requires the admission date to be submitted when the claim involves an inpatient stay. Also, required on all ambulance claims when the patient was known to be admitted to the hospital.**
2300	DTP	DTP01	Date/Time Qualifier	"435" (Admission)
2300	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format)
2300	DTP	DTP03	Date Time Period	<Related Hospitalization Admission Date>
2300	**DTP**		**Segment – Discharge Date**	**MDHHS requires the discharge date to be submitted when the claim involves an inpatient stay and the patient has been discharged.**
2300	DTP	DTP01	Date/Time Qualifier	"096" (Discharge)
2300	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format)
2300	DTP	DTP03	Date Time Period	<Related Hospitalization Discharge Date>
2300	**DTP**		**Segment – Repricer Received Date**	**MDHHS requires the date the plan received the claim from the provider to be reported on all encounters.**
2300	DTP	DTP01	Date/Time Qualifier	"050" (Received)
2300	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format)
2300	DTP	DTP03	Date Time Period	<Repricer Received Date> MDHHS expects this to correlate to the date the health plan received the clean claim from their provider.
2300	**PWK**		**Segment – Claim Supplemental Information**	**MDHHS requires the use of this segment to report how the plan received their claim from the provider. (ex: electronic, paper, direct data entry)**
2300	PWK	PWK01	Report Type Code	<Attachment Report Type Code> "OZ" (Support Data for Claim)
2300	PWK	PWK02	Report Transmission Code	<Attachment Transmission Code> "BM" (By Mail) This value should be used when the provider

				submitted the claim to the plan via paper. "EL" (Electronically Only) This value should be used when the provider submitted the claim to the plan electronically via 837 or via direct data entry. "EM" (E-Mail) This value should be reported if you received the claim via email. "FT" (File Transfer) This value should be reported if you received the claim via file transfer. "FX" (By Fax) This value should be reported if you received the claim via fax.
2300	PWK	PWK05	Identification Code Qualifier	"AC" (Attachment Control Number)
2300	PWK	PWK06	Identification Code	MDHHS expects plans to report the descriptions below that correlate to the code sent in PWK02: Submit "Paper" when PWK02 is "BM" Submit "Electronic" or "Direct Data Entry" when PWK02 is "EL" or "FT". The text submitted should reflect how the claim was received. Submit "Email" when PWK02 is "EM" Submit "Fax" when PWK02 is "FX"
2300	**CN1**		**Segment – Contract Information**	
2300	CN1	CN101	Contract Type Code	MDHHS requires this data element for encounters. Use "09" Other if none of the codes listed below defined in the x12 guide are applicable. "01" Diagnosis Related Group (DRG) "02" Per Diem "03" Variable Per Diem "04" Flat "05" Capitated "06" Percent

2300	CN1	CN102	Monetary Amount	<Contract Amount> Associated monetary amount paid or denied by the health plan.
2300	CN1	CN104	Reference Identification	<Contract Code> "P" – must be reported if the encounter is considered a paid encounter by the health plan. "D" – must be reported if the encounter is considered a denied encounter by the health plan.
2300	**REF**		**Segment – Claim Identifier for Transmission Intermediaries**	
2300	REF	REF01	Reference Identification Qualifier	"D9" – Claim Number
2300	REF	REF02	Reference Identification	<Value Added Network Trace Number> This data element should represent the provider's claim number. Please submit the unique provider claim number that is submitted to you in theCLM01 of the provider's 837 claim file. If the claim number is greater than the allowed 20 characters, please include the first 20 characters of the claim number in this field.
2310B			**Loop – Rendering Provider Name**	
2310B	**NM1**		**Segment – Rendering Provider Name**	**Required when the rendering provider information is different than loop 2010AA (billing provider)**
2310B	NM1	NM101	Entity Identifier Code	"82" (Rendering Provider)
2310B	NM1	NM102	Entity Type Qualifier	"1" (Person) "2" (Non-Person Entity)
2310B	NM1	NM103	Name Last or Organization Name	<Rendering Provider Last or Organization Name>
2310B	NM1	NM104	Name First	<Rendering Provider First Name> Required when NM102 = "1"
2310B	NM1	NM105	Name Middle	<Rendering Provider Middle Name or Initial> For out of state providers submit "OS"
2310B	NM1	NM108	Identification Code Qualifier	"XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2310B	NM1	NM109	Identification Code	<Rendering Provider Identifier> Provider NPI

2310B	**PRV**		**Segment – Rendering Provider Specialty Information**	
2310B	PRV	PRV01	Provider Code	"PE" (Performing)
2310B	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310B	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2310B	**REF**		**Segment – Rendering Provider Name**	**Required when the provider is an atypical provider and unable obtain an NPI.**
2310B	REF	REF01	Rendering Provider Secondary ID Code Qualifier	Report the "G2" qualifier when the rendering provider is an atypical provider.
2310B	REF	REF02	Rendering Provider Secondary ID	Report the MMIS Provider ID (7-digit CHAMPS provider ID) when the rendering provider is an atypical provider.
2310C			**Loop – Service Facility Location Name**	
2310C	**NM1**		**Segment – Service Facility Location Name**	**Required when the service facility location is different than that reported in loop 2010AA (Billing provider)**
2310C	NM1	NM101	Entity Identifier Code	"77" (Service Location)
2310C	NM1	NM102	Entity Type Qualifier	"2" (Non-Person Entity)
2310C	NM1	NM103	Name Last or Organization Name	<Laboratory or Facility Name>
2310C	NM1	NM108	Identification Code Qualifier	Required when the service location has an NPI and is not associated with the billing provider entity. "XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2310C	NM1	NM109	Identification Code	<Laboratory or Facility Primary Identifier> Report the Service Facility NPI
2310C	**N3**		**Segment – Service Facility Location Address**	
2310C	N3	N301	Address Information	<Laboratory or Facility Address Line>
2310C	N3	N302	Address Information	<Laboratory or Facility Address Line> Required when there is a second address line. Apt, Suite, etc.
2310C	**N4**		**Segment – Service Facility Location City, State, ZIP Code**	

