



KY Medicaid

**837 D KY MMIS 837D Companion Guide Batch Health
Care Dental Health Care Claim and Encounter Claims
(837D) Companion Guide**

Version 3.4_FINAL

*Cabinet for Health and Family Services
Department for Medicaid Services*

January 18, 2013

(DMS Approved 01/18/2013)

Companion Guide Version 3.4_FINAL
Version 005010 X224A2

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.

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1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) require 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://www.cms.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

The HIPAA Implementation Guides can be accessed at <http://www.wpc-edi.com/content/view/817/1>

1.1 Purpose

The 837 Dental Transactions are used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic dental 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 dental claims and dental encounters. The 837 Dental is the electronic correspondent to the paper ADA claim forms; therefore, any claim types or encounter data submitted on the ADA forms correlate to the 837 Dental, if data is submitted electronically.

All required segments within the 837 Dental Transaction must always be sent by the submitter 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 transactions may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.1.1 Special Considerations for 837 Dental 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:

As of May 23, 2008, KY Medicaid will 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.

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

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. 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. 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 will be 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 will be validated within the MMIS;

12. 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

13. Processing for the 2300HI Segment for ‘Diagnosis Codes’;

The Commonwealth of Kentucky will accept the following value:

HI01-1 – BK International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis – one iteration of this HI segment is allowed – HI01-1 and HI01-2 are required data elements;

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 = 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 = 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. (837P/I/D/NCPDP);

- 837P – Professional;
- 837I – Institutional;
- 837D – Dental;
- NCPDP – Pharmacy;

16. (TPID) – 10 digit Trading Partner ID**17. (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.

18. K3 – File Information

- Loop 2400 K3 - MCO must use this segment with the value of A1 for all paid dental claims with denied details

2 CONTROL SEGMENT DEFINITIONS FOR KENTUCKY MEDICAID

2.1 837 DENTAL 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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
C.4	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
C.4	N/A	ISA	ISA02 - Authorization Information	[space fill]
C.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
C.4	N/A	ISA	ISA04 – Security Information	[space fill]
C.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined This ID qualifies the Sender in ISA06.
C.4	N/A	ISA	ISA06 - Interchange Sender ID	'ID Supplied by KY Medicaid' – Sender ID
C.5	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined This ID qualifies the Receiver in ISA08.

837 Dental Health Care Claim and Encounter Claims

Page	Loop	Segment	Data Element	Comments
C.5	N/A	ISA	ISA08 - Interchange Receiver ID	'KY Medicaid' – Receiver ID
C.5	N/A	ISA	ISA09 – Interchange Date	The date format is YYMMDD
C.5	N/A	ISA	ISA10 – Interchange Time	The time format is HHMM
C.5	N/A	ISA	ISA11 – Repetition Separator	Repetition Separator – '^'
C.5	N/A	ISA	ISA12 – Interchange Control Version Number	'00501' – Control Version Number
C.5	N/A	ISA	ISA13 – Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
C.6	N/A	ISA	ISA14 – Acknowledgment Requested	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested
C.6	N/A	ISA	ISA15 – Interchange Usage Indicator	'T' – Test Data 'P' – Production Data
C.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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
C.10	N/A	IEA	IEA01 – Number of included Functional Groups	Number of included Functional Groups
C.10	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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
C.7	N/A	GS	GS01 - Functional Identifier Code	'HC' – Health Care Claim (837)
C.7	N/A	GS	GS02 - Application Sender's Code	This will be equal to the value in ISA06.
C.7	N/A	GS	GS03 - Application Receiver's Code	This will be equal to the value in ISA08. 'KYMEDICAID'
C.7	N/A	GS	GS04 – Date	The date format is CCYYMMDD
C.8	N/A	GS	GS05 – Time	The time format is HHMM
C.8	N/A	GS	GS06 – Group Control Number	Group Control Number
C.8	N/A	GS	GS07 – Responsible Agency Code	'X' – Responsible Agency Code

837 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
C.8	N/A	GS	GS08 - Version/Release/ Industry Identifier Code	'005010X224A2' – 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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
C.9	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
C.9	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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
65	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
65	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number
65	NA	ST	ST03 – Implementation Convention Reference	'005010X224A2' – Version/Release/Industry Identifier Code

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 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
353	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
353	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. TA1 Structure can be found in the ASC X12N 837 (004010X097) Implementation Guide.

