Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC X12N 837D

Dental Encounter

Dental Health Plans and Healthy Michigan Dental

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Effective January 1, 2016

MDHHS Michigan Department of Health & Human Services

MSA MEDICAL SERVICES ADMINISTRATION

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 MDHHS website at: michigan.gov/tradingpartners

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1. Introduction

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).

This document is intended as a companion to the 005010X224 • 837-D Health Care Claim: Dental Implementation Guide dated June 2006. This document also includes updates appearing in:

- Errata 005010X224A1 • 837D Health Care Claim: Dental dated October 2007
- Errata 005010X224E1 • 837D Health Care Claim: Dental dated January 2009
- Errata 005010X224A2 • 837D Health Care Claim: Dental dated June 2010

The 5010 Implementation Guide and related Errata documents can be purchased from the Washington Publishing Company web site at: www.wpc-edi.com/content/view/817/1

1.1 Scope

This document is expected to be used in conjunction with the Implementation Guide and related Errata for the 837D transaction set. 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.

This document provides MDHHS-specific instructions regarding certain elements within the Implementation Guide 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 Overview

This Companion Guide is intended for use in the electronic submission of health care Encounter transactions. Please refer to the MDHHS website for the Companion Guide supporting the submission of health care Fee-For-Service claims. Claims and Encounters cannot be sent on the same 837 Transaction file.

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

- Interaction with the MDHHS File Transfer Service (FTS), formerly known as the Data Exchange Gateway (DEG)
- Modes of submission (SSL FTP, or HTTPS)
- Interchange Acknowledgement (TA1) transaction
- Interchange Acknowledgement (999) transaction

1.3 References

In order to successfully download HIPAA transactions from the CHAMPS system, it is necessary to comply with the information contained in the MDHHS Electronic Submissions Manual. The most current version of this manual can be downloaded from the MDHHS web site at the following location:

michigan.gov/tradingpartners >> HIPAA Companion Guides >> Electronic Submissions Manual

The following reference document will help you perform testing of your encounters with MDHHS:

- ICD-10 837 Test Instructions Encounters, available at: michigan.gov/tradingpartners >> HIPAA ICD-10 >> Testing >> Business-to-Business (B2B) Testing >> 2) CHAMPS ICD-10 B2B Testing

This document provides testing instructions for Billing Agents (e.g., Health Plans) who send 837 encounter transactions to MDHHS. This document includes instructions on ICD-10 testing as well as instructions to be used by prospective Billing Agents seeking approval for production encounter submission to MDHHS.

1.4 Transaction Description

The ANSI ASC X12N 837D is used to submit dental health care encounter information from providers of health care services to payers, including managed care organizations. This transaction can be submitted either directly or via intermediary billing services and/or claims clearinghouses.

1.5 General Information

All alpha characters must be in UPPER CASE.

Claims and 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.

Effective January 1, 2016, MIChild beneficiary encounters and inquiries must use the Medicaid (CHAMPS) Beneficiary Identification Number, rather than the previous Client Identification Number (CIN); refer to MDHHS Medicaid Bulletin MSA 15-51.

2. Getting Started

2.1 Working with MDHHS

An entity (Provider, billing agent, clearinghouse, etc.) who wishes to submit transactions or 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:

michigan.gov/tradingpartners >> Electronic Submissions Transactions >> How to Enroll

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. Please note that the rates included in the ICD-10 B2B Test system may vary from the actual rates used in the production CHAMPS claims-payment 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 ICD-10 B2B Testing.

2.2.2 CHAMPS ICD-10 B2B Testing

Providers and Trading Partners may test claims and encounters using the CHAMPS ICD-10 B2B Test environment. Test claim adjudication reports, encounter processing reports and 835 remittance advice transactions 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 References*).
More information on testing is available at:

michigan.gov/tradingpartners >> HIPAA ICD-10 >> Testing

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

4.1 System Availability

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 Biller “B” Aware page at the following location:

michigan.gov/tradingpartners >> Communications and Training >> Medicaid Alerts >> Biller "B" Aware

4.2 Process Flows

MDHHS supports batch submission for ANSI ASC X12N 837D transactions.

