KY Medicaid

837 Dental Companion Guide

Cabinet for Health and Family Services
Department for Medicaid Services

June 18, 2020

Document Change Log

Version	Changed Date	Changed By	Reason
2.0	11/02/2011	Kathy Dugan	Removed NTE ESC Instructions
2.1	2/1/2012	Martha Senn	Inserted Encounter usage for 2300B NM109 page 23. Final version DMS approved on 02/01/2012.
2.2	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 new data elements, REF01 and REF02 in Loop 2010BB on Page 18
3.1	10/24/2012	Keri Hicks	Updates
3.2	11/16/2012	Martha Senn	Added K3 segment for denied details on page 26 Added Region '09' to 2010BB REF on page 18
3.3	11/19/2012	Keri Hicks	Updates
3.4	1/18/2013	Martha Senn	Changed 2310B SBR01 to 2320 on page 21
3.4	1/18/2013	Keri Hicks	Updates DMS Approved 01/18/2013.
3.5	8/14/2013	Martha Senn	Rewritten to conform to the ACA required template and ASCX12 authorization guidelines.
3.6	1/23/2014	Martha Senn	Updates for ASC X12 authorization guidelines X12 approved on 6/5/2014
3.7	3/8/2017	Martha Senn	CO 24712 -Updates for ORP for Referring provider header segment DMS approved 3/27/2017
3.8	6/18/2020	Brianna Hicks	Removed region "03" from 2010BB REF segment

Companion Guide Version Number: FINAL 3.8

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
005010X224A1	Health Care Claim: Dental (837)

1 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.

005010X224A1 Health Care Claim Dental (837)

2 Companion Guide for the 837 Dental Transaction

Loop ID	Reference	Name	Codes	Notes/Comments
N/A	BHT	Beginning of Hierarchical Transaction		
N/A	BHT02	Transaction Set Purpose Code	'00'	
N/A	BHT05	Transaction Set Creation Time		The time format is HHMMSS
1000A	NM1	Submitter Name		
1000A	NM109	Submitter Identifier		'Kentucky Medicaid assigned EDI Trading Partner ID
1000B	NM1	Receiver Name		
1000B	NM103	Receiver Name		'KYMEDICAID'
1000B	NM109	Receiver Primary Identifier		'KYMEDICAID'
2000B	SBR	Subscriber Information		
2000B	SBR09	Claim Filing Indicator Code	'MC'	
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier	'1'	
2010BA	NM109	Subscriber Primary Identifier		'10 digit' – Kentucky Medicaid Member Identification Number (MAID)
2010BB	NM1	Payer Name		

Loop ID	Reference	Name	Codes	Notes/Comments
2010BB	NM103	Payer Name		'KYMEDICAID'
2010BB	NM108	Identification Code Qualifier	'PI'	
2010BB	NM109	Payer Identifier		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'	For Encounters only
2300	CLM	Claim Information		
2300	CLM05-3	Claim Frequency Code		Refer to Code source 235 – National Uniform Billing Data Element Specifications Type of Bill Position 3
2300	REF	Payer Claim Control Number		
2300	REF02	Payer Claim Control Number	'FFS'	
2300	NTE	Claim Note		
2310A	NM1	Referring Provider Name		
2310A	NM101	Entity Identifier Code	'DN' 'P3'	
2310A	NM108	Identification Code Qualifier	'XX'	
2310A	NM109	Identification Code		KY Medicaid NPI number
2310A	PRV	Referring Provider Specialty Information		
2310A	PRV01	Provider Code	'RF'	
2310A	PRV02	Reference Identification Qualifier	'PXC'	
2310A	PRV03	Reference Identification		Provider Taxonomy Code
2320	SBR	Other Subscriber Information		

Loop ID	Reference	Name	Codes	Notes/Comments
2320	SBR09	Claim Filing Indicator	'CI', 'MA', 'MB'	
2320	OI	Other Insurance Coverage Information		
2320	OI03	Benefit Assignment Certification Indicator	'Y'	
2320	OI06	Release of Information Code	'Y'	KY Medicaid only processes claims with "Y" in these elements.
2400	SV3	Dental Services		
2400	SV304-1	Oral Cavity Designation Code		See Section 4 – of the Program specific required information for KY Medicaid claims processing
2400	REF	Prior Authorization		
2400	REF02	Prior Authorization or Referral Number		Prior authorization Number Assigned by HP

3 Program Specific Required Information for KY Medicaid Claims Processing Loop 2400 – SV304-1

DDE Value	KY Description	KY Value	X12 Value
Lower Left Quadrant	Lower Left Quadrant	'LL'	'30'
Upper Left Quadrant	Upper Left Quadrant	'UL'	'20'
Lower Right Quadrant	Lower Right Quadrant	'LR'	'40'
Upper Right Quadrant	Upper Right Quadrant	'UR'	'10'
Maxillary Area	Upper Arch	'UA'	'01'
Mandibular Area	Lower Arch	'LA'	'02'

4 TI Additional Information

1.3 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;

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 or MB

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 or MB

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.

17. **(O/R/A/V)**;

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- R – Resubmission (claims that have been billed before but did not process for some reason);
- A – Adjustment (adjustments to existing claims);
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- D – Denied.