



# *KY Medicaid*

**MMIS Batch Health Care  
Institutional Health Care Claim  
And Encounter Claims (837I)  
Companion Guide**

*Version 3.5\_FINAL*

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

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## Document Change Log

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2.1	1/6/2012	Martha Senn	Inserted HI – Value code page on page 24
2.0	11/02/2011	Kathy Dugan-Ellett	Removed reference to ESC in NTE segments
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2.2	1/27/2012	Martha Senn	Update to DTP – Admission Date/Hour page 20
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2.4	2/15/2012	Martha Senn	Update to DTP – Admission Date/Hour was removed page 20. DMS approved 2/15/2012.
2.5	6/1/2012	Martha Senn	Removed NDC length requirement from LIN03 page 31
2.6	6/21/2012	Martha Senn	Inserted MCO SBR clarifications in section 1.1.1 Special Considerations as #16; 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.  Removed REF segment for Billing Provider Secondary Identification Number as 837I does not apply to KY Medicaid on Page 18
3.1	10/24/2012	Keri Hicks	Updates
3.2	11/16/2012	Martha Senn	Added NTE with value of A1 for denied detail on page 32  Added Region '09' to 2010BB REF on page 19
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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://www.cms.gov/TransactionCodeSetsStandards/02\\_TransactionsandCodeSetsRegulations.asp#TopOfPage](http://www.cms.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp#TopOfPage). The HIPAA Implementation Guides can be accessed at <http://www.wpc-edi.com/content/view/817/1>

## 1.1 Purpose

The 837 Institutional Transactions 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 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 transaction 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 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:**  
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. 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 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. Processing for the 2300-HI Segment for “Diagnosis Codes”:**

**The Commonwealth of Kentucky will accept the following values:**

- HI01-1 – BK Principal Diagnosis Code – 1 iteration of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required data elements;
- HI01-1 = BJ Admitting Diagnosis Code – 1 iterations of this HI segment is allowed – HI01-1 and HI01-2 are required data elements for an Inpatient Admission;
- HI01-1 = PR Patient Reason for Visit – 3 iterations of this HI segment is allowed – HI01-1 and HI01-2 are required for an Outpatient Visit;
- HI01-1 = BN External Cause of Injury – 12 iterations of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required if this segment is sent;
- HI01-1 = DR Diagnosis Related Group – 1 iteration of this HI segment is allowed – HI01-1 and HI01-2 are required if this segment is sent; and,
- HI01-1 = BF Other Diagnosis Codes – 12 iterations of this HI segment is allowed – HI01-1, HI01-2 and HI01-9 are required if this segment is sent.

**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. 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;

**17. Provider Types Required to Bill NDC:**

Provider types 01 (inpatient hospital) and 39 (renal dialysis clinics) are required to bill the NDC. They are required to bill the NDC quantity and NDC unit of measurement; and,

**18. 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.

19. NTE Billing Note – The Loop 2400 NTE segment must be used by MCO with the value of A1 for all paid claims with denied details.



## 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>ISA – INTERCHANGE CONTROL HEADER</b>				
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.
C.5	N/A	ISA	ISA08 - Interchange Receiver ID	'KY Medicaid' – Receiver ID

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
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

**2.2 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
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

**2.3 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
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
C.8	N/A	GS	GS08 - Version/Release/ Industry Identifier Code	'005010X223A2' – 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
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

**2.5 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
67	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
67	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number
67	N/A	ST	ST03 – Implementation Convention Reference	'005010X223A2' – Version / Release / Industry Identifier Code  Must be Identical to the value in GS08

## 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
488	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set Including ST and SE.
488	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. TA1 Structure can be found in the ASC X12N 837 (004010X096) Implementation Guide.

