
# KY Medicaid

## 837I Companion Guide

*Cabinet for Health and Family Services*
*Department for Medicaid Services*

*November 15, 2022*

Document Change Log

| Version | Changed Date | Changed By | Reason |
|---|---|---|---|
| 2.0 | 11/02/2011 | Kathy Dugan-Ellett | Removed reference to ESC in NTE segments |
| 2.1 | 1/25/2012 | Martha Senn | Inserted HI – Value code page on page 24. Final formatting for DMS approval date of 01/25/2012. |
| 2.2 | 1/27/2012 | Martha Senn | Update to DTP – Admission Date/Hour page 20 |
| 2.3 | 2/1/2012 | Martha Senn | Inserted Encounter usage for 2300B NM109 on page 30. DMS approved on 02/01/2012 final version. |
| 2.4 | 2/15/2012 | Martha Senn | Update to DTP – Admission Date/Hour was removed page 20. DMS approved 2/15/2012. |
| 2.5 | 6/1/2012 | Martha Senn | Removed NDC length requirement from LIN03 page 31 |
| 2.6 | 6/21/2012 | Martha Senn | Inserted MCO SBR clarifications in section 1.1.1 Special Considerations as #16; comment inserted at 2000B & 2320 SBR segments to reference Special Considerations. |
| 3.0 | 10/21/2012 | Kathy Dugan | Added new data elements, REF01 and REF02 in Loop 2010BB on Page 18.<br>Removed REF segment for Billing Provider Secondary Identification Number as 837I does not apply to KY Medicaid on Page 18 |
| 3.1 | 10/24/2012 | Keri Hicks | Updates |
| 3.2 | 11/16/2012 | Martha Senn | Added NTE with value of A1 for denied detail on page 32<br>Added Region ‘09’ to 2010BB REF on page 19 |
| 3.3 | 11/19/2012 | Keri Hicks | Updates |
| 3.4 | 12/5/2012 | Martha Senn | Removed blank segments 2010BB page 19 |
| 3.5 | 12/7/2012 | Keri Hicks | Updates |
| 3.6 | 11/4/2013 | Martha Senn | Rewritten to conform to the ACA required template and ASCX12 authorization guidelines. |
| 4.0 | 1/24/2014 | Martha Senn | Updates for ASCX12 authorization guidelines. |
| 4.1 | 12/24/2014 | Martha Senn | Updates for ASCX12 authorization guidelines. |
| 4.2 | 1/29/2015 | Martha Senn | Updates for ASCX12 authorization guidelines. ASCX12 approved 2/24/2015. |

| Version | Changed Date | Changed By | Reason |
|---|---|---|---|
| 4.3 | 6/17/2015 | Martha Senn | Special instructions for Hospice TOB 81 & 82<br><br>DMS approved 6/18/2015 |
| 4.4 | 10/6/2016 | Martha Senn | Removal of TOB reference<br><br>DMS approved 10/10/2016 |
| 4.5 | 2/27/2017 | Martha Senn | CO 24712 - Updates due to ORP for Referring and Attending provider segments<br><br>DMS approved 3/27/2017 |
| 4.6 | 6/18/2020 | Brianna Hicks | Removed region “03” from REF segment 2010BB |
| 4.7 | 11/24/2021 | Brianna Hicks | Updated Header Logo from Kentucky Unbridled (CO33090) |
| 4.8 | 1/11/2022 | Brianna Hicks | Updated taxonomy language under Special Considerations (CO32815) |
| 4.9 | 9/19/2022 | Brianna Hicks | Updated Header Logo from Kentucky Sunrise to Team Kentucky (CO33931) |
| 4.10 | 11/15/2022 | Brianna Hicks | Added Medicare Advantage / Part C Language (CO33961) |

# Companion Guide Version Number: FINAL 4.10

This template is Copyright © 2010 by The Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA), on behalf of the Accredited Standards Committee (ASC) X12. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided "as is" without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12. The ASC X12 TR3 that details the full requirements for this transaction is available at http://store.x12.org.

Express permission to use ASC X12 copyrighted materials has been granted.