837 Dental 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 without errors. ‘E’ – Transmitted interchange control structure header/trailer received and accepted, errors are noted. ‘R’ – Transmitted interchange control structure header/trailer

837 Dental Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
				rejected due to errors.
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 Terminator	~	126	7E
Data Element Separator	*	42	2A
Compound Element Separator	:	58	3A
Repetition Separator	^	94	5E

3 COMPANION GUIDE FOR THE 837D TRANSACTION

Page	Loop	Segment	Data Element	Comments
Header				
66	N/A	BHT	BHT01 – Hierarchical Structure Code	‘0019’ Information Source, Subscriber, Dependent
66	N/A	BHT	BHT02 - Transaction Set Purpose Code	‘00’ – Original
67	N/A	BHT	BHT03 – Originator Application Transaction Identifier	Originator Application Transaction Identifier
67	N/A	BHT	BHT04 – Transaction Set Creation Date	Transaction Set Creation Date
67	N/A	BHT	BHT05 – Transaction Set Creation Time	Transaction Set Creation Time
67	N/A	BHT	BHT06 - Claim Identifier	‘CH’ – Chargeable (Use with Dental Health Care Claim) ‘RP’ – Reporting (Use with Dental Health Care Encounter)
Submitter Name				
69	1000A	NM1	NM101 – Entity Identifier Code	‘41’ - Submitter
70	1000A	NM1	NM102 – Entity Type Qualifier	‘1’ – Person ‘2’ – Non-Person Entity
70	1000A	NM1	NM103 – Submitter Last or Organization Name	Required but not used in processing
70	1000A	NM1	NM104 – Submitter First Name	Required when NM102 = 1 Not used in processing
70	1000A	NM1	NM105 – Submitter Middle Name or Initial	Required when NM102 = 1 Not used in processing
70	1000A	NM1	NM108 – Identification Code Qualifier	‘46’ Electronic Transmitter Identification Number (ETIN) Established by trading partner

Page	Loop	Segment	Data Element	Comments
				agreement
70	1000A	NM1	NM109 - Submitter Identifier	'Kentucky Medicaid assigned EDI Trading Partner ID'
72	1000A	PER	PER01 – Contact Function Code	'IC' - Information Contact
72	1000A	PER	PER02 – Contact Name	Contact Name
72	1000A	PER	PER03 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax
72	1000A	PER	PER04 – Communication Number	Format = AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number
72	1000A	PER	PER05 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax 'EX' – Telephone Extension
73	1000A	PER	PER06 – Communication Number	
73	1000A	PER	PER07 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax 'EX' – Telephone Extension
73	1000A	PER	PER08 – Communication Number	
Receiver Name				
74	1000B	NM1	NM101 – Entity Identifier Code	'40' – Receiver
74	1000B	NM1	NM102 – Entity Type Qualifier	'2' Non-Person Entity
75	1000B	NM1	NM103 – Receiver Name	'KYMEDICAID'

Page	Loop	Segment	Data Element	Comments
75	1000B	NM1	NM108 – Identification Code Qualifier	'46' Electronic Transmitter Identification Number (ETIN)
75	1000B	NM1	NM109 - Receiver Primary Identifier	'KYMEDICAID'
Billing Provider Hierarchical Level				
Page	Loop	Segment	Data Element	Comments
76	2000A	HL	HL01 – Hierarchical ID Number	The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the Transaction. Only numeric values are allowed in HL01.
76	2000A	HL	HL03 – Hierarchical Level Code	'20' Information Source
77	2000A	HL	HL04 – Hierarchical Child Code	'1' – Additional Subordinate HL Data Segment in This Hierarchical Structure.
Billing Provider Specialty Information				
78	2000A	PRV	PRV01 – Provider Code	'BI' – Billing Provider
78	2000A	PRV	PRV02 - Reference Identification Qualifier	'PXC' – Health Care Provider Taxonomy
78	2000A	PRV	PRV03 - Reference Identification	'Provider Taxonomy Code'
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.)				
83	2010AA	NM1	NM101 – Entity Identifier Code	'85' – Billing Provider
83	2010AA	NM1	NM102 – Entity Type Qualifier	'1' Person '2' Non-Person Entity