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 without errors.  'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted.  'R' – Transmitted interchange control structure header/trailer

**837 Institutional 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

**2.8 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 837I TRANSACTION

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
<b>Header</b>				
68	N/A	BHT	BHT01 – Hierarchical Structure Code	'0019' – Information Source, Subscriber, Dependent
68	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
69	N/A	BHT	BHT03 – Originator Application Transaction Identifier	The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number.  This data element is limited to 30 characters
69	N/A	BHT	BHT04 – Transaction Set Creation Date	This is the date that the original submitter created the claim file from their business application system.  Format = CCYYMMDD
69	N/A	BHT	BHT05 – Transaction Set Creation Time	This is the time that the original submitter created the claim file from their business application system.  Format = HHMM or HHMMSS or HHSSMMD or HHSSMMDD
69	N/A	BHT	BHT06 - Claim Identifier	'CH' – Chargeable (Use with Institutional Health Care Claim)  'RP' – Reporting (Use with Institutional Health Care Encounter)
<b>Submitter Name</b>				
71	1000A	NM1	NM101 – Entity Identifier Code	'41' – Submitter

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
72	1000A	NM1	NM102 – Entity Type Qualifier	'1' – Person '2' – Non-Person Entity
72	1000A	NM1	NM103 – Submitter Last or Organization Name	Required but not used in processing
72	1000A	NM1	NM104 – Submitter First Name	Required when NM102 = 1 Not used in processing
72	1000A	NM1	NM105 – Submitter Middle Name or Initial	Required when NM102 = 1 Not used in processing
72	1000A	NM1	NM108 – Identification Code Qualifier	'46' Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement
72	1000A	NM1	NM109 - Submitter Identifier	'Kentucky Medicaid assigned EDI Trading Partner ID'
74	1000A	PER	PER01 – Contact Function Code	'IC' – Information Contact
74	1000A	PER	PER02 – Submitter Contact Name	Submitter Contact Name
74	1000A	PER	PER03 - Communication Number Qualifier	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
74	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
74	1000A	PER	PER05 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' – Telephone
75	1000A	PER	PER06 – Communication Number	
75	1000A	PER	PER07 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' – Telephone

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
75	1000A	PER	PER08 – Communication Number	
<b>Receiver Name</b>				
76	1000B	NM1	NM101 – Entity Identifier Code	'40' – Receiver
76	1000B	NM1	NM102 – Entity Type Qualifier	'2' Non-Person Entity
77	1000B	NM1	NM103 – Receiver Name	'KYMEDICAID'
77	1000B	NM1	NM108 – Identification Code Qualifier	'46' Electronic Transmitter Identification Number (ETIN)
77	1000B	NM1	NM109 - Receiver Primary Identifier	'KYMEDICAID'
<b>Billing Provider Hierarchical Level</b>				
78	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.
78	2000A	HL	HL03 – Hierarchical Level Code	'20' – Information Source
79	2000A	HL	HL04 – Hierarchical Child Code	'1' – Additional Subordinate HL Data Segment in This Hierarchical Structure.
<b>Billing Provider Specialty Information</b>				
80	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider
80	2000A	PRV	PRV02 - Reference Identification Qualifier	'PXC' – Health Care Provider Taxonomy Code
80	2000A	PRV	PRV03 - Reference Identification	'Provider Taxonomy Code'
<b>Billing Provider Name</b>				

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
85	2010AA	NM1	NM101 – Entity Identifier Code	'85' – Billing Provider
85	2010AA	NM1	NM102 – Entity Type Qualifier	'2' – Non-Person Entity
85	2010AA	NM1	NM103 – Billing Provider Organizational Name	Billing Provider Organizational Name
85	2010AA	NM1	NM104 – Name First	Billing Provider First Name
86	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers
86	2010AA	NM1	NM109 - Billing Provider Identifier	'10 digit' NPI assigned to the provider
<b>Billing Provider Address</b>				
87	2010AA	N3	N301 – Billing Provider Address Line	The Billing Provider Address must be a street address. Post Office  Box or Lock Box addresses are to be sent in the Pay-To Address Loop  (Loop ID-2010AB), if necessary. Required but Kentucky Medicaid will not use in processing
87	2010AA	N3	N302 – Billing Provider Address Line	Required when there is a second address line  Kentucky Medicaid will not use this address in processing
<b>Billing Provider City, State, Zip Code</b>				
88	2010AA	N4	N401 – Billing Provider City Name	Required but Kentucky Medicaid will not use in processing
89	2010AA	N4	N402 – Billing Provider State or Province Code	Kentucky Medicaid will not use in processing
89	2010AA	N4	N403 – Billing Provider Postal Zone or Zip Code	Required but Kentucky Medicaid will not use in processing

