



KY Medicaid
MMIS Batch Health Care
Institutional Health Care Claim
and Encounter Claims (837I)
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 Institutional 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 institutional 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 institutional claims and institutional encounters. The 837 Institutional is the electronic correspondent to the paper UB92 / UB04 claim forms; therefore, any claim types or encounter data submitted on the UB92 / UB04 forms correlate to the 837 Institutional, if data is submitted electronically.

All required segments within the 837 Institutional 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 Institutional 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

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; 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.

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/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.

8. When NM108 = 24 or REF01=EI

If the NM108 equals 24 (Employer Identification Number (EIN) For atypical only) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

NOTE This format include the hyphen (-).

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.

13. Identification of TPL

- Non-Medicare Payer (TPL) Paid Amount – The non-Medicare Paid Amount is the sum of the Payer Prior Payment Amounts (AMT01=C4) 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.

14. 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.

15. 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.

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 not required to bill the NDC quantity or NDC unit of measurement.

2 CONTROL SEGMENT DEFINITIONS FOR KENTUCKY MEDICAID 837 INSTITUTIONAL TRANSACTION

X12N EDI Control Segments	
➤	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

2.1 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 Institutional 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 Standards Identifier	'U' – Interchange Control 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

2.2 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 Institutional 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
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2.3 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 Institutional 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	'004010X096A1' – Version / Release / Industry Identifier Code

2.4 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 Institutional 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

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

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

2.7 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 Institutional 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)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received

				<p>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

2.8 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 837I TRANSACTION

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
Header				
58	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
59	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Institutional Health Care Claim) 'RP' – Reporting (Use with Institutional Health Care Encounter)
Submitter Name				
63	1000A	NM1	NM109 - Identification Code	'Kentucky Medicaid assigned EDI Trading Partner ID'
65	1000A	PER	PER03 - Communication Number Qualifier	'TE' – Telephone
Receiver Name				
68	1000B	NM1	NM103 – Name Last or Organization Name	'KYMEDICAID'
68	1000B	NM1	NM109 - Identification Code	'KYMEDICAID'
Billing Provider Name				
71	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider 'PT' – Pay-to-Provider
72	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
72	2000A	PRV	PRV03 - Provider Specialty Code	'Provider Taxonomy Code'
77	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers

78	2010AA	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider
81	2010AA	N4	N403 - Zip Code N404 – Country Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
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.				
100	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
102	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Refer to Implementation Guide for Valid Values
104	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' - Medicaid
Subscriber Name				
109	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
110	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
110	2010BA	NM1	NM109 - Identification Code	'10 digit' - Kentucky Medicaid Member Identification Number (MAID)
Payer Name				
127	2010BC	NM1	NM103 - Name Last or Organization Name	'KYMEDICAID'
127	2010BC	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
127	2010BC	NM1	NM109 - Identification Code	'KYMEDICAID'
Claim Information				
158	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.
159	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value received is the 3 rd position of the Type of Bill (TOB) See External Code Source List 235 for valid values.
160	2300	CLM	CLM06 - Yes/No Condition or Response Code	'Y' - Yes
160	2300	CLM	CLM08 - Yes/No Condition or Response Code	'Y' - Yes
165	2300	DTP	DTP01 - Date/Time Qualifier	'096' – Discharge
165	2300	DTP	DTP02 – Date Time Period Format Qualifier	'TM' – Time (HHMM)
166	2300	DTP	DTP03 - Date Time Period	Discharge Hour
167	2300	DTP	DTP01 - Date/Time Qualifier	'434' – Statement Covers Period Dates
167	2300	DTP	DTP02 - Date Time Period Qualifier	'RD8' – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
168	2300	DTP	DTP03 - Date Time Period	Statement Covers Period (From-Through)
169	2300	DTP	DTP01 - Date/Time Qualifier	'435' – Admission
169	2300	DTP	DTP02 - Date Time Period Qualifier	'DT' – Date and Time Expressed in Format CCYYMMDDHHMM
169	2300	DTP	DTP03 - Date Time Period	'CCYYMMDD' – Admission Date 'HHMM' – Admission Hour
171	2300	CL1	CL101 – Admission Type Code	Admission Type code are available from: Nation Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697