Page	Loop	Segment	Data Element	Comments
83	2010AA	NM1	NM103 – Billing Provider Organizational Name	Billing Provider Organizational Name
84	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
85	2010AA	NM1	NM109 - Billing Provider Identifier	'10 digits' NPI assigned to the provider.
Billing Provider Address				
86	2010AA	N3	N301 – Address Information	
Bill Provider City, State, Zip Code				
87	2010AA	N4	N401 – City Name	Billing Provider City Name
88	2010AA	N4	N402 – State or Province Code	Billing Provider State
88	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks)
Billing Provider Tax Identification				
89	2010AA	REF	REF01 – Reference Identification Qualifier	'EI' – Employer's Identification Number 'SY' Social Security Number
89	2010AA	REF	REF02 – Reference Identification	
Billing Provider Contact Information				
94	2010AA	PER	PER01 – Contact Function Code	'IC' - Information Contact
94	2010AA	PER	PER03 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax
94	2010AA	PER	PER04 – Communication Number	

Page	Loop	Segment	Data Element	Comments
94	2010AA	PER	PER05 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax 'EX' – Telephone Extension
95	2010AA	PER	PER06 – Communication Number	
95	2010AA	PER	PER07 - Communication Number Qualifier	'TE' – Telephone 'EM' – Electronic Mail 'FX' – Fax 'EX' – Telephone Extension
95	2010AA	PER	PER08 – Communication Number	
Subscriber Hierarchical				
<p>Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC).</p> <p>Claims containing data in the 2000C Patient Hierarchical Level (i.e. Dependent) will be processed using only the subscriber data.</p>				
109	2000B	HL	HL01 – Hierarchical ID Number	1' – Additional Subordinate HL Data Segment in This Hierarchical Structure.
110	2000B	HL	HL02 – Hierarchical Parent ID Number	
110	2000B	HL	HL03 – Hierarchical Level Code	'22' Subscriber
110	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure 1' Additional Subordinate HL Data Segment in This Hierarchical Structure
Subscriber Information				
111	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	A – Payer Responsibility Four B – Payer Responsibility Five C – Payer Responsibility Six D – Payer Responsibility Seven E – Payer Responsibility Eight F – Payer Responsibility Nine G – Payer Responsibility Ten H – Payer Responsibility Eleven P – Primary

Page	Loop	Segment	Data Element	Comments
				S – Secondary T – Tertiary U – Unknown <i>*See section 1.1.1 Special Clarification #14 for MCO usage.</i>
112	2000B	SBR	SBR02 – Individual Relationship Code	'18' – Self
113	2000B	SBR	SBR09 - Claim Filing Indicator Code	'MC' – Medicaid
Subscriber Name				
114	2010BA	NM1	NM101 – Entity Identifier Code	'IL' – Insured or Subscriber
115	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
115	2010BA	NM1	NM103 – Name Last or Organization Name	Subscriber Last Name
115	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
116	2010BA	NM1	NM109 - Subscriber Primary Identifier	'10 digit' – Kentucky Medicaid Member Identification Number (MAID)
120	2010BA	DMG	DMG01 – Date/Time Period Format Qualifier	'D8' – Date Expressed in Format CCYYMMDD
120	2010BA	DMG	DMG02 – Subscriber Birth Date	Subscriber Birth Date
121	2010BA	DMG	DMG03 – Subscriber Gender Code	'F' – Female 'M' – Male 'U' – Unknown
122	2010BA	REF	REF01 – Reference Identification Qualifier	'SY' – Social Security Number
122	2010BA	REF	REF02 – Subscriber Supplemental Identifier	9 digit Social Security Number of Subscriber
Payer Name				