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
				When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code must be provided.
<b>Billing Provider Tax Identification</b>				
90	2010AA	REF	REF01 – Reference Identification Qualifier	'EI' – Employer's Identification Number
90	2010AA	REF	REF02 – Billing Provider Tax Identification Number	The Employer's Identification Number must be a string of exactly nine numbers with no separators.
<b>Billing Provider Contact Information</b>				
92	2010AA	PER	PER01 – Contact Function Code	'IC' – Information Code
92	2010AA	PER	PER02 – Billing Provider Contact Name	Billing Provider Contact Name
92	2010AA	PER	PER03 – Communication Number Qualifier	'EM' – Electronic Mail 'FX' – Facsimile 'TE' – Telephone
92	2010AA	PER	PER04 – Communication Number	
92	2010AA	PER	PER05 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' – Telephone
93	2010AA	PER	PER06 – Communication Number	
93	2010AA	PER	PER07 – Communication Number Qualifier	'EM' – Electronic Mail 'EX' – Telephone Extension 'FX' – Facsimile 'TE' – Telephone
93	2010AA	PER	PER08 – Communication Number	
<b>Subscriber Hierarchical Level</b>				
<b>Note: For Commonwealth of Kentucky, the subscriber is always the same as the patient (2000B SBR02=18, SBR09=MC).</b>				

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
107	2000B	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.
108	2000B	HL	HL02 –Hierarchical Parent ID Number	
108	2000B	HL	HL03 –Hierarchical Level Code	‘22’ – Subscriber
108	2000B	HL	HL04 - Hierarchical Child Code	‘0’ – No Subordinate HL Segment in this Hierarchical Structure
<b>Subscriber Information</b>				
109	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 S - Secondary T – Tertiary U - Unknown <i>*See section 1.1.1 Special Clarification #16 for MCO usage.</i>
110	2000B	SBR	SBR02 – Individual Relationship Code	‘18’ – Self
110	2000B	SBR	SBR09 - Claim Filing Indicator Code	‘MC’ – Medicaid
<b>Subscriber Name</b>				
112	2010BA	NM1	NM101 – Entity Identifier Code	‘IL’ – Insured or Subscriber

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
113	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
113	2010BA	NM1	NM103 – Subscriber Last Name	Required but Kentucky Medicaid will not use in processing
113	2010BA	NM1	NM104 – Subscriber First Name	Required but Kentucky Medicaid will not use in processing
113	2010BA	NM1	NM108 - Identification Code Qualifier	'MI' – Member Identification Number
114	2010BA	NM1	NM109 - Subscriber Primary Identifier	'10 digit' – Kentucky Medicaid Member Identification Number (MAID)
<b>Subscriber Address</b>				
115	2010BA	N3	N301 – Subscriber Address Line	Required but Kentucky Medicaid will not use in processing
115	2010BA	N3	N302 – Subscriber Address Line	Required when there is a second address line  Kentucky Medicaid will not use this address in processing
<b>Subscriber City, State, Zip Code</b>				
116	2010BA	N4	N401 – Subscriber City Name	Required but Kentucky Medicaid will not use in processing
116	2010BA	N4	N402 – Subscriber State Code	Required but Kentucky Medicaid will not use in processing
117	2010BA	N4	N403 – Subscriber Postal Zone or Zip Code	Required but Kentucky Medicaid will not use in processing
<b>Subscriber Demographic Information</b>				
118	2010BA	DMG	DMG01 – Date/Time Period Format Qualifier	'D8' – Date Expressed in Format CCYYMMDD