2310C	N4	N401	City Name	<Laboratory or Facility City Name>
2310C	N4	N402	State or Province Code	<Laboratory or Facility State or Province Code>
2310C	N4	N403	Postal Code	<Laboratory or Facility Postal Zone or Zip Code> When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.
2320			**Loop – Other Subscriber Information**	**MDHHS does require the health plan to report Loop - 2320 Other Subscriber Information. The health plan will be identified as a payer in Loop - 2330B Other Payer Name. The information reported in this iteration of Loop - 2320 is specific to the subscriber's coverage through the health plan. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name.**
2320	**SBR**		**Segment – Other Subscriber Information**	
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	If the patient has other insurance, report Primary payer coverage with code "P" and any other insurance with codes "S" or "T", as appropriate, for Secondary or Tertiary. If the patient has no other insurance, report the health plan coverage with "P". For HIDE-SNP beneficiaries, there will be at least two iterations of this loop: one with Medicare (generally "P"), one with Medicaid (generally "T"). If the patient has other insurance besides the Medicare and Medicaid benefits, then assign Other Insurance codes "P", "T", or "A" as appropriate.
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber's group number (assigned by the health plan or the other payer), not the number that uniquely identifies the subscriber.
2320	SBR	SBR09	Claim Filing Indicator Code	"MC" (Medicaid including MIChoice) "TV" (Title V) for CSHCS

				"OF" (Other Federal) for MIChild "11" (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. "MA" or "MB" for Medicare as appropriate (Cannot be applied to the 2330B loop with the CHAMPS-assigned PlanID) If recipient qualifies for more than one program, or other MDHHS program not listed, use "MC" (Medicaid).
2320	**CAS**		**Segment – Claim Level Adjustments**	**MDHHS requires all COB adjudication to be submitted in the service line level Loop/Segment - 2430 CAS.**
2320	**AMT**		**Segment – Coordination of Benefits (COB) Payer Paid Amount**	**MDHHS requires the payer paid amount on all encounters.**
2320	AMT	AMT01	Amount Qualifier Code	"D" (Payer Amount Paid)
2320	AMT	AMT02	Monetary Amount	<Payer Paid Amount> Report the amount that the health plan paid. "0" is an acceptable amount.
2330A			**Loop – Other Subscriber Name**	**Loop - 2330A Other Subscriber Name, segment NM1 is required for all encounters. The subscriber information reported is specific/related to the health plan and/or any other additional other payer information submitted on Loop - 2330B Other Payer Name.**
2330A	**NM1**		**Segment – Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number")
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> 10-digit ID number assigned by MDHHS. MIChild plans: 1) Use the Client Identification Number (CIN) with a value of 'D00111-MIChild' in 2100A Loop NM109 for dates prior to January 1, 2016; and 2) Use the CHAMPS Beneficiary Identification Number with a value of 'D00111' in 2100A Loop NM109 for dates on or after January 1, 2016.

				When reporting TPL, this element is intended to report the unique member identifier assigned by the other payer.
2330B			**Loop – Other Payer Name**	**Loop - 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the health plan (MHPs, County Health Plans, MiChoice, MIChild, HIDE-SNP) is required to report themselves as an Other Payer.** **In the event that there are other payers identified as having financial responsibility for the services being reported, the health plan would report them in subsequent iterations of Loop - 2330B.**
2330B	**NM1**		**Segment – Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> For health plans use the CHAMPS provider ID assigned by MDHHS. For Other payers use the payer ID submitted on the claim. For Medicare use the plan ID assigned by CMS that begins with “H”.
2330B	**REF**		**Segment – Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"F8" (Original Reference Number)
2330B	REF	REF02	Reference Identification	<Payer Claim Control Number> For encounters, MDHHS requires a unique Encounter Reference Number (ERN) to always be submitted. For the health plan, enter the plan assigned unique identifier Encounter Reference Number (ERN) for the encounter. Include the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a replacement or void. This value must be equal to the value in Loop 2300 CLM01.

2400			**Loop – Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 50 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV1**		**Segment – Professional Service**	
2400	SV1	SV102	Monetary Amount	<Line item charge amount> MDHHS requires the provider's usual and customary charge or billed amount. Zero (0) is a valid amount if: 1) The health plan has a sub-capitated contract arrangement with the provider as designated in Loop - 2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop - 2400 Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 2) The service(s) is/are recognized by MDHHS as having no associated charge(s), for example, vaccines.
2400	**DTP**		**Segment – Service Date**	
2400	DTP	DTP01	Date/Time Qualifier	"472" (Service)
2400	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format) "RD8" (Range of dates expressed in CCYYMMDD-CCYYMMDD format) RD8 is required only when the "to and from" dates are different. When billing a date range, be sure units agree with date span.
2400	DTP	DTP03	Date Time Period	<Service Date> Submit the date of service in CCYYMMDD format
2400	**CN1**		**Segment – Contract Information**	**MDHHS requires this data element for encounters.**
2400	CN1	CN101	Contract Type Code	Use "09" Other if none of the codes listed below defined in the x12 guide are applicable. "01" Diagnosis Related Group (DRG) "02" Per Diem "03" Variable Per Diem

				"04" Flat "05" Capitated "06" Percent
2400	CN1	CN102	Monetary Amount	<Contract Amount> Associated monetary amount paid or denied by the health plan.
2400	CN1	CN104	Reference Identification	<Contract Code> "P" (Paid) must be reported if the encounter is considered a paid encounter by the health plan. "D" (Denied) must be reported if the encounter is considered a denied encounter by the health plan.
2400	**NTE**		**Segment – Line Note**	**Required for HIDE-SNP MICH personal care service encounters**
2400	NTE	NTE01	Note Reference Code	"ADD" (Additional information)
2400	NTE	NTE02	Description	Four-digit code identifying waiver service. Can be referenced in the *MICH HCBS Waiver Services Resource Document*. This document can be located at the following link Information For Health Plans & Providers
2420A			**Loop – Line Rendering Provider Name**	
2420A	**PRV**		**Segment – Line Rendering Provider Specialty Information**	
2420A	PRV	PRV01	Provider Code	"PE" (Performing)
2420A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2420A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2420A	**REF**		**Segment – Line Rendering Provider Secondary Identification**	
2420A	REF	REF01	Reference Identification Qualifier	Report the "G2" qualifier when the rendering provider is an atypical provider.
2420A	REF	REF02	Reference Identification	Report the MMIS Provider ID (7-digit CHAMPS provider ID) when the rendering provider is an atypical provider.