Page	Loop	Segment	Data Element	Comments
124	2010BB	NM1	NM101 – Entity Identifier Code	‘PR’ Payer
125	2010BB	NM1	NM102 – Entity Type Qualifier	‘2’ Non-Person Entity
125	2010BB	NM1	NM103 - Payer Name	‘KYMEDICAID’
125	2010BB	NM1	NM108 - Identification Code Qualifier	‘PI’ – Payer Identification
125	2010BB	NM1	NM109 - Payer Identifier	‘KYMEDICAID’
129	2010BB	REF	REF01 – Reference Identification Qualifier	‘FY – Claim Office Number This data element is required by KY Medicaid
130	2010BB	REF	REF02 – Reference Identification	Submit the Member Region in this data element. ‘01’, ‘02’, ‘03’, ‘04’, ‘05’, ‘06’, ‘07’, ‘08’, ‘09’, ‘31’ This data element is required by KY Medicaid
Claim Information				
146	2300	CLM	CLM01 - Patient Control Number	Patient Control Number Length allowed: 20. The value received will be returned on the 835 transaction.
147	2300	CLM	CLM02 – Total Claim Charge Amount	Total Claim Charge Amount
147	2300	CLM	CLM05-1 – Place of Service Code	Place of Service Code
147	2300	CLM	CLM05-2 – Facility Code Qualifier	‘B’ – Place of Service Codes for Professional or Dental Services
147	2300	CLM	CLM05-3 - Claim Frequency Code	Refer to Code source 235 – National Uniform Billing Data Element Specifications Type of Bill Position 3

Page	Loop	Segment	Data Element	Comments
147	2300	CLM	CLM06 – Provider or Supplier Signature Indicator	‘N’ – No ‘Y’ – Yes
148	2300	CLM	CLM07 – Assignment or Plan Participation Code	‘A’ – Assigned ‘
148	2300	CLM	CLM08 – Benefits Assignment Certification Indicator	‘Y’ – Yes
148	2300	CLM	CLM09 – Release of Information Code	‘Y’ – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data
149	2300	CLM	CLM11-1 - Related-Causes Code	‘AA’ Auto Accident ‘EM’ Employment ‘OA’ Other Accident
149	2300	CLM	CLM11-2 - Related-Causes Code	‘AA’ Auto Accident ‘EM’ Employment ‘OA’ Other Accident
150	2300	CLM	CLM12 - Special Program Indicator	‘01’ – Early & Periodic Screening, Diagnosis, and Treatment (EPSDT)
154	2300	DTP	DTP01 – Service Date Qualifier	‘472’ – Service Date
154	2300	DTP	DTP02 – Date Time Period Format Qualifier	‘D8’ – Date Expressed in Format CCYYMMDD ‘RD8’ – Date Expressed in Format CCYYMMDD-CCYYMMDD
154	2300	DTP	DTP03 – Service Date	Date Service was Provided
158	2300	DN	DN201 – Tooth Number	The Universal National Tooth Designation System must be used to identify tooth numbers for this element. See Code Source 135: American Dental Association.
158	2300	DN	DN202 – Tooth Status Code	‘E’ – Tooth to be Extracted ‘M’ – Missing
168	2300	REF	REF01 - Reference Identification Qualifier	‘F8’ – Original Reference Number
168	2300	REF	REF02 - Payor Claim Control Number	FFS: Original KY Medicaid Internal Control Number (ICN) – Previously called Transaction Control Number

