



KYMedicaid MMIS Batch Health Care Professional Health Care Claim and Encounter Claims (837P) Companion Guide

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1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at <http://aspe.hhs.gov/admsimp/final/txfin00.htm>. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1.1 Purpose

The 837 Professional Transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic professional claim submissions to the Commonwealth of Kentucky. The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections and reversals. This transaction will support the submission of professional claims, professional encounters, and Coordination of Benefits for Medicare Part B. The 837 Professional is the electronic correspondent to the paper CMS-1500 claim form; therefore, any claim types or encounter data submitted on the CMS-1500 form correlate to the 837 Professional, if data is submitted electronically.

All required segments within the 837 Professional Transaction Set must always be sent by the submitted and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transaction such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.1.2 Special Considerations for 837 Professional Transaction

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:

The Commonwealth of Kentucky implementation date for NPI is scheduled for May 23, 2008.

As of May 23, 2008, KY Medicaid will not allow continued use of the *KyHealth Choices* provider IDs (atypical is exempt); 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.

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

4. Atypical Providers

Providers classified as an 'atypical provider' are excluded from NPI and taxonomy and will continue to use their legacy id after May 23, 2008.

The following provider types are considered Atypical Providers:

- Hands;
- Non-emergency Transportation;
- Commission for Handicapped Children;
- Title V/DSS;
- First Steps; and,
- Impact Plus.

5. 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;

6. Submitter:

Submissions by non-approved trading partners will be rejected;

7. Claims and Encounters

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

8. Response/997 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 997 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 are only provided weekly.

9. 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);

10. 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 will be reported on the 997;

11. Dependent Loop:

For Commonwealth of Kentucky, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly;

12. Compliance Checking:

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the MMIS; and,

13. Identification of TPL:

For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to Medicare, the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

- *NOTE* The 2320 loop can repeat multiple times per claim.

2 CONTROL SEGMENT DEFINITIONS FOR KENTUCKY MEDICAID

2.1 837 PROFESSIONAL TRANSACTION

X12N EDI Control Segments
<ul style="list-style-type: none"> ➤ ISA – Interchange Control Header Segment ➤ IEA – Interchange Control Trailer Segment ➤ GS – Functional Group Header Segment ➤ GE – Functional Group Trailer Segment ➤ ST – Transaction Set Header ➤ SE – Transaction Set Trailer ➤ TA1 – Interchange Acknowledgement

2.2 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	'ID Supplied by KY Medicaid' – Sender ID
B.4	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	'KY Medicaid' – Receiver ID
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control	'U' – Interchange Control

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
			Standards Identifier	Standards Identifier
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Sequential Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
B.6	N/A	ISA	ISA14 - Acknowledgment Request	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

2.3 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

2.4 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.8	N/A	GS	GS01 - Functional ID Code	'HC' – Health Care Claim (837)
B.8	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06.
B.8	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08. 'KYMEDICAID'
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD
B.8	N/A	GS	GS05 – Time	The time format is HHMM
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/Release/ Industry ID Code	'004010X098A1' – Version / Release / Industry Identifier Code

2.5 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

2.6 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
62	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
62	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

2.7 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
572	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
572	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02

2.8 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM Time within the original interchange received (ISA/IEA)

837 Professional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	<p>'A' – Transmitted interchange control structure header/trailer received without errors.</p> <p>'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted.</p> <p>'R' – Transmitted interchange control structure header/trailer rejected due to errors.</p>
B.12	N/A	TA1	TA105 - Interchange Note Code	See Implementation Guide for valid values

2.9 Valid Delimiters for Kentucky Medicaid EDI

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

3 COMPANION GUIDE FOR THE 837P TRANSACTION

837 Professional Health Care Claim and Encounter Claims				
<p>The following EDI mapping is required by Commonwealth of Kentucky Medicaid and has been derived from the guidelines and notes outlined in the Health Care Claim: Professional Implementation Guide. This mapping details several different ways that the 837 should be completed, depending on your provider information.</p>				
Page	Loop	Segment	Data Element	Comments
Header				
64	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
65	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Professional Health Care Claim) 'RP' – Reporting (Use with Professional Health Care Encounter)
Submitter Name				
69	1000A	NM1	NM109 - Identification Code	'Kentucky Medicaid assigned EDI Trading Partner ID'
72	1000A	PER	PER03 - Communication Number Qualifier	'TE' – Telephone
Receiver Name				
75	1000B	NM1	NM103 – Name Last or Organization Name	'KYMEDICAID'
75	1000B	NM1	NM109 - Identification Code	'KYMEDICAID'
Billing Provider Name				
<p>This is the Individual Provider Information if <u>not</u> 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 or 2420A.)</p> <p>Atypical providers must submit the REF segment where REF01 equals 1D.</p> <p>NOTE: For Provider types 31 and 35, enter the pay-to provider number in this loop, 2010AA.</p>				
Billing Provider Using NPI				
<p>This mapping format is used when the Billing Provider is a Healthcare provider. NPI is required for all Healthcare providers. Billing Provider at Loop 2000A is required when the payer's adjudication is known to be impacted by the billing provider taxonomy code. The Rendering Individual Provider Information should be entered in 2310B or 2420A.</p>				