2012 © Companion Guide copyright by KY Medicaid and Hewlett- Packard Enterprise Services

# Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

# Table of Contents

# Transaction Instruction (TI)

## 1 TI Introduction

### 1.1 Background

#### 1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

#### 1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

#### 1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

### 1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

# 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

| Unique ID | Name |
|---|---|
| 005010X223A2 | Institutional Health Care Claim (837I) |

# 3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

| Legend |
|---|
| SHADED rows represent “segments” in the X12N implementation guide. |
| NON-SHADED rows represent “data elements” in the X12N implementation guide. |

**005010X222A1 Professional Health Care Claim Transaction**

# 4 Companion Guide for the 837I Transaction

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | BHT | Beginning of Hierarchical Transaction | | |
| | BHT02 | Transaction Set Purpose Code | ‘00’ | “KY Medicaid only processes claims submitted with “00” in this element.” |
| | BHT05 | Transaction Set Creation Time | | The time format is HHMMSS |
| | BHT06 | Transaction Type Code | ‘CH’, ‘RP’, ‘HC’ or ‘MI’ | “KY Medicaid only processes claims submitted with “CH”, “RP”, “HC” or “MI” in this element.” |
| 1000A | NM1 | Submitter Level | | |
| 1000A | NM109 | Identification | | Kentucky Medicaid assigned EDI Trading Partner ID |
| 1000B | NM1 | Receiver Level | | |
| 1000B | NM103 | Name Last or Organization Name | | KYMEDICAID |
| 1000B | NM109 | Identification Code | | KYMEDICAID |
| 2000B | SBR | Subscriber Information | | |
| 2000B | SBR09 | Claim Filing Indicator | ‘MC’ | “KY Medicaid only processes claims submitted with “MC” in this element.” |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010BA | NM1 | Subscriber Level | | |
| 2010BA | NM102 | Entity Type Qualifier | '3' | "KY Medicaid requires Persons (3) to identify the entity." |
| 2010BA | NM109 | Identification Code | '10 Digit' | "Kentucky Medicaid Member Identification Number (MAID)" |
| 2010BB | NM1 | Payer Name | | |
| 2010BB | NM103 | Name Last or Organization Name | | KYMEDICAID |
| 2010BB | NM108 | Identification Code Qualifier | | "KY Medicaid requires Payor Identification (PI) to identify the entity." |
| 2010BB | NM109 | Identification Code | | KYMEDICAID |
| 2010BB | REF | Payer Secondary Identification | | |
| 2010BB | REF01 | Reference Identification Qualifier | 'FY' | "KY Medicaid requires the Claim Office Number (FY) to identify the entity."<br><br>For Encounters only |
| 2010BB | REF02 | Reference Identification | '01', '02', '04', '05', '06', '07', '08', '09', '31' | Submit the Member Region in this data element<br>For Encounters only |
| 2010BB | REF | Billing Provider Secondary Identification | | |
| 2010BB | REF01 | Reference Identification Qualifier | 'G2' | "KY Medicaid requires the Provider Commercial Number (G2) to identify the entity." |
| 2010BB | REF02 | Reference Identification | | Legacy KY Medicaid Provider ID of the Atypical provider |
| 2300 | CLM | Claim Information | | |
| 2300 | CLM07 | Provider Accept Assignment Code | 'A' | "KY Medicaid only processes claims submitted with Assigned (A) in this element." |
| 2300 | CLM08 | Benefits Assignment Certification Indicator | 'Y' | "KY Medicaid only processes claims submitted with Yes (Y) in this element." |
| 2300 | CLM09 | Release of Information Code | 'Y' | "KY Medicaid only processes claims submitted with Yes (Y) in this element." |
| 2300 | REF | Reference | | |
| 2300 | REF02 | Reference Identification Payer Claim Control Number | | FFS: Original KY Medicaid Internal Control Number (ICN)<br>MCO: Original MCO Assigned Internal Control Number |
| **Loop ID** | **Reference** | **Name** | **Codes** | **Notes/Comments** |