2430			**Loop – Line Adjudication Information**	
2430	**SVD**		**Segment – Line Adjudication Information**	
2430	SVD	SVD05	Quantity – Paid Service Unit Count	MDHHS requires paid units be submitted in the SVD05 data element. If a claim line is denied SVD05 should be 0. If a claim line is bundled, billed units should be submitted in SVD05.
2430	SVD	SVD06	Assigned Number	MDHHS requires SVD06 when the service has been bundled. This data element should contain the line number that the service was bundled into.
2430	**CAS**		**Segment – Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC x12N/005010X223 837I (Institutional)

Applicable to Medicaid Managed Care Programs including but not limited to CHCP, MICH, HKD, and MI Choice

Version Date April 22, 2026
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9. HIPAA 5010 ANSI ASC X12N 837I Implementation Guide

9.1 Encounter 837I - Interchange Control Header and Functional Group Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment – Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present [No Meaningful Information in ISA02])
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present [No Meaningful Information in ISA04])
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID. Use the FTS Username ID (Formerly the DEG ID), left justified, followed by spaces. This value must also appear in the GS02 data element.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces. This value must also appear in the GS03 data element.
			Functional Group Header	
	GS		**Segment – Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID. Use the FTS Username ID (Formerly the DEG ID). This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDHHS. This value should always match ISA08 <Interchange Receiver ID>.

9.2 837I Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment – Transaction Set Header**	**MDHHS accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment – Beginning of Hierarchical Transaction**	
	BHT	BHT03	Reference Identification	<Originator Application Transaction Identifier> MDHHS requires this number to always be unique. This number may not be used again even if the prior batch is rejected.
	BHT	BHT06	Transaction Type Code	<Claim Identifier>. "'RP" (Reporting) for Encounters.
1000A			**Loop – Submitter Name**	
1000A	**NM1**		**Segment – Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000A	NM1	NM109	Identification Code	<Submitter Identifier> Use the FTS ID (Formerly the DEG ID). This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>
1000B			**Loop – Receiver Name**	
1000B	**NM1**		**Segment – Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name> "Michigan Department of Health and Human Services" or "MDHHS".
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDHHS.
2000A			**Loop – Billing Provider Hierarchical Level**	

2000A	**PRV**		**Segment – Billing Provider Specialty Information**	
2000A	PRV	PRV01	Provider Code	"BI" (Billing)
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2000B			**Loop – Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment – Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"P" if MDHHS is the only payer (patient has no Medicare or other insurance). HIDE- SNPs: “S” as all MICH beneficiaries are dual eligible
2000B	SBR	SBR09	Claim Filing Indicator Code	“MC” (Medicaid) “TV” (Title V) for CSHCS “OF” (Other Federal) for MIChild “11” (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. HIDE-SNPs: “16” Health Maintenance Organization (HMO) Medicare Risk If recipient qualifies for more than one program, or other MDHHS program not listed, use “MC” (Medicaid).
2010BA			**Loop – Subscriber Name**	
2010BA	**NM1**		**Segment – Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> 10-digit beneficiary ID number assigned by MDHHS. MIChild plans:

				1) Use the Client Identification Number (CIN) with a value of 'D00111-MIChild' in 2100A Loop NM109 for dates prior to January 1, 2016; and 2) Use the CHAMPS Beneficiary Identification Number with a value of 'D00111' in 2100A Loop NM109 for dates on or after January 1, 2016.
2010BB			**Loop – Payer Name**	
2010BB	**NM1**		**Segment – Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDHHS.
2000C			**Loop – Patient Hierarchical Level**	**MDHHS business rules require that the patient is always the subscriber. Therefore, MDHHS does not expect health plans to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set. Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**
2300			**Loop – Claim information**	**Note that the HIPAA mandated implementation guide allows a maximum of 5000 repetitions of the Loop - 2300 Claim Information 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**		**Segment – Claim information**	
2300	CLM	CLM01	Plan Internal Claim Number	<Patient Control Number> Must be the same as 2330B REF02. This number should match what is sent back to providers on their 835 in CLP07.
2300	CLM	CLM05-1	Facility Code Value	<Facility Type Code> First 2 digits of Type of Bill.
2300	CLM	CLM05-3	Claim Frequency Type Code	<Claim Frequency Code> "1" on original encounter submissions "7" for encounter replacement/adjustment "8" for encounter void/cancel For both "7" and "8", include the original Encounter

				Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number).
2300	**DTP**		**Segment – Discharge Hour**	**MDHHS requires the discharge hour on all final inpatient encounters.**
2300	DTP	DTP01	Date/Time Qualifier	<Date Time Qualifier> “096” (Discharge)
2300	DTP	DTP02	Date Time Period Format Qualifier	“TM” (Time expressed in HHMM format)
2300	DTP	DTP03	Date Time Period	<Discharge Time>
2300	**DTP**		**Segment – Statement Dates**	
2300	DTP	DTP01	Date/Time Qualifier	<Date Time Qualifier> “434” (Statement)
2300	DTP	DTP02	Date Time Period Format Qualifier	“RD8” (Range of dates expressed in CCYYMMDD-CCYYMMDD format) Use RD8 to indicate the from and through date, if the encounter is for a single date the from and through date are the same. On inpatient encounters the to date should be reflective of the discharge date. The length of stay must equal the total number of days reported with revenue codes 010X-021X.
2300	DTP	DTP03	Date Time Period	<Statement From and To Date>
2300	**DTP**		**Segment – Admission Date/Hour**	**MDHHS requires the admission date to be reported on all inpatient encounters.**
2300	DTP	DTP01	Date/Time Qualifier	<Date Time Qualifier> “435” (Admission)
2300	DTP	DTP02	Date Time Period Format Qualifier	“D8” (Date expressed in CCYYMMDD format) “DT” (Date and time expressed in CCYYMMDDHHMM format)
2300	DTP	DTP03	Date Time Period	<Admission Date and Hour>
2300	**DTP**		**Segment – Repricer Received Date**	**MDHHS requires the date the plan received the claim from the provider to be reported on all encounters.**
2300	DTP	DTP01	Date/Time Qualifier	“050” (Received)
2300	DTP	DTP02	Date Time Period Format Qualifier	“D8” (Date expressed in CCYYMMDD format)