Page	Loop	Segment	Data Element	Comments
				(TCN) MCO: Original MCO Assigned Internal Control Number
172	2300	REF	REF01 - Reference Identification Qualifier	'G1' – Prior Authorization Number
172	2300	REF	REF02 - Prior Authorization Number	Assigned Prior Authorization Number
179	2300	NTE	NTE01 - Note Reference Code	'ADD' – Additional Information
179	2300	NTE	NTE02 - Claim Note Text	'MCO Receipt Date – Format CCYYMMDD'
Referring Provider Name				
191	2310A	NM1	NM101 – Entity Identifier Code	'DN' - Referring Provider 'P3' Primary Care Provider
191	2310A	NM1	NM102 - Entity Type Qualifier	'1' – Person
191	2310A	NM1	NM103 – Referring Provider Last Name	Referring Provider Last Name
192	2310A	NM1	NM108 - Identification Code Qualifier	'XX' Centers for Medicare and Medicaid Services National Provider Identifier
192	2310A	NM1	NM109 - Referring Provider Identifier	'10 digit' NPI assigned to the provider.
193	2310A	PRV	PRV01 – Provider Code	'RF' – Referring
193	2310A	PRV	PRV02 – Reference Identification Qualifier	'PXC' – Health Care Provider Taxonomy Code
193	2310A	PRV	PRV03 – Provider Taxonomy Code	10' digit Taxonomy Code
Rendering Provider Name				
Rendering/Individual/Billing Provider Information: This is the Individual Provider Number if billed in conjunction with a Clinic or Group.				

Page	Loop	Segment	Data Element	Comments
197	2310B	NM1	NM101 – Entity Identifier Code	'82' – Rendering Provider
197	2310B	NM1	NM102 - Entity Type Qualifier	1' Person '2' Non-Person Entity
197	2310B	NM1	NM103 – Rendering Provider Name Last or Organization Name	Rendering Provider Last Or Organization Name
198	2310B	NM1	NM108 - Identification Code Qualifier	'XX' Centers for Medicare and Medicaid Services National Provider Identifier
198	2310B	NM1	NM109 - Rendering Provider Identifier	'10 digit' NPI assigned to the provider.
199	2310B	PRV	PRV01 - Provider Code	'PE' – Performing
199	2310B	PRV	PRV02 - Reference Identification Qualifier	'PXC' Health Care Provider Taxonomy Code
199	2310B	PRV	PRV03 - Provider Taxonomy Code	'10 digit' Taxonomy Code
222	2320	SBR	SBR01 – Payer Responsibility Sequence Number Code	A- Payer Responsibility Four B – Payer Responsibility Five C – Payer Responsibility Six D – Payer Responsibility Seven E – Payer Responsibility Eight F – Payer Responsibility Nine G – Payer Responsibility Ten H – Payer Responsibility eleven P – Primary S – Secondary T – Tertiary U – Unknown <i>*See section 1.1.1 Special Clarification #14 for MCO usage.</i>
222	2320	SBR	SBR02 – Individual Relationship Code	01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner

Page	Loop	Segment	Data Element	Comments
				G8 Other Relationship
223	2320	SBR	SBR03 – Insured Group or Policy Number	
224	2320	SBR	SBR09 – Claim Filing Indicator	“11” Other Non-Federal Programs “12” Preferred Provider Organization (PPO) “13” Point of Service (POS) “14” Exclusive Provider Organization (EPO) “15” Indemnity Insurance “16” Health Maintenance Organization (HMO) Medicare Risk “17” Dental Maintenance Organization “AM” Automobile Medical “BL” Blue Cross/Blue Shield “CH” Champus “CI” Commercial Insurance Co. “DS” Disability “FI” Federal Employees Program “HM” Health Maintenance Organization “LM” Liability Medical “MC” Medicaid “TV” Title V “VA” Veterans Affairs Plan “WC” Workers’ Compensation Health Claim “ZZ” Mutually Defined <i>Use Code ZZ when Type of Insurance is not known.</i>
Service Facility Location Name				