172	2300	CL1	CL102 – Admission Source Code	Admission Source code are available from: Nation Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697
172	2300	CL1	CL103 – Patient Status Code	Patient Status code are available from: Nation Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697
191	2300	REF	REF01 – Reference Identification Qualifier	'F8' – Original Reference Number
192	2300	REF	REF02 – Reference Identification	FFS: Original KY Medicaid Internal Control Number (ICN) MCO: Original MCO Assigned Internal Control Number
198	2300	REF	REF01 – Reference Identification Qualifier	'G1' – Prior Authorization Number
199	2300	REF	REF02 – Reference Identification	Assigned Prior Authorization Number
204	2300	K3	K301 - Fixed Format Information	'MCO Receipt Date – Format CCYYMMDD' Required for MCO Encounters
213	2300	CR6	CR607 - Yes/No Condition or Response Code Home Health providers only	'Y' – Medicare Coverage Indicator
242-243	2300	HI	HI01-1 - Industry Code	'BR' – ICD-9-CM
242-243	2300	HI	HI01-2 - Industry Code	ICD-9-CM Principal Procedure Code
244-255	2300	HI	HIxx-1 - Industry Code	'BQ' – ICD-9-CM
244-255	2300	HI	HIxx-2 - Industry Code	ICD-9-CM Other Procedure Codes

306-307	2300	QTY	QTY01 - Quantity Qualifier	'CA' – Covered Days 'NA' – Number of Non-Covered Days
Attending Physician Name				
Attending Provider information is required for Inpatient Services				
321	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
321	2310A	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider
327	2310A	REF	REF01 - Reference Identification Qualifier	'1G' – Provider UPIN number
Other Provider Name				
KenPAC Provider Information				
KenPAC Provider Information should be billed in this loop when required for Inpatient/Outpatient Services.				
336	2310C	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
336	2310C	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider
Service Facility Name				
350	2310E	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
350	2310E	NM1	NM109 - Identification Code	'10 digit' NPI assigned to the provider
356	2310E	N4	N403 – Zip Code	Service Facility Zip Code
Other Subscriber Information				
367-370	2320	CAS	CAS02 – Adjustment Reason Code Also CAS05, CAS08, CAS 11,	All external code source values from code source 139 are allowed. For Encounters recommend values are 1,

			CAS14, CAS17	2, 3, 24, and 107 When 24 or 107 are used Monetary Amounts equal 0.
371	2320	AMT	AMT01 - Amount Qualifier Code	'C4' – Payer Amount Paid
371	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
372	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
372	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
376	2320	AMT	AMT01 - Amount Qualifier Code	'N1' – Net Worth
Other Payer Name				
Note: 2330B DTP or 2430 DTP segment required for Encounters. 2330B REF segment required for Encounters.				
415	2330B	DTP	DTP01 - Date/Time Qualifier	'573' - Other Payer or MCO Claim Adjudication Date
415	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
415	2330B	DTP	DTP03 – Date Time Period	TPL or MCO Adjudication Date (CCYYMMDD)
416	2330B	REF	REF01 - Reference Identification Qualifier	'F8' – Original Reference Number
417	2330B	REF	REF02 - Reference Identification	Other Insurance Original ICN
Service Line Number				
446	2400	SV2	SV202-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS)

				Codes
449	2400	SV2	SV206 - Unit Rate	Service Line Unit Rate
449	2400	SV2	SV207 - Monetary Amount	Service Line Non-Covered Charge Amount
450	2410	LIN	LIN02 – Product/Service Id Qualifier	N4 – National Drug Code
450	2410	LIN	LIN03 – Product/Service ID	National Drug Code 11 digit NDC number with no dashes or spaces