2300	DTP	DTP03	Date Time Period	<Repricer Received Date> MDHHS expects this to correlate to the date the health plan received the clean claim from their provider.
2300	**PWK**		**Segment – Claim Supplemental Information**	**MDHHS requires the use of this segment to report how the plan received their claim from the provider. (ex: electronic, paper, direct data entry)**
2300	PWK	PWK01	Report Type Code	<Attachment Report Type Code> "OZ" (Support Data for Claim)
2300	PWK	PWK02	Report Transmission Code	<Attachment Transmission Code> "BM" (By Mail) This value should be used when the provider submitted the claim to the plan via paper. "EL" (Electronically Only) This value should be used when the provider submitted the claim to the plan electronically via 837. "EM" (E-Mail) This value should be reported if you received the claim via email. "FT" (File Transfer) This value should be reported if you received the claim via file transfer. "FX" (By Fax) This value should be reported if you received the claim via fax.
2300	PWK	PWK05	Identification Code Qualifier	"AC" (Attachment Control Number)
2300	PWK	PWK06	Identification Code	MDHHS expects plans to report the descriptions below that correlate to the code sent in PWK02: Submit "Paper" when PWK02 is "BM" Submit "Electronic" or "Direct Data Entry" when PWK02 is "EL" or "FT". The text submitted should reflect how the claim was received. Sumit "Email" when PWK02 is "EM" Submit "Fax" when PWK02 is "FX"
2300	**CN1**		**Segment – Contract Information**	
2300	CN1	CN101	Contract Type Code	MDHHS requires this data element for encounters. Use "09" Other if none of the codes listed below defined in the x12 guide are applicable.

				“01” Diagnosis Related Group (DRG) “02” Per Diem “03” Variable Per Diem “04” Flat “05” Capitated “06” Percent
2300	CN1	CN102	Monetary Amount	<Contract Amount> Associated monetary amount paid or denied by the health plan.
2300	CN1	CN104	Reference Identification	<Contract Code> “P” – must be reported if the encounter is considered a paid encounter by the health plan. “D” – must be reported if the encounter is considered a denied encounter by the health plan.
2300	**REF**		**Segment – Claim Identifier for Transmission Intermediaries**	
2300	REF	REF01	Reference Identification Qualifier	“D9” – Claim Number
2300	REF	REF02	Reference Identification	<Value Added Network Trace Number> This data element should represent the provider’s claim number. Please submit the unique provider claim number that is submitted to you in theCLM01 of the provider’s 837 claim file. If the claim number is greater than the allowed 20 characters, please include the first 20 characters of the claim number in this field.
2300	**HI**		**Segment – Diagnosis Related Group (DRG) Information**	**MDHHS considers this field situational. If not required by the HIPAA 005010X223 837I implementation guide do not send.**
2300	HI	HI01-1	Code List Qualifier Code	“DR” (Diagnosis Related Group)
2300	HI	HI01-2	Industry Code	Submit the All Patient Refined (APR) Diagnosis Related Group (DRG) Code used for reimbursement. HIDE-SNPs: Submit the All Patient Refined (APR) Diagnosis Related Group (DRG) Code or the Medicare Severe (MS) DRG. MDHHS expects to see the DRG which is being used for reimbursement.

2300	**HI**		**Segment – Occurrence Information**	**MDHHS considers this field situational. However, occurrence codes are required on certain nursing facility encounters when Medicare is the primary payer.**
2300	HI	HI01-1	Code List Qualifier Code	"BH" Occurrence
2300	HI	HI01-2	Industry Code	<Occurrence Code> When Medicare non-covered days are reported because Medicare benefits are exhausted, Occurrence Code A3 and the date benefits were exhausted must be reported. **Occurrence code 70 is waived for MICH program**.
2300	HI	HI01-3	Date Time Period Format Qualifier	"D8" Date expressed in format CCYYMMDD
2300	HI	HI01-4	Date Time Period	<Occurrence Code Date>
2300	**HI**		**Segment – Value Information**	**MDHHS considers this field situational. However, value codes are required to be reported on nursing facility encounters when Medicare is the primary payer.**
2300	HI	HI01-1	Code List Qualifier Code	"BE" Value
2300	HI	HI01-2	Industry Code	<Value Code> Covered days must be reported using Value Code 80. Non-covered days must be reported using Value Code 81. Medicare coinsurance days must be reported using Value Code 82.
2300	HI	HI01-5	Monetary Amount	<Value Code Amount>
2310A			**Loop – Attending Provider Name**	
2310A	**PRV**		**Segment – Attending Provider Specialty Information**	
2310A	PRV	PRV01	Provider Code	"AT" (Attending)
2310A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to identify the provider specialty.

2310B			**Loop – Operating Physician Name**	**MDHHS requires an operating physician when revenue codes 036x are billed on the claim.**
2310B	NM1		**Segment – Operating Physician Name**	
2310B	NM1	NM101	Entity Identifier Code	"72" (Operating Physician)
2310B	NM1	NM102	Entity Type Qualifier	"1" (Person)
2310B	NM1	NM103	Name Last or Organization Name	<Operating Physician Last Name>
2310B	NM1	NM104	Name First	<Operating Physician First Name>
2310E			**Loop – Service Facility Location Name**	
2310E	**NM1**		**Segment – Service Facility Location Name**	**Required when the service facility location is different than that reported in loop 2010AA (Billing provider)**
2310E	NM1	NM101	Entity Identifier Code	"77" (Service Location)
2310E	NM1	NM102	Entity Type Qualifier	"2" (Non-Person Entity)
2310E	NM1	NM103	Name Last or Organization Name	<Laboratory or Facility Name>
2310E	NM1	NM108	Identification Code Qualifier	Required when the service location has an NPI and is not associated with the billing provider entity. "XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2310E	NM1	NM109	Identification Code	<Laboratory or Facility Primary Identifier> Report the Service Facility NPI
2310E	**N3**		**Segment – Service Facility Location Address**	
2310E	N3	N301	Address Information	<Laboratory or Facility Address Line>
2310E	N3	N302	Address Information	<Laboratory or Facility Address Line> Required when there is a second address line. Apt, Suite, etc.
2310E	**N4**		**Segment – Service Facility Location City, State, ZIP Code**	
2310E	N4	N401	City Name	<Laboratory or Facility City Name>
2310E	N4	N402	State or Province Code	<Laboratory or Facility State or Province Code>