Page	Loop	Segment	Data Element	Comments
203	2310C	NM1	NM101 – Entity Identifier Code	'77' – Service Location
203	2310C	NM1	NM102 – Entity Type Qualifier	'2' – Non-Person Entity
203	2310C	NM1	NM103 – Laboratory or Facility Name	Name of Service Facility or Laboratory
203	2310C	NM1	NM108 – Identification Code Qualifier	'XX' Centers for Medicare and Medicaid Services National Provider Identifier
204	2310C	NM1	NM109 – Identification Code	'10 digit' NPI assigned to the provider.
205	2310C	N3	N301 – Laboratory or Facility Address Line	Laboratory or Facility Address Line
206	2310C	N4	N401 – Laboratory or Facility City Name	Laboratory or Facility City Name
207	2310C	N4	N402 – Laboratory or Facility State or Province Code	Laboratory or Facility State or Province Code
207	2310C	N4	N403 – Laboratory or Facility Postal Zone or ZIP Code	Laboratory or Facility Postal Zone or ZIP Code
Other Subscriber Information				
227	2320	CAS	CAS02 – Adjustment Reason Code	All external code source values from code source 139 are allowed. All denied encounters must submit value 'A1'.
227	2320	CAS	CAS03 – Adjustment Amount	Adjustment Amount For denied encounters this amount will equal the Total Charge Amount in CLM02 in Loop 2300
234	2320	OI	OI03 - Benefit Assignment Certification Indicator	'Y' – Yes
235	2320	OI	OI06 – Release of Information Code	'Y' – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data

Page	Loop	Segment	Data Element	Comments
Other Subscriber Name				
240	2330A	NM1	NM101 – Entity Identifier Code	‘IL’ Insured or Subscriber
240	2330A	NM1	NM102 – Entity Type Qualifier	‘1’ Person
240	2330A	NM1	NM103 – Other Insured Last Name	Other Subscriber Last Name
241	2330A	NM1	NM108 – Identification Code Qualifier	‘MI’ member Identification Number
241	2330A	NM1	NM109 – Other Insured Identifier	Other Subscriber Member Identification
245	2330A	REF	REF01 – Reference Identification Qualifier	‘SY’ – Social Security Number
245	2330A	REF	REF02 – Other Insured Additional Identifier	‘9’ digit Other Subscriber Member social Security Number
Other Payer Name				
Note: 2330B DTP or 2430 DTP segment required for Encounters. 2330B REF segment required for Encounters.				
246	2330B	NM1	NM101 – Entity Identifier Code	‘PR’ Payer
246	2330B	NM1	NM102 – Entity Type Qualifier	‘2’ Non-Person Entity
247	2330B	NM1	NM103 – Other Payer Name Last or Organization	
247	2330B	NM1	NM108 – Identification Code Qualifier	‘PI’ Payer Identification
247	2330B	NM1	NM109 – Other Payer Primary Identifier	For ENCOUNTER only. Use MCO or Passport 10 digit trading partner ID when NM101 PR represents MCO or Passport as the payer.

Page	Loop	Segment	Data Element	Comments
251	2330B	DTP	DTP01 – Date Time Qualifier	'573' – Date Claim Paid
251	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Expressed in Format CCYYMMDD
251	2330B	DTP	DTP03 – Adjudication or Payment Date	Adjudication or Payment Date
Service Line Number				
281	2400	LX	LX01 – Assigned Number	Submitter Assigned Number
282	2400	SV3	SV301 -1 Product/Service ID Qualifier	'AD' American Dental Association Codes
282	2400	SV3	SV301-2 Procedure Code	
284	2400	SV3	SV301-7 – Procedure Code Description	Send at discretion of submitter
284	2400	SV3	SV302 - Line Item Charge Amount	Line Item Charge Amount
285	2400	SV3	SV304-1 - Oral Cavity Designation Code	See Section 4 – of the Program specific required information for KY Medicaid claims processing
288	2400	TOO	TOO01 – Tooth Qualifier Code	'JP' – Universal National Tooth Designation
288	2400	TOO	TOO02 - Tooth Code	Tooth Number (This segment cannot be repeated, one tooth number per line only.)
289	2400	TOO	TOO03-1- TOO03-5 - Tooth Surface Code	B – Buccal D – Distal F – Facial I – Incisal L – Lingual M – Mesial O – Occlusal