| | | | | |
|---|---|---|---|---|
| 2300 | HI | Value Information | | |
| 2300 | HI01-2 | Industry Code | ‘80’<br>‘82’ | Covered Days<br>Co-insurance days for Crossover Claims.<br>Value codes are necessary for inpatient & psych hospital, PRTF, nursing facilities, psych distinct part unit & rehab distinct part unit |
| 2310A | NM1 | Attending Provider Name | | |
| 2310A | NM101 | Entity Identifier Code | ‘71’ | |
| 2310A | NM108 | Identification Code Qualifier | ‘XX’ | |
| 2310A | NM109 | Identification Code | | KY Medicaid NPI number |
| 2310A | PRV | Attending Provider Specialty Information | | |
| 2310A | PRV01 | Provider Code | ‘AT’ | |
| 2310A | PRV02 | Reference Identification Qualifier | ‘PXC’ | |
| 2320 | SBR | Other Subscriber Information | | |
| 2320 | SBR09 | Claim Filing Indicator Code | CI, MA, MB, 16 | "16" Health Maintenance Organization (HMO) Medicare *Use for Medicare Advantage / Part C |
| 2320 | OI | Other Insurance Coverage Information | | |
| 2320 | OI03 | Benefits Assignment Certification Indicator | ‘Y’ | KY Medicaid only processes claims with a; Y; in this element. |
| 2320 | OI06 | Release of Information Code | ‘Y’ | KY Medicaid only processes claims with a ;Y; in this element |
| 2310F | NM1 | Referring Provider Name | | |
| 2310F | NM101 | Entity Identifier Code | ‘DN’ | |
| 2310F | NM108 | Identification Code Qualifier | ‘XX’ | |
| 2310F | NM109 | Identification Code | | KY Medicaid NPI number |

| | | | | |
|---|---|---|---|---|
| 2400 | SV2 | Institutional Service Line | | |
| 2400 | SV202-1 | Product/Service ID Qualifier | HC | Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes |
| 2420D | NM1 | Referring Provider Name | | |
| 2420D | NM101 | Entity Identifier Code | 'DN' | |
| 2420D | NM108 | Identification Code Qualifier | 'XX' | |
| 2420D | NM109 | Identification Code | | KY Medicaid NPI number |

# 5 TI Additional Information

## 5.1 Payer Specific Business Rules and Limitations

### 1.2.1 Subscriber, Insured = Member in the Kentucky Medicaid System

The Kentucky Medicaid System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each program or MCO (Managed Care Organization). If Dependent Level Segments are received, they will be ignored during processing and will not be returned in the response.

### 1.2.2 Compliance Checking

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. All other levels will be validated within the MMIS;

# 6 TI Change Summary

One of the visual changes from version 4010 X098A1 companion guide to the version 005010 X223A2 companion guide is the format. The new format was the collaborative efforts of the Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA); on behalf of the ASC X12 workgroups to better serve the health care community with a standard document. KY Medicaid adopted this standard to be consistence with the health care industry.
The 837I transactions consist of segments required by KY Medicaid; however, segments which are not used by KY Medicaid are identified throughout the companion guide.

## 6.1 Payer Specific Business Rules and Limitations

### 1.2.3 Special Considerations for 837 Institutional Transactions

1. **Subscriber, Insured = Member in the Kentucky Medicaid Eligibility Verification System:**

   The Commonwealth of Kentucky Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each program or MCO (Managed Care Organization)';

2. **Provider Identification = Commonwealth of Kentucky Medicaid ID or NPI:**

   As of May 23, 2008, KY Medicaid does not allow use of the *Kentucky Medicaid* provider IDs (atypical is exempt); only NPI is permitted on any inbound or outbound transaction;

   **Taxonomy:**

   Billing Provider taxonomy at Loop 2000A is required when the payer's adjudication is known to be impacted by the provider taxonomy code. NOTE: Taxonomy code is required if the Billing Provider NPI is linked to multiple Medicaid Provider IDs and must match taxonomy code reported during provider enrollment.

   Rendering Provider, taxonomy at Loop 2310B applies to the entire claim unless overridden on the service line level at Loop 2420A;

3. **Logical File Structure:**
   There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type;

4. **Submitter:**
   Submissions by non-approved trading partners will be rejected;

5. **Claims and Encounters:**
   Claims and encounters must be submitted in separate ISA/IEA envelopes;

6. **Response/999 Acknowledgement:**
   A response transaction will be returned to the trading partner that is present within the ISA06 data element.
   Commonwealth of Kentucky will provide a 999 Acknowledgment for all transactions that are received.
   You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.
   *NOTE* The 835 and unsolicited 277 are only provided weekly;

7. **Claims Allowed per Transaction (ST/SE envelope):**
   The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.
   Commonwealth of Kentucky does not have a maximum for the number of claims per transaction (ST/SE envelope);

8. **Document Level:**
   Commonwealth of Kentucky processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance are processed within the Medicaid Management Information System (MMIS). Those claims that fail compliance are reported on the 999;