2310E	N4	N403	Postal Code	<Laboratory or Facility Postal Zone or Zip Code> When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.
2320			**Loop – Other Subscriber Information**	**MDHHS does require the health plan to report Loop – 2320 Other Subscriber Information. The health plan (MHPs, County Health Plans, MIChild, HIDE-SNP) will be identified as a payer in Loop - 2330B Other Payer Name. The information reported in this iteration of Loop - 2320 is specific to the subscriber's coverage through the health plan. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name.**
2320	**SBR**		**Segment – Other Subscriber Information**	
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	If the patient has other insurance, report Primary payer coverage with code "P" and any other insurance with codes "S" or "T", as appropriate, for Secondary or Tertiary. If the patient has no other insurance, report the health plan coverage with "P". For HIDE-SNP beneficiaries, there will be at least two iterations of this loop: one with Medicare (generally "P"), one with Medicaid (generally "T"). If the patient has other insurance besides the Medicare and Medicaid benefits, then assign Other Insurance codes "P", "T", or "A" as appropriate.
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber's group number (assigned by the health plan or the other payer), not the number that uniquely identifies the subscriber.
2320	SBR	SBR09	Claim Filing Indicator Code	"MC" (Medicaid) "TV" (Title V) for CSHCS

				"OF" (Other Federal) for MIChild "11" (Other Non-Federal) for State Medical Plan or for persons not enrolled in Medicaid. "MA" or "MB" for Medicare as appropriate (Cannot be applied to the 2330B loop with the CHAMPS-assigned Plan ID) If recipient qualifies for more than one program, or other MDHHS program not listed, use "MC" (Medicaid).
2320	**CAS**		**Segment – Claim Level Adjustments**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**
2320	**AMT**		**Segment – Coordination of Benefits (COB) Payer Paid Amount**	**MDHHS requires the payer paid amount on all encounters.**
2320	AMT	AMT01	Amount Qualifier Code	"D" (Payer Amount Paid)
2320	AMT	AMT02	Monetary Amount	<Payer Paid Amount> Report the amount that the health plan paid. "0" is an acceptable amount.
2330A			**Loop – Other Subscriber Name**	**Loop - 2330A Other Subscriber Name, segment NM1 is required for all encounters. The subscriber information reported is specific/related to the health plan and/or any other additional other payer information submitted on Loop - 2330B Other Payer Name.**
2330A	**NM1**		**Segment – Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> 10-digit beneficiary ID number assigned by MDHHS. MIChild plans: 1) Use the Client Identification Number (CIN) with a value of 'D00111-MIChild' in 2100A Loop NM109 for dates prior to January 1, 2016; and 2) Use the CHAMPS Beneficiary Identification Number with a value of 'D00111' in 2100A Loop NM109 for dates on or after January 1, 2016.

				This element is intended to report the unique member number assigned by the health plan or other payer.
2330B			**Loop – Other Payer Name**	**Loop - 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the health plan (MHPs, County Health Plans, MIChild, HIDE-SNPs) is required to report themselves as an Other Payer.** **In the event that there are other payers identified as having financial responsibility for the services being reported, the** **health plan would report them in subsequent iterations of Loop - 2330B.**
2330B	**NM1**		**Segment – Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification).
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> For health plans use the CHAMPS provider ID assigned by MDHHS. For Medicare, use the plan ID assigned by CMS that begins with "H". For Other payers use the payer ID submitted on the claim.
2330B	**REF**		**Segment – Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"'F8" (Original Reference Number)
2330B	REF	REF02	Reference Identification	<Payer Claim Control Number> For encounters, MDHHS requires a unique Encounter Reference Number (ERN) to always be submitted. For the health plan, enter the plan assigned unique identifier Encounter Reference Number (ERN) for the encounter. Include the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a

				replacement or void. This value must be equal to the value in Loop 2300 CLM01.
2400			**Loop –Service Line Number**	**Note that the HIPAA mandated implementation guide allows a maximum of 999 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV2**		**Segment – Institutional Service**	
2400	SV2	SV203	Monetary Amount	<Line Item Charge Amount> MDHHS requires the provider's usual and customary charge or billed amount. Zero (0) is a valid amount if: 1) The health plan has a sub-capitated contract arrangement with the provider as designated in Loop - 2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop - 2400 Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or 2) The service(s) is/are recognized by MDHHS as having no associated charge(s), for example, vaccines.
2400	**DTP**		**Segment – Service Date**	
2400	DTP	DTP01	Date/Time Qualifier	<Date Time Qualifier> "472" (Service)
2400	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format) "RD8" (Range of dates expressed in CCYYMMDD-CCYYMMDD format) RD8 is required when the to and from dates are different.
2400	DTP	DTP03	Date Time Period	<Service Date>

2430			**Loop – Line Adjudication Information**	**MDHHS requires this loop for each payer identified in Loop - 2320 Other Subscriber Information, except when that payer has adjudicated this claim at the claim level only.**
2430	**SVD**		**Segment – Line Adjudication Information**	
2430	SVD	SVD05	Quantity – Paid Service Unit Count	MDHHS requires paid units be submitted in the SVD05 data element. If a claim line is denied SVD05 should be 0. If a claim line is bundled, billed units should be submitted in SVD05.
2430	SVD	SVD06	Assigned Number	MDHHS requires SVD06 when the service has been bundled. This data element should contain the line number that the service was bundled into.
2430	**CAS**		**Segment – Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC x12N/005010X224 837D (Dental)

Applicable to Medicaid Managed Care Programs including but not limited to CHCP, MICH, HKD, and MI Choice

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10. HIPAA 5010 ANSI ASC X12N 837D Implementation Guide

10.1 Encounter 837D - Interchange Control Header and Functional Group Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present [No Meaningful Information in ISA02])
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present [No Meaningful Information in ISA04])
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID. Use the FTS Username ID (Formerly the DEG ID), left justified, followed by spaces. This value must also appear in the GS02 data element.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"ENCOUNTER" left justified followed by spaces. This value must also appear in the GS03 data element.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID. Use the FTS Username ID (Formerly the DEG ID). This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"ENCOUNTER" for MDHHS. This value should always match ISA08 <Interchange Receiver ID>.

