KY Medicaid

837P 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	Removed NTE Segment Instructions
2.1	12/22/2012	Martha Senn	Atypical provider id updates
2.2	2/1/2012	Martha Senn	Inserted Encounter usage for 2300B NM101 – NM109 page 25. Final version, DMS approved on 02/01/2012.
2.3	6/21/2012	Martha Senn	Inserted MCO SBR clarifications in section 1.1.1 Special Considerations as #14; comment inserted at 2000B & 2320 SBR segments to reference Special Considerations.
3.0	10/21/2012	Kathy Dugan	Added NM101 and NM102 in Loop 2010BB to be consistent with 837I and 837D Companion Guides on page 17. Added new data elements, REF01 and REF02 in Loop 2010BB on Page 18
3.1	10/24/2012	Keri Hicks	Updates
3.2	11/19/2012	Martha Senn	Added K3 segment for denied details on page 28 Added Region '09' to 2010BB REF on page 18
3.3	11/19/2012	Keri Hicks	Updates
4.0	08/13/2013	Stephanie Barr	Rewritten to conform to the ACA required template and ASCX12 authorization guidelines.
4.1	1/23/2014	Martha Senn	Updates for ASCX12 authorization guidelines. X12 approval 6/4/2014
4.2	7/1/2015	Martha Senn	Changed HP name to Hewett-Packard Enterprise
4.3	2/27/2017	Martha Senn	CO 24712 – ORP updates to include Referring and Ordering provider header and detail segment DMS approved 3/27/2017
4.4	8/1/2017	Martha Cohorn	Update to Program Specific Requirements Community Mental Health employee ID value CO27941 DMS approved 11/22/2017
4.5	6/18/2020	Brianna Hicks	Removed region "03" in REF segment 2010BB
4.6	11/24/2021	Brianna Hicks	Updated Header Logo from Kentucky Unbridled (CO33090)
4.7	1/11/2022	Brianna Hicks	Updated Taxonomy language under Payer Specific Business Rules and Limitations (CO32815)
4.8	9/19/2022	Brianna Hicks	Updated Header Logo from Kentucky Sunrise to Team Kentucky (CO33931)
4.9	11/15/2022	Brianna Hicks	Added Medicare Advantage / Part C Language (CO33961)

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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
005010X222A1	Professional Health Care Claim (837P)

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 837P Transaction

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00	
	BHT05	Transaction Set Creation Time		The time format is HHMMSS
	BHT06	Transaction Type Code	‘CH’ ‘RP’	
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Kentucky Medicaid assigned EDI Trading Partner ID
1000B	NM1	Receiver Name		
1000B	NM103	Name Last or Organization Name		KYMEDICAID
1000B	NM109	Identification Code		KYMEDICAID
2000B	SBR	Subscriber Information		
2000B	SBR09	Claim Filing Indicator	‘MC’	
2000B	PAT	Patient Information		
2000B	PAT07	Unit or Basis for Measurement Code	‘01’	
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier	‘1’	
2010BA	NM109	Identification Code	‘10 Digit’	
2010BB	NM1	Payer Name		

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	NM103	Name Last or Organization Name		KYMEDICAID
2010BB	NM108	Identification Code Qualifier	'PI'	
2010BB	NM109	Identification Code		KYMEDICAID
2010BB	REF	Payer Secondary Identification		
2010BB	REF01	Reference Identification Qualifier	'FY'	For Encounters only
2010BB	REF02	Reference Identification	'01', '02', '04', '05', '06', '07', '08', '09', '31'	Submit the Member Region in this data element For Encounters only
2010BB	REF	Billing Provider Secondary Identification		
2010BB	REF01	Reference Identification Qualifier	'G2'	
2010BB	REF02	Reference Identification		Legacy KY Medicaid Provider ID of the Atypical provider
2300	REF	Payer claim Control Number		
2300	REF02	Reference Identification	'FFS' 'MCO'	
2310A	NM1	Other Referring Provider		
2310A	NM101	Entity Identifier Code	'DN' 'P3'	
2310A	NM108	Identification Code Qualifier	'XX'	
2310A	NM109	Identification Code		NPI assigned to the provider
2310B	NM1	Rendering Provider Name		
2310B	NM108	Identification Code Qualifier	'XX'	**Atypical Providers Do Not Send**
2310B	NM109	Identification Code		NPI assigned to the provider **Atypical Providers Do Not Send**
2310B	REF	Rendering Provider Secondary Identification		
2310B	REF01	Reference Identification Qualifier	'G2'	
2310B	REF02	Reference Identification		**For Atypical providers only** Use 8 or 10 digit Medicaid Provider
2330C	NM1	Other Payer Referring Provider		
2330C	NM101	Entity Identifier Code	'DN' 'P3'	
2330C	NM108	Identification Code Qualifier	'XX'	

