



***KY Medicaid***  
**MMIS Batch Health Care**  
**Institutional Health Care Claim**  
**and Encounter Claims (837I)**  
**Companion Guide**  
**Version 4.0**  
**Version 004010 X096A1**

*Cabinet for Health and Family Services*  
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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](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).

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## 1.1.2 Special Considerations for 837 Institutional Transaction

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### 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<br>'1' – Acknowledgement Requested                  |
| B.6 | N/A | ISA | ISA15 - Usage Indicator                          | 'T' - Test Data<br>'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 |
|-----|-----|-----|------------------------------------|---|

### 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<br>Date within the original interchange received (ISA/IEA) |
| B.11   | N/A  | TA1     | TA103 - Interchange Time                 | The time format is HHMM<br>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  |
| <b>Header</b>  |        |         |  |   |
| 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)<br><br>'RP' – Reporting (Use with Institutional Health Care Encounter) |
| <b>Submitter Name</b>                                    |        |         |  |   |
| 63   | 1000A  | NM1     | NM109 - Identification Code                | 'Kentucky Medicaid assigned EDI Trading Partner ID'   |
| 65   | 1000A  | PER     | PER03 - Communication Number Qualifier     | 'TE' – Telephone  |
| <b>Receiver Name</b>                                     |        |         |  |   |
| 68   | 1000B  | NM1     | NM103 – Name Last or Organization Name     | 'KYMEDICAID'  |
| 68   | 1000B  | NM1     | NM109 - Identification Code                | 'KYMEDICAID'  |
| <b>Billing Provider Name</b>                             |        |         |  |   |
| 71   | 2000A  | PRV     | PRV01 - Provider Code                      | 'BI' – Billing Provider<br><br>'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<br>N404 – Country Code            | Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)                       |
| <b>Subscriber Hierarchical</b>  |        |     |   |  |
| <b>Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC).</b> |        |     |   |  |
| <b>Claims containing data in the 2000C Patient Hierarchical Level (i.e. Dependent) may not process correctly.</b>       |        |     |   |  |
| 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  |
| <b>Subscriber Name</b>  |        |     |   |  |
| 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)                                       |
| <b>Payer Name</b>   |        |     |   |  |
| 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'   |
| <b>Claim Information</b>  |        |     |   |  |
| 158   | 2300   | CLM | CLM01 - Claim Submitter's Identifier              | Patient Control Number<br><br>Length allowed: 1 to 38.<br>The value received will be returned on the 835 |

|     |      |     |   |   |
|-----|------|-----|---|---|
|     |      |     |   | transaction.  |
| 159 | 2300 | CLM | CLM05-3 - Claim Frequency Type Code       | Value received is the 3 <sup>rd</sup> position of the Type of Bill (TOB)<br><br>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<br><br>'HHMM' – Admission Hour  |
| 171 | 2300 | CL1 | CL101 – Admission Type Code               | Admission Type code are available from:<br><br>Nation Uniform Billing Committee<br>American Hospital Association<br>840 Lake Shore Drive<br>Chicago, IL 60697 |

|         |      |     |   |   |
|---------|------|-----|---|---|
| 172     | 2300 | CL1 | CL102 – Admission Source Code   | Admission Source code are available from:<br><br>Nation Uniform Billing Committee<br>American Hospital Association<br>840 Lake Shore Drive<br>Chicago, IL 60697             |
| 172     | 2300 | CL1 | CL103 – Patient Status Code   | Patient Status code are available from:<br><br>Nation Uniform Billing Committee<br>American Hospital Association<br>840 Lake Shore Drive<br>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)<br><br>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'<br><br><i>Required for MCO Encounters</i><br><br><b>POA</b> = Yes (Y), No (N), Unknown (U), Clinically undetermined (W) as of 9/1/2010 |
| 213     | 2300 | CR6 | CR607 - Yes/No Condition or Response Code<br><br>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<br>'NA' – Number of Non-Covered Days  |
| <b>Attending Physician Name</b>   |       |     |  |   |
| <b>Attending Provider information is required for Inpatient Services</b>  |       |     |  |   |
| 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   |
| <b>Other Provider Name</b>  |       |     |  |   |
| <b>KenPAC Provider Information</b>  |       |     |  |   |
| <b>KenPAC Provider Information should be billed in this loop when required for Inpatient/Outpatient Services.</b> |       |     |  |   |
| 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   |
| <b>Service Facility Name</b>  |       |     |  |   |
| 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   |
| <b>Other Subscriber Information</b>   |       |     |  |   |

|  |       |     |   |  |
|--|-------|-----|---|--|
| 367-370  | 2320  | CAS | CAS02 – Adjustment Reason Code<br><br>Also<br>CAS05, CAS08, CAS 11,<br>CAS14, CAS17 | All external code source values from code source 139 are allowed.<br><br>For Encounters recommend values are 1, 2, 3, 24, and 107<br><br>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)<br><br>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)<br><br>Used for Fee-for-Service and Encounters  |
| 376  | 2320  | AMT | AMT01 - Amount Qualifier Code   | 'N1' – Net Worth   |
| <b>Other Payer Name</b>  |       |     |   |  |
| <b>Note: 2330B DTP or 2430 DTP segment required for Encounters. 2330B REF segment required for Encounters.</b> |       |     |   |  |
| 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<br>11 digit NDC number with no dashes or spaces                        |