10.2 837D Transaction Set

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment – Transaction Set Header**	**MDHHS accepts a maximum of 5,000 CLM segments in a single transaction (ST - SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment – Beginning of Hierarchical Transaction**	
	BHT	BHT03	Reference Identification	<Originator Application Transaction Identifier> MDHHS requires this number to always be unique. This number may not be used again even if the prior batch is rejected.
	BHT	BHT06	Transaction Type Code	<Claim or Encounter Identifier> "RP" (Reporting) for encounters
1000A			**Loop – Submitter Name**	
1000A	**NM1**		**Segment – Submitter Name**	
1000A	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000A	NM1	NM109	Identification Code	<Submitter Identifier>. Use the FTS Username ID (formerly known as the DEG ID). This value should always match ISA06 <Interchange Sender ID> and GS02 <Application Sender's Code>.
1000B			**Loop – Receiver Name**	
1000B	**NM1**		**Segment – Receiver Name**	
1000B	NM1	NM103	Name Last or Organization Name	<Receiver Name> "Michigan Department of Health and Human Services" or "MDHHS"
1000B	NM1	NM108	Identification Code Qualifier	"46" (Electronic Transmitter Identification Number [ETIN] Established by trading partner agreement)
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> "D00111" for MDHHS.
2000A			**Loop – Billing Provider Hierarchical Level**	

2000A	**PRV**		**Segment – Billing Provider Specialty Information**	
2000A	PRV	PRV01	Provider Code	"BI" (Billing)
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2000A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2000B			**Loop – Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment – Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	"P" if MDHHS is the only payer (patient has no Medicare or other insurance). HIDE-SNP: “S” as all beneficiaries are dual eligible
2000B	SBR	SBR04	Name	<Subscriber Group Name> Use “MICHILD” for children enrolled in the MIChild Program. Use “MEDICAID” for Healthy Michigan
2000B	SBR	SBR09	Claim Filing Indicator Code	“MC” (Medicaid or Healthy Michigan) “TV” (Title V) for CSHCS “OF” (Other Federal) for MIChild HIDE SNP: “16” Health Maintenance Organization (HMO) Medicare Risk If recipient qualifies for more than one program, or other MDHHS program is not listed, use “MC” (Medicaid).
2010BA			**Loop – Subscriber Name**	
2010BA	**NM1**		**Segment – Subscriber Name**	
2010BA	NM1	NM108	Identification Code Qualifier	“MI” (Member Identification Number).
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> 10-digit beneficiary ID number assigned by MDHHS. MIChild enrollees: 1) Use the Client Identification Number (CIN) for dates prior to January 1, 2016; and

				2) Use the CHAMPS Beneficiary Identification Number for dates on or after January 1, 2016.
2010BB			**Loop – Payer Name**	
2010BB	**NM1**		**Segment – Payer Name**	
2010BB	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2010BB	NM1	NM109	Identification Code	<Payer Identifier> "D00111" for MDHHS
2000C			**Loop – Patient Hierarchical Level**	**MDHHS business rules require that the patient is always the subscriber. Therefore, MDHHS does not expect dental plans to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set. Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**
2300			**Loop – Claim Information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 repetitions of the Loop - 2300 Claim Information 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**		**Segment – Claim Information**	
2300	CLM	CLM*01	Claim Submitter's Identifier	<Patient Control Number> Must be the same as 2330B REF02. This number should match what is sent back to providers on their 835 in CLP07.
2300	CLM	CLM5-3	Claim Frequency Type Code	<Claim Frequency Code> "1" on original encounter submissions "7" for encounter replacement "8" for encounter void/cancel For both "7" and "8", include the original Encounter Reference Number (ERN), as indicated in Loop - 2330B REF02 (Other Payer Claim Control Number).
2300	**DTP**		**Segment – Repricer Received Date**	**MDHHS requires the date the plan received the claim from the provider to be reported on all encounters.**
2300	DTP	DTP01	Date/Time Qualifier	"050" (Received)
2300	DTP	DTP02	Date Time Period Format Qualifier	"D8" (Date expressed in CCYYMMDD format)

2300	DTP	DTP03	Date Time Period	<Repricer Received Date> MDHHS expects this to correlate to the date the health plan received the clean claim from their provider.
2300	**PWK**		**Segment – Claim Supplemental Information**	**MDHHS requires the use of this segment to report how the plan received their claim from the provider. (ex: electronic, paper, direct data entry)**
2300	PWK	PWK01	Report Type Code	<Attachment Report Type Code> "OZ" (Support Data for Claim)
2300	PWK	PWK02	Report Transmission Code	<Attachment Transmission Code> "BM" (By Mail) This value should be used when the provider submitted the claim to the plan via paper. "EL" (Electronically Only) This value should be used when the provider submitted the claim to the plan electronically via 837. "EM" (E-Mail) This value should be reported if you received the claim via email. "FT" (File Transfer) This value should be reported if you received the claim via file transfer. "FX" (By Fax) This value should be reported if you received the claim via fax.
2300	PWK	PWK05	Identification Code Qualifier	"AC" (Attachment Control Number)
2300	PWK	PWK06	Identification Code	MDHHS expects plans to report the descriptions below that correlate to the code sent in PWK02: Submit "Paper" when PWK02 is "BM" Submit "Electronic" or "Direct Data Entry" when PWK02 is "EL" or "FT". The text submitted should reflect how the claim was received. Sumit "Email" when PWK02 is "EM" Submit "Fax" when PWK02 is "FX"
2300	**CN1**		**Segment – Contract Information**	
2300	CN1	CN101	Contract Type Code	MDHHS requires this data element for encounters. Use "09" Other if none of the codes listed below defined in the x12 guide are applicable. "01" Diagnosis Related Group (DRG) "02" Per Diem

				“03” Variable Per Diem “04” Flat “05” Capitated “06” Percent
2300	CN1	CN102	Monetary Amount	<Contract Amount> Associated monetary amount paid or denied by the health plan.
2300	CN1	CN104	Reference Identification	<Contract Code> “P” – must be reported if the encounter is considered a paid encounter by the health plan. “D” – must be reported if the encounter is considered a denied encounter by the health plan.
2310B	**NM1**		**Segment – Rendering Provider Name**	**Required when the rendering provider information is different than loop 2010AA (billing provider)**
2310B	NM1	NM101	Entity Identifier Code	“82” (Rendering Provider)
2310B	NM1	NM102	Entity Type Qualifier	“1” (Person) “2” (Non-Person Entity)
2310B	NM1	NM103	Name Last or Organization Name	<Rendering Provider Last or Organization Name>
2310B	NM1	NM104	Name First	<Rendering Provider First Name> Required when NM102 = “1”
2310B	NM1	NM105	Name Middle	<Rendering Provider Middle Name or Initial> For out of state providers submit “OS”
2310B	NM1	NM108	Identification Code Qualifier	“XX” (Centers for Medicare and Medicaid Services National Provider Identifier)
2310B	NM1	NM109	Identification Code	<Rendering Provider Identifier> Provider NPI
2310B	**PRV**		**Segment – Rendering Provider Specialty Information**	
2310B	PRV	PRV01	Provider Code	"PE" (Performing)