9. **Dependent Loop:**
   For Commonwealth of Kentucky, the subscriber is always the same as the patient (dependent). Data submitted in the Patient Hierarchical Level (2000C loop) are ignored;

10. **Compliance Checking:**
    Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. All other levels are validated within the MMIS;

11. **Identification of TPL:**
    Non-Medicare Payer (TPL) Paid Amount – The non-Medicare Paid Amount is the sum of the Payer Prior Payment Amounts (AMT01=D) obtained from 2320 Loop(s) (Other Subscriber Information) per claim, where the payer is NOT Medicare (SBR09 (Claim Filing Indicator) does NOT equal MA (Medicare Part A) or MB (Medicare Part B)).
    *NOTE* The 2320 loop can repeat multiple times per claim;

12. **Processing for the 2300-HI Segment for "Diagnosis Codes":**
    **The Commonwealth of Kentucky will accept the following values:**

- HI01-1 – BK Principal Diagnosis Code – 1 iteration of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required data elements;
- HI01-1 = BJ Admitting Diagnosis Code – 1 iterations of this HI segment is allowed – HI01-1 and HI01-2 are required data elements for an Inpatient Admission;
- HI01-1 = PR Patient Reason for Visit – 3 iterations of this HI segment is allowed – HI01-1 and HI01-2 are required for an Outpatient Visit;
- HI01-1 = BN External Cause of Injury – 12 iterations of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required if this segment is sent;
- HI01-1 = DR Diagnosis Related Group – 1 iteration of this HI segment is allowed – HI01-1 and HI01-2 are required if this segment is sent; and,
- HI01-1 = BF Other Diagnosis Codes – 12 iterations of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required if this segment is sent.

13. **Processing for the 2300-HI Segment for the "Principal Procedure Information":**
The Commonwealth of Kentucky will only use the value sent in the HI01-2, where HI01-1 equals BR in the Principal Procedure Information HI segment. If the value of BP is sent within the HI01-1, the value received in the HI01-2 will not be used for processing the claim.
NOTE: HIPAA allows the BP and/or BR qualifier values at the claim level within the Hixx-1 composite element, the HCPCS procedure code value would then be placed in the Hixx-2 composite element. For Institutional Claims, the Commonwealth of Kentucky only allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = "HC". If, the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system;

14. **Processing the 2300 HI Segment for the "Other Procedure Information":**
The Commonwealth of Kentucky will only use the value sent in the HI01-2, where HI01-1 equals BQ in the Principal Procedure Information HI segment. If the value of BO is sent within the HI01-1, the value received in the HI01-2 will not be used for processing the claim.
NOTE: HIPAA allows the BQ and/or BO qualifier values at the claim level within the Hixx-1 composite element, the HCPCS procedure code value would then be placed in the Hixx-2 composite element. For Institutional Claims, the Commonwealth of Kentucky only allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = "HC". If, the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system;

**15. Subscriber information:**

Loop 2000B SBR01 –MCO's must send the value of S if one other payer is submitted in Loop 2320. If two payers paid value of T should be sent. If three payers paid value of A should be sent, continue up to ten payer's submitted in Loop 2320 value G should be sent.

Example: 2000B SBR01 value = S

2320 SBR01 value = P if Medicare paid SBR09 value MA, MB or 16

2320 SBR01 value = T MCO SBR09 value = HM

Example: 2000B SBR01 value = T

2320 SBR01 value = P if commercial insurance payer 1 paid SBR09 value = CI

2320 SBR01 value = S if Medicare paid SBR09 value MA, MB or 16

2320 SBR01 value = A MCO SBR09 value = HM

Loop 2320B SBR01 – The MCO will always be the highest payer with value H if ten other payers paid.

Loop 2320 SBR09 – MCO will always send HM;

16. **Provider Types Required to Bill NDC:**
Provider types 01 (inpatient hospital) and 39 (renal dialysis clinics) are required to bill the NDC. They are required to bill the NDC quantity and NDC unit of measurement; and,

17. **Naming Conventions: File**

(837P/I/D/NCPDP);

- 837P – Professional;
- 837I – Institutional;
- 837D – Dental;
- NCPDP – Pharmacy;
    - (TPID) – 10 digit Trading Partner ID;
    - (O/R/A/V) ;
- O – Original (new claims);
- R – Resubmission (claims that have been billed before but did not process for some reason);
- A – Adjustment (adjustments to existing claims);
- V – Void (voids for both 837 and pharmacy); and,
- D – Denied.