Page	Loop	Segment	Data Element	Comments
290	2400	DTP	DTP01 – Date/Time Qualifier	'472' – Service
290	2400	DTP	DTP02 – Date Time Period Format Qualifier	D8 – Date Expressed in Format CCYYMMDD
290	2400	DTP	DTP03 – Service Date	Service Date
300	2400	REF	REF01 – Reference Identification Qualifier	'G1' – Prior Authorization Number
300	2400	REF	REF02 – Prior Authorization or Referral Number	Prior authorization Number Assigned by HP
302	2400	REF	REF01 – Reference Identification Qualifier	'6R' – Provider Control Number
303	2400	REF	REF02 – Line Item Control Number	Line Item Control Number The value received will be returned on the 835 transaction.
309	2400	K3	K301 – Fixed Format Information	Use to report denied details This segment is in conjunction with the CAS segment for denied information
317	2420A	NM1	NM101 –Entity Identifier Code	'82' – Rendering Provider Qualifier
317	2420A	NM1	NM102 – Rendering Provider Entity Type Qualifier	'1' - Person '2' - Non-Person Entity
317	2420A	NM1	NM103 – Rendering Provider Last Name or Organization Name	Last Name of Rendering Provider
318	2420A	NM1	NM108 – Identification Code Qualifier	XX - Centers for Medicare and Medicaid Services National Provider Identifier
318	2420A	NM1	NM109 – Rendering Provider Identifier	10-digit NPI Number assigned to Provider
319	2420A	PRV	PRV01 – Rendering Provider Qualifier	PE – Performing Provider

Page	Loop	Segment	Data Element	Comments
319	2420A	PRV	PRV02 – Reference Identification Qualifier	'PXC' Health Care Provider Taxonomy Code
319	2420A	PRV	PRV03 – Provider Taxonomy Code	Rendering Provider Taxonomy Code
346	2430	CAS	CAS01 – Claim Adjustment Group Code	'CO' - Contractual Obligations 'CR' - Correction and Reversals 'OA' - Other adjustments 'PI' - Payer Initiated Reductions 'PR' - Patient Responsibility
347	2430	CAS	CAS02 – Adjustment Reason Code	Adjustment Reason Code – Line Level All denied encounters must submit value 'A1'.
347	2430	CAS	CAS03 – Adjustment Amount	Adjustment Amount – Line Level For denied encounters this amount will equal the Total Charge Amount in CLM02 in Loop 2300
347	2430	CAS	CAS04 – Adjustment Quantity	Adjustment Quantity – Line Level
347	2430	CAS	CAS05 – Adjustment Reason Code	Adjustment Reason Code – Line Level
347	2430	CAS	CAS06 – Adjustment Amount	Adjustment Amount – Line Level
347	2430	CAS	CAS07 – Adjustment Quantity	Adjustment Quantity – Line Level
348	2430	CAS	CAS08 – Adjustment Reason Code	Adjustment Reason Code – Line Level
348	2430	CAS	CAS09 – Adjustment Amount	Adjustment Amount – Line Level
348	2430	CAS	CAS10 – Adjustment Quantity	Adjustment Quantity – Line Level
348	2430	CAS	CAS11 – Adjustment Reason Code	Adjustment Reason Code – Line Level

Page	Loop	Segment	Data Element	Comments
348	2430	CAS	CAS12 – Adjustment Amount	Adjustment Amount – Line Level
349	2430	CAS	CAS13– Adjustment Quantity	Adjustment Quantity – Line Level
349	2430	CAS	CAS14 – Adjustment Reason Code	Adjustment Reason Code – Line Level
349	2430	CAS	CAS15 – Adjustment Amount	Adjustment Amount – Line Level
349	2430	CAS	CAS16– Adjustment Quantity	Adjustment Quantity – Line Level
349	2430	CAS	CAS17– Adjustment Reason Code	Adjustment Reason Code – Line Level
350	2430	CAS	CAS18 – Adjustment Amount	Adjustment Amount – Line Level
350	2430	CAS	CAS19– Adjustment Quantity	Adjustment Quantity – Line Level

3.1 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