NOTE: For Provider types 31 and 35, enter the pay-to provider information in this loop, 2010AA.				
79	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider.
80	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy.
80	2000A	PRV	PRV03 - Provider Specialty Code	'Provider Taxonomy Code'
86	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers.
86	2010AA	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider.
89	2010AA	N4	N403 - Zip Code N404 – Country Code	Billing Provider Zip Code + 4 digit postal code. (excluding punctuation and blanks.)
92	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – Employee identification number or 'SY' – Social Security number will be used.
92	2010AA	REF	REF02 - Reference Identification	'10 digit' Employee Identification number or Social Security number of the provider.
Billing Provider for Atypical Providers using KY Provider numbers				
This mapping format is reserved for Atypical providers who will not receive an NPI number. Atypical providers must submit the REF segment where REF01 equals 1D, and the number is their Ky. Medicaid provider number.				
Note: The Rendering Individual Provider ID should be entered in 2310B.				
86	2010AA	NM1	NM108 - Identification Code Qualifier	'24' – Employer's Identification number or '34' – Social Security number will be used.
86	2010AA	NM1	NM109 - Identification Code	'10 digit' Employee Identification number or Social Security number of the provider.
89	2010AA	N4	N403 - Zip Code N404 – Country Code	Billing Provider Zip Code + 4 digit postal code. (Excluding punctuation and blanks.)
92	2010AA	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number
92	2010AA	REF	REF02 - Reference Identification	'10 digit' Kentucky Group or Individual Provider Number.

Subscriber Hierarchical				
Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC).				
Claims containing data in the 2000C Patient Hierarchical Level (i.e. Dependent) may not process correctly.				
109	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
110	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Refer to Implementation Guide for Valid Values
112	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
Subscriber Name				
118	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
119	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
119	2010BA	NM1	NM109 - Identification Code	'10 digit' - Kentucky Medicaid Member Identification Number (MAID)
Payer Name				
131	2010BB	NM1	NM103 - Name Last or Organization Name	'KYMEDICAID'
131	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
131	2010BB	NM1	NM109 - Identification Code	'KYMEDICAID'
Claim Information				
171	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number Length allowed: 1 to 38. The value received will be returned on the 835 transaction.
173	2300	CLM	CLM05-3 - Claim Frequency Type Code	Refer to Implementation Guide for Valid Values
228	2300	REF	REF01 - Reference Identification Qualifier	'G1' – Prior Authorization Number
228	2300	REF	REF02 - Reference Identification	Assigned Prior Authorization Number
230	2300	REF	REF01 - Reference Identification	'F8' – Original Reference

			Qualifier	Number
230	2300	REF	REF02 - Reference Identification	FFS: Original KY Medicaid Internal Control Number (ICN) MCO: Original MCO Assigned Internal Control Number
245	2300	K3	K301 - Fixed Format Information	'MCO Receipt Date – Format CCYYMMDD' Required for MCO Encounters
247	2300	NTE	NTE01 - Note Reference Code	'ADD' - Additional Information
247	2300	NTE	NTE02 - Claim Note Text	'Physician Assistant Number'
Referring Provider Name (KenPAC or Lock-in)				
284	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
284	2310A	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider.
Rendering Provider Name using NPI				
Rendering/Individual Provider Information: (This is the Individual Provider Number) This loop is required when the Rendering Provider's NPI is different than the Billing Provider's NPI.				
NOTE: For Provider types 31 and 35 enter the Rendering Provider information in loop 2310B or 2420A. For Provider Type 31: If Medical Services are Rendered by Medical Staff (Such as a Nurse, Respiratory Therapist, Dietitian or Other who are not allowed to obtain an Individual Medicaid Provider Number), enter the NPI and Taxonomy of the Clinic or Group provider.				
292	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers.
292	2310B	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider.
293	2310B	PRV	PRV01 - Provider Code	'PE' – Performing
293	2310B	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
293	2310B	PRV	PRV03 - Reference Identification	Provider Taxonomy Code