4.3 Transmission Administrative Procedures

4.3.1 Structure Requirements

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

4.3.2 Response Times

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

4.3.3 Interchange Acknowledgements

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

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

4.4 Communication Protocols

Please see the Electronic Submissions Manual for information on using communication protocols (see: *Section 1.3 References*).

5. Contacts

EDI Services	EDI Services handles all issues and questions related to the FTS (formerly known as the DEG) or files exchanged with CHAMPS.
	Website: michigan.gov/tradingpartners
	Email: AutomatedBilling@michigan.gov
Provider Support Unit	The Provider Support Unit handles all billing questions related to the 837 and questions regarding provider and billing agent enrollment.
	Website: michigan.gov/tradingpartners >> Communications and Training >> Health Care Providers >> CHAMPS
	Provider Support Line: 1-800-292-2550
	Email: ProviderSupport@michigan.gov

6. Control Segments / Envelopes

This document uses several text conventions to distinguish MDHHS data elements from the Implementation Guide data elements.

6.1 ANSI ASC X12 837D Dental Encounter Companion Guide Rules

The following table lists the text conventions used in this document:

Convention used	Explanation
< >	Text included within < > is the “Implementation Name” field from the Implementation Guide 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 HIPAA Implementation Guide description of the value in quotes, described above, is provided parenthetically.
Light yellow shading	Light yellow shading indicates items changed in this revision of the Companion Guide.

6.2 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 I02])

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Authorization Information Present [No Meaningful Information in I04])
	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 known as 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 known as 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>.

6.3 Encounter 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)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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).
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 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).

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> Dental and Healthy Michigan plans use the 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.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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	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	**CN1**		**Segment - Contract Information**	
2300	CN1	CN101	Contract Type Code	Report this data element on encounters where the dental plan contract arrangement with the provider is other than fee-for-service.
2310B	**PRV**		**Segment - Rendering Provider Specialty Information**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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.
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**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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".
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 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.**
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.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330A	**NM1**		**Segment - Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number)
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> This element is intended to report the unique member number assigned by the dental plan or other payer. Dental or Healthy Michigan plans use the 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.
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 or Healthy Michigan) 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.**

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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 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.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2400			**Loop - Service Line Counter**	**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	**CN1**		**Segment - Contract Information**	
2400	CN1	CN101	Contract Type Code	MDHHS requires this data element on encounters where the dental plan contract arrangement with the provider is other than fee-for-service.
2400	**DPT**		**Date - Service Date**	
2400	DPT	DPT03	Date Time Period	<Service Date>. MDHHS requires service date on every service line.
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.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
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	**CAS**		**Segment - Line Adjustment**	**MDHHS requires the providers to use the HIPAA mandated Claim Adjustment Reason Codes to report other payer 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.**

7. Michigan Medicaid Specific Business Rules and Limitations

7.1 Supported Service Types

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

8. 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.

Revision Log

Version Date	Effective Date	Revision Description
March 1, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide for the HIPAA 837 Dental Encounter Addenda Version 4010A1* dated October 26, 2009.
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.
December 1, 2014	December 1, 2014	1. Updated Plan references. 2. Updated location and link to Electronic Submissions Manual. 3. Updated the HIPAA maximum to 50 repetitions of the Loop – 2300 Claim Information within each Loop – 2000B Subscriber Hierarchical Level. 4. 4. Updated the maximum from 50 to 99 repetitions of the Loop – 2400 Service Line Number within each Loop – 2300 Claim Information. 5. Added Healthy Michigan plan references.
January 1, 2016	January 1, 2016	Updated rules for MIChild and other minor rule updates
May 10, 2024	June 28, 2024	Updated MDHHS requirements as it relates to the SVD05 data element and paid units.