2310B	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2310B	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.
2310C			**Loop – Service Facility Location Name**	
2310C	**NM1**		**Segment – Service Facility Location Name**	**Required when the service facility location is different than that reported in loop 2010AA (Billing provider)**
2310C	NM1	NM101	Entity Identifier Code	"77" (Service Location)
2310C	NM1	NM102	Entity Type Qualifier	"2" (Non-Person Entity)
2310C	NM1	NM103	Name Last or Organization Name	<Laboratory or Facility Name>
2310C	NM1	NM108	Identification Code Qualifier	Required when the service location has an NPI and is not associated with the billing provider entity. "XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2310C	NM1	NM109	Identification Code	<Laboratory or Facility Primary Identifier> Report the Service Facility NPI
2310C	**N3**		**Segment – Service Facility Location Address**	
2310C	N3	N301	Address Information	<Laboratory or Facility Address Line>
2310C	N3	N302	Address Information	<Laboratory or Facility Address Line> Required when there is a second address line. Apt, Suite, etc.
2310C	**N4**		**Segment – Service Facility Location City, State, ZIP Code**	
2310C	N4	N401	City Name	<Laboratory or Facility City Name>
2310C	N4	N402	State or Province Code	<Laboratory or Facility State or Province Code>
2310C	N4	N403	Postal Code	<Laboratory or Facility Postal Zone or Zip Code> When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided.
2320			**Loop – Other Subscriber Information**	**MDHHS does require the dental plan to report Loop - 2320 Other Subscriber Information. The dental plan (Healthy Kids, MIChild or Healthy Michigan) will be identified as a payer in Loop - 2330B Other Payer Name. The information**

				reported in this iteration of Loop - 2320 is specific to the subscriber's coverage through the dental plan. Other payers such as Medicare or other commercial carriers are reported in additional iterations of this loop. In the event of additional payers, Loop - 2320 Other Subscriber Information would be repeated and would be specific to its respective Loop - 2330B Other Payer Name.
2320	**SBR**		**Segment – Other Subscriber Information**	
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	If the patient has other insurance, report Primary payer coverage with code "P" and any other insurance with codes "S" or "T", as appropriate, for Secondary or Tertiary. If the patient has no other insurance, report the dental plan coverage with "P". For HIDE-SNP beneficiaries, there will be at least two iterations of this loop: one with Medicare (generally "P"), one with Medicaid (generally "T"). If the patient has other insurance besides the Medicare and Medicaid benefits, then assign Other Insurance codes "P", "T", or "A" as appropriate.
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber.
2320	SBR	SBR09	Claim Filing Indicator Code	"MC" (Medicaid or Healthy Michigan) "TV" (Title V) for CSHCS "OF" (Other Federal) for MIChild "MA" or "MB" for Medicare as appropriate (Cannot be applied to the 2330B loop with the CHAMPS-assigned PlanID) If recipient qualifies for more than one program, or other MDHHS program not listed, use "MC" (Medicaid).
2320	**CAS**		**Segment – Claim Level Adjustments**	**MDHHS requires all COB adjudication to be submitted in the service line level Loop - 2430 Segment CAS - Line Adjustment.**

2320	**AMT**		**Segment – Coordination of Benefits (COB) Payer Paid Amount**	**MDHHS requires the payer paid amount on all encounters.**
2320	AMT	AMT01	Amount Qualifier Code	"D" (Payer Amount Paid)
2320	AMT	AMT02	Monetary Amount	<Payer Paid Amount> Report the amount that the health plan paid. "0" is an acceptable amount.
2330A			**Loop – Other Subscriber Name**	**Loop - 2330A Other Subscriber Name, segment NM1 is required for all encounters. The subscriber information reported is specific/related to the dental plan and/or any other additional other payer information submitted on Loop - 2330B Other Payer Name.**
2330A	**NM1**		**Segment – Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> 10-digit beneficiary ID number assigned by MDHHS MICHILD Enrollees: 1) Use the Client Identification Number (CIN) for dates prior to January 1, 2016 and 2) Use the CHAMPS Beneficiary Identification Number for dates on or after January 1, 2016. When reporting TPL, this element is intended to report the unique member identifier assigned by the other payer.
2330B			**Loop – Other payer Name**	**Loop – 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the dental plan (Healthy Kids, MIChild, etc.) is required to report themselves as an Other Payer. In the event that there are other payers identified as having financial responsibility for the services being reported, the dental plan would report them in subsequent iterations of Loop – 2330B,**
2330B	**NM1**		**Segment – Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)

2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> For dental plans use the CHAMPS provider ID assigned by MDHHS. For Medicare, use the plan ID assigned by CMS that begins with “H” For Other payers use the payer ID submitted on the claim.
2330B	**REF**		**Segment – Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"'F8" (Original Reference Number)
2330B	REF	REF02	Reference Identification	<Payer Claim Control Number> For encounters, MDHHS requires a unique Encounter Reference Number (ERN) to always be submitted. For the dental plan, enter the plan-assigned unique identifier Encounter Reference Number (ERN) for the encounter. Include the Encounter Reference Number (ERN) of the previously adjudicated encounter when CLM05-3 <Claim Frequency Code> indicates this encounter is a replacement or void.
2400			**Loop – Service Line Counter**	**Note that the HIPAA mandated implementation guide allows a maximum of 50 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**SV3**		**Segment – Dental Service**	
2400	SV3	SV302	Monetary Amount	<Line Item Charge Amount> MDHHS requires the provider’s usual and customary charge or billed amount. Zero (0) is a valid amount if: 1) The health plan has a subcapitated contract arrangement with the provider as designated in Loop - 2300 Claim Information, Segment CN1, CN101 (Contract Type Code) or Loop - 2400 Service Line Number, Segment CN1, CN101 (Contract Type Code) and the contract permits zero as a charged amount, or