Loop ID	Reference	Name	Codes	Notes/Comments
2330C	NM109	Identification Code		NPI assigned to the provider
2330C	REF	Other Payer Referring Provider Secondary Identification		
2330C	REF01	Reference Identification Qualifier	'G2'	
2330C	REF02	Reference Identification		NPI assigned to the provider
2320	SBR	Other Subscriber Information		
2320	SBR09	Claim Filing Indicator Code	'11', '12', '13', '14', '15','16', '17', 'AM', 'BL', 'CH', 'CI', 'DS', 'FI', 'HM', 'LM', 'MA', 'MB', 'MC', 'OF', 'TV', 'VA', 'WC', 'ZZ'	"16" Health Maintenance Organization (HMO) Medicare *Use for Medicare Advantage / Part C
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
2320	AMT01	Amount Qualifier Code	'D'	
2320	AMT02	Monetary Amount		Other Payer Amount Paid (TPL, MCO and Medicare) Used for Fee-for-Service and Encounters
2400		Professional Services		
2400	SV105	Facility Code Value		Reference the KY Medicaid Billing Instructions
2400	SV111	Yes/No Condition or Response Code		If Disposition Code is 'Y' for EPSDT Services, information required in 2400 NTE02. See Section 4 – 3 of the Program specific required information for KY Medicaid claims processing.
2420E	NM1	Ordering Provider Name		
2420E	NM101	Entity Identifier Code	'DK'	
2420E	NM108	Identification Code Qualifier	'XX'	
2420E	NM109	Identification Code		NPI assigned to the provider
2420F	NM1	Referring Provider Name		
2420F	NM101	Entity Identifier Code	'DN' 'P3'	
2420F	NM108	Identification Code Qualifier	'XX'	

Loop ID	Reference	Name	Codes	Notes/Comments
2420F	NM109	Identification Code		NPI assigned to the provider
2430	CAS	Line Adjustment		
2430	CAS02	Claim Adjustment Reason Code		All external code source values from code source 139 are allowed. All denied encounters must submit value 'A1'. For Medicare recommend values are the following: '1' – Deductible '2' – Co-Insurance r

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.
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 X222A1 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 837P 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. 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);

Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC).

2. Provider Identification = Commonwealth of Kentucky Medicaid ID:

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

3. 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.

4. 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;

5. Submitter:

Submissions by non-approved trading partners will be rejected;

6. Claims and Encounters:

Claims and encounters must be submitted in separate ISA/IEA envelopes;

7. 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. 837, you will receive either the 835 or the unsolicited 277;

NOTE The 835 and unsolicited 277 are only provided weekly;

8. 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);

9. 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 will be processed within the Medicaid Management Information System (MMIS). Those claims that fail compliance are reported on the 999;

10. 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) will be ignored;

11. Compliance Checking:

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

12. 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;

13. Billing Provider Name

This is the Individual Provider Information if not billed in conjunction with a Clinic or Group.
OR *Clinic/Group Provider Information: Required for KY Medicaid IF REIMBURSEMENT IS TO BE ISSUED TO A GROUP PRACTICE OR ASSOCIATION (P.S.C). Note: (The Rendering Individual Provider Information should be entered in 2310B.)

14. 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;

15. File Naming Conventions:

(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.