Rendering Provider Name for Atypical Providers using KY Provider numbers				
Rendering/Individual Information: (This is the Individual Provider Number)				
This loop is only valid for Atypical providers.				
This loop is required when the Rendering Provider's ID number is different than the Billing Provider's ID.				
292	2310B	NM1	NM108 - Identification Code Qualifier	'24' – Employer's Identification number or '34' – Social Security number for Atypical provider
292	2310B	NM1	NM109 - Identification Code	'10 digit' Employee Identification number or Social Security number of the provider.
296	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number
297	2310B	REF	REF02 - Reference Identification	'10 digit' Kentucky Individual Provider Number
Other Subscriber Information				
327-330	2320	CAS	CAS02 – Adjustment Reason Code Also CAS05, CAS08, CAS 11, CAS14, CAS17	All external code source values from code source 139 are allowed. For Encounters recommend values are 1, 2, 3, 24, and 107 When 24 or 107 are used Monetary Amounts equal 0.
321	2320	SBR	SBR05 – Insurance Type Code	Group or Policy Number MB = Medicare part B
321	2320	SBR	SBR09 – Claim Filing Indicator Code	Insurance type code MB = Medicare part B
332	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
332	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL, MCO and Medicare) Used for Fee-for-Service and Encounters
334	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
334	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (TPL, MCO and Medicare) Used for Fee-for-Service and Encounters

Other Payer Name				
Note: 2330B DTP or 2430 DTP segment required for Medicare and Encounters. 2330B REF segment required for Encounters.				
366	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer, Medicare or MCO Claim Adjudication Date
366	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
367	2330B	DTP	DTP03 – Date Time Period	TPL, Medicare or MCO Adjudication Date (CCYYMMDD)
369	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
369	2330B	REF	REF02 - Reference Identification	Other Insurance ICN
Service Line				
401	2400	SV1	SV101-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
404	2400	SV1	SV105 - Facility Code Value	Reference the KY Medicaid Billing Instructions
406	2400	SV1	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.
488	2400	NTE	NTE01 - Note Reference Code	'ADD' – Additional Information
485	2400	AMT	AMT01 - Amount Qualifier Code	AAE – Medicare Allow Amount
485	2400	AMT	AMT02 – Approved Amount	Other Payer Allow Amount Paid – Required for Medicare Professional Crossovers.
488	2400	NTE	NTE02 - Description Time of Pick-up – Military Time	See Section 4 – 1 of the Program specific required information for KY Medicaid claims processing
488	2400	NTE	NTE02 - Description	See Section 4 – 2 of the Program specific required information for KY Medicaid

			School Location Identifier	claims processing
488	2400	NTE	NTE02 - Description Number of Students – Employee ID	See section 4 – 4 of the Program specific required information for the KY Medicaid claims processing
488	2400	NTE	NTE02 - Description Employee ID	See section 4 – 5 of the Program specific required information for the KY Medicaid claims processing
488	2400	NTE	NTE02 - Description Referral Code – Vaccine Code	See section 4 – 6 of the Program specific required information for the KY Medicaid claims processing
500	2410	LIN	LIN03 – Product/Service ID	National Drug Code (NDC)
555	2430	SVD	SVD01 – Identification Code	Other Payer Primary identifier
555	2430	SVD	SVD02 – Monetary Amount	Service Line Paid Amount
560	2430	CAS	CAS01 – Claim Adjustment Group Code	‘PR’ Patient Responsibility
560	2430	CAS	CAS02 – Claim Adjustment Reason Code	All external code source values from code source 139 are allowed. For Medicare recommend values are the following: ‘1’ – Deductible ‘2’ – Co-Insurance
560	2430	CAS	CAS03 – Monetary Amount	Adjustment Amount
560	2430	CAS	CAS04 – Quantity Adjusted units	Adjustment Quantity
566	2430	DTP	DTP03 – Date Time Period	Adjudication or Payment Date – Medicare paid

4 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 value 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 position 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); and,
 - 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 a 4 position Employee ID must enter that number in loop 2400, NTE02 data element :
 - Employee ID: 4 position value preceded by a qualifier of EI, (EIxxxx).
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); and,
- 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.