				2) The service(s) is/are recognized by MDHHS as having no associated charge(s), for example, vaccines.
2400	**DTP**		**Date – Service Date**	
2400	DTP	DTP03	Date Time Period	<Service Date> MDHHS requires service date on every service line.
2400	**CN1**		**Segment – Contract Information**	
2400	CN1	CN101	Contract Type Code	Use “09” Other if none of the codes listed below defined in the x12 guide are applicable. “01” Diagnosis Related Group (DRG) “02” Per Diem “03” Variable Per Diem “04” Flat “05” Capitated “06” Percent
2400	CN1	CN102	Monetary Amount	<Contract Amount> Associated monetary amount paid or denied by the health plan.
2400	CN1	CN104	Reference Identification	<Contract Code> “P” (Paid) must be reported if the encounter is considered a paid encounter by the health plan. “D” (Denied) must be reported if the encounter is considered a denied encounter by the health plan.
2420A			**Loop – Rendering Provider Name**	
2420A	**PRV**		**Segment – Rendering Provider Specialty Information**	
2420A	PRV	PRV01	Provider Code	“PE” (Performing)
2420A	PRV	PRV02	Reference Identification Qualifier	“PXC” (Health Care Provider Taxonomy Code)
2420A	PRV	PRV03	Reference Identification	<Provider Taxonomy Code> MDHHS requires taxonomy code to always be submitted to identify the provider specialty.

2430			**Loop – Line Adjudication Information**	
2430	**SVD**		**Segment – Line Adjudication Information**	**MDHHS expects this loop to be populated for each payer identified in Loop - 2320 (Other Subscriber Information).**
2430	SVD	SVD02	Monetary Amount	<Service Line Paid Amount >MDHHS requires the amount the dental health plan paid the provider for the service(s) reported. A value of zero "0" may be reported.
2430	**SVD**		**Segment – Line Adjudication Information**	
2430	SVD	SVD05	Quantity – Paid Service Unit Count	MDHHS requires paid units be submitted in the SVD05 data element. If a claim line is denied SVD05 should be 0. If a claim line is bundled, billed units should be submitted in SVD05.
2430	SVD	SVD06	Assigned Number	MDHHS requires SVD06 when the service has been bundled. This data element should contain the line number that the service was bundled into.
2430	**CAS**		**Segment - Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer adjudication information.**

11. Revision Log

Version Date	Effective Date	Revision Description
February 23, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide For the HIPAA 837 Professional Encounter Addenda Version 4010A1 Medicaid Health Plans (MHPs), County Health Plans and MIChild Health Plans,* dated February 5, 2010.
November 30, 2011	January 1, 2012	This document includes changes identified as part of business to business testing and reflects the 5010 implementation effective January 1, 2012. Updated location and link for Electronic Submitter's Guide.
April 22, 2014	April 22, 2014	Updated to include MIChoice Health Plans and location and link for Electronic Submitter's Guide.
December 1, 2014	December 1, 2014	1. Updated references to current health plans. 2. Updated the link to the Electronic Submissions Manual. 3. Added NEMT and Healthy Michigan plan references and removed ABW plan references. 4. Updated the HIPAA maximum to 50 repetitions of the Loop - 2300 Claim Information within each Loop - 2000B Subscriber Hierarchical Level. 5. Updated the HIPAA maximum from 50 to 99 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.
January 1, 2016	January 1, 2016	Updated rules for MIChild and other minor rule changes.
May 10, 2024	June 28, 2024	Updated MDHHS requirements as it relates to the SVD05 data element and paid units.
March 12, 2025		Updated guide to reflect where an atypical provider ID would be reported if submitted.
June 23, 2025	January 1, 2026	Combined all program companion guides into one. Added data elements to better outline MDHHS expectations. (2300*DTP, 2300*CN1, 2300*K3, 2310B*NM1, 2310C*NM1, 2310C*N3, 2320*AMT, 2400*DTP, 2400*CN1)
July 23, 2025	January 1, 2026	In the dental invoice guide moved the 2400 CN1 loop and segment information to the correct spot below the DTP segments.
September 02, 2025	January 1, 2026	Updated MDHHS comments in the 837P 2400 loop, NTE*02 segment to clearly outline where to find the 4-digit codes to be reported in this segment on waiver services for the MICH program. Removed K3 segment from all invoice types as this will not be required to be submitted effective 1/1/2026. This implementation has been pushed back to at least

		4/1/2026. Updated 2400 loop SV3 segment as this incorrectly stated “SV1” which does not exist in 837D.
October 03, 2025	January 1, 2026	Added HI Occurrence information and HI Value Information to 2300 loop of the institutional guide. This is to clarify that we expect these values on nursing facility encounters. Please reference section 8.17 of the Billing & Reimbursement for Institutional Providers in the Medicaid Provider Manual for guidance. Added 2300 loop REF*D9 requirement on all invoice types P, I, D. Added 2310C loop N4 segment clarification on the professional and dental guides. Added 2310E loop N4 segment clarification on the institutional and dental guides. Added clarification to the CLM*01 segment 2300 loop of all invoice types that this should match the number returned to providers on their 835.
October 22, 2025	January 1, 2026	Removed 2300 loop REF*D9 from dental invoice.
January 7, 2026	April 1, 2026	Added loop 2300 DTP*050 to capture the date plans received the claim from their providers. Added clarification to the REF*D9 guidance when the claim number is greater than 20 characters.
February 24, 2026	April 1, 2026	Re-added DRG clarification in loop 2300 HI of 837I. This was removed from the previous version in error.
March 17, 2026	June 1, 2026	Added PWK segment to all invoice types to clarify MDHHS requirement to report the mode of claim submission from providers to plans.
March 19, 2026	June 1, 2026	Updated professional invoice Loop 2400 to state a “maximum of 50 lines” as this is the line maximum on professional invoices. Moved 2430 CAS segment below SVD segment for all invoice types.
April 22, 2026	June 1, 2026	Removed “AA” from PWK02 and clarified what should be submitted in PWK06 when the claim was submitted via direct data entry.
July 27, 2026	December 1, 2014	Updated dental invoice Loop 2400 to state a “maximum of 50 lines” as this is the line maximum on dental invoices.