Note: 2330B DTP or 2430 DTP segment required for Encounters. 2330B REF segment required for Encounters.

2 Program Specific Required Information for Kentucky Medicaid Professional Claims Processing

1. Transportation Providers must enter the required information in loop 2400 NTE02 data element (Previously billed in the 2300 NTE02):

   - Time of Pickup (Format is HHMM) Must be preceded by a qualifier of PT, (PTHHMM); and,
   - Location of Pickup and Destination Code within the new MMIS will be billed as a modifier. (Please see Transportation Billing Manual for valid Modifiers).

2. Preventive Care Providers who bill claims that require a seven position school ID must enter that number in loop 2400, NTE02 data element (Previously billed in the 2300 NTE02):

   - School Location Identifier: 7 position values must be preceded by a qualifier of ST, (STxxxxxxx).

3. All Providers billing Early Periodic Screening, Diagnosis and Treatment Procedures (EPSDT) must use disposition codes when abnormal conditions are found. Please refer to the Billing Instructions for the applicable disposition codes. The disposition codes must be placed in loop 2400 NTE02 data element:

   - Disposition Code: Each disposition code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of DC, (DCxxxxxx).

4. School-Based Health Service Providers who bill claims that require Number of Students or Number of Students and 3 positions Employee ID must enter those values in loop 2400, NTE02 data element. If Number of Students and Employee ID are submitted each value must be preceded by the appropriate qualifier and separated with a comma (,). If only sending Number of Students or Employee ID do not send the comma (,) after the data. Local modifier codes were also billed with the number of students for dates of service prior to 10/16/03. Local modifiers will not be used within the new MMIS.

   - Number of Students: Valid values 1-6, preceded by a qualifier of SB, (SBx);
   - Employee ID: 3 position value preceded by a qualifier of EI, (EIxxx);
     - Example of both values being billed: SBx,Eixxx; and,
     - Example of single value being billed: SB2.

5. Community Mental Health Center and Substance Abuse Providers who bill claims that require an Employee ID must enter that number in loop 2400, NTE02 data element :

   - Employee ID: 4, 5, or 6 position value (left justified) preceded by a qualifier of EI, (EIxxxx; EIxxxxx, or EIxxxxxx)
   - Valid CMHC Employee ID values are 0001 thru 9999, 00001 thru 99999, and 000001 thru 999999 (for example, 0001 and 00001 represent two different employees)

-

6. All Providers who bill claims that require "EPSDT Referral Codes" and/or "Vaccine Codes" must enter those values in loop 2400, NTE02 data element. If EPSDT Referral Codes and Vaccine Codes are submitted each must value be preceded by the appropriate qualifier and separated with a comma (,). If only sending EPSDT Referral Code or Vaccine Code do not send the comma (,) after the data.

    - EPSDT Referral Codes: Each EPSDT Referral code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of RC, (RCxxxxxx);

    - Vaccine Codes: Each Vaccine code must be a length of 2. Up to 3 occurrences can be billed. Must be preceded by a qualifier of VC, (VCxxxxxx);

        - Example of both values being billed: RCxx,VCxxxx; and,

        - Example of single value being billed: VCxx.

7. Effective for dates of service **04/01/2017** and after, referring or ordering NPI must be entered for encounters (including crossovers) with the following billing provider types:

    All services billed by a DME provider (provider type 90)
    All crossover services billed by a Pharmacy (provider type 54)
    All services billed by an Independent Lab (provider type 37)
    All services billed by an X-Ray/Miscellaneous Supplier (provider type 86)
    All services billed by a Private Duty Nurse (provider type 18)
    All services billed by a Physical Therapist (provider type 87)
    All services billed by an Occupational Therapist (provider type 88)
    All services billed by a Speech Language Pathologist (provider type 79)
    All services billed by an Optician (provider type 52)
    All services billed by a Hearing Aid Dealer (provider type 50)
    All services billed by an Ambulatory Surgery Center (provider type 36)
    All services billed by a Multi-therapy Agency (provider type 76)
    All services billed by an Audiologist (provider type 70)