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
118	2010BA	DMG	DMG02 – Subscriber Birth Date	Required but Kentucky Medicaid will not use in processing
119	2010BA	DMG	DMG03 – Subscriber Gender Code	'F' – Female 'M' – Male 'U' – Unknown Required but Kentucky Medicaid will not use in processing
<b>Payer Name</b>				
122	2010BB	NM1	NM101 – Entity Identifier Code	'PR' – Payer
123	2010BB	NM1	NM102 – Entity Type Qualifier	'2' – Non-Person Entity
123	2010BB	NM1	NM103 - Payer Name	'KYMEDICAID'
123	2010BB	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
123	2010BB	NM1	NM109 - Payer Identifier	'KYMEDICAID'
127	2010BB	REF	REF01 – Reference Identification Qualifier	'FY' – Claim Office Number  This data element is required by KY Medicaid
128	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
<b>Claim Information</b>				
144	2300	CLM	CLM01 - Patient Control Number	Patient Control Number  Length allowed: 1 to 38. The value received will be returned on the 835 transaction.

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Page	Loop	Segment	Data Element	Comments
145	2300	CLM	CLM02 – Total Claim Charge Amount	The Total Claim Charge Amount must be greater than or equal to zero.  The total claim charge amount must balance to the sum of all service line charge amounts reported in the Institutional Service  Line (SV2) segments for this claim.
145	2300	CLM	CLM05-1 – Facility Type Code	Value received is the 1 <sup>st</sup> position of the Type of Bill (TOB)  See External Code Source List 235 for valid values
145	2300	CLM	CLM05-2 – Facility Code Qualifier	'A' – Uniform Billing Claim Form Bill Type
145	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value received is the 3 <sup>rd</sup> position of the Type of Bill (TOB) See External Code Source List 235 for valid values.
146	2300	CLM	CLM07 – Assignment or Plan Participation Code	'A' – Assigned
146	2300	CLM	CLM08 - Benefits Assignment Certification Indicator	'Y' – Yes
147	2300	CLM	CLM09 – Release of Information Code	'Y' – Yes
149	2300	DTP	DTP01 - Date/Time Qualifier	'096' – Discharge Required on all Final Inpatient Claims
149	2300	DTP	DTP02 – Date Time Period Format Qualifier	'TM' – Time (HHMM)
149	2300	DTP	DTP03 - Discharge Time	Discharge Hour

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
150	2300	DTP	DTP01 - Date/Time Qualifier	'434' – Statement Covers Period Dates
150	2300	DTP	DTP02 - Date Time Period Qualifier	'RD8' – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
150	2300	DTP	DTP03 - Statement From and To Date	Statement Covers Period (From-Through)
151	2300	DTP	DTP01 - Date/Time Qualifier	'435' – Admission Required on all Inpatient Claims
151	2300	DTP	DTP02 - Date Time Period Qualifier	'DT' – Date and Time Expressed in Format CCYYMMDDHHMM
151	2300	DTP	DTP03 - Admission Date/ and Hour	'CCYYMMDD' – Admission Date 'HHMM' – Admission Hour
153	2300	CL1	CL101 – Admission Type Code	Required when patient is being admitted for inpatient services. Admission Type code are available from: Nation Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697
153	2300	CL1	CL102 – Admission Source Code	Required for all inpatient and outpatient services Admission Source code are available from: Nation Uniform Billing Committee American Hospital Association 840 Lake Shore Drive Chicago, IL 60697
153	2300	CL1	CL103 – Patient Status Code	Patient Status code are available from: Nation Uniform Billing Committee American Hospital Association 840

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
				Lake Shore Drive Chicago, IL 60697
164	2300	REF	REF01 – Reference Identification Qualifier	'G1' – Prior Authorization Number
165	2300	REF	REF02 – Prior Authorization Number	Assigned Prior Authorization Number
166	2300	REF	REF01 – Reference Identification Qualifier	'F8' – Original Reference Number
166	2300	REF	REF02 – Payer Claim Control Number	FFS: Original KY Medicaid Internal Control Number (ICN) MCO: Original MCO Assigned Internal Control Number
172	2300	REF	REF01 – Reference Identification Qualifier	'LU' – Location Code
172	2300	REF	REF02 – Auto Accident State or Province Code	Required when the services reported on this claim are related to an auto accident
181	2300	CRC	CRC01 – Code Qualifier	'ZZ' – EPSDT Screening Referral Information Required on Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) claims when the screening service is being billed in this claim.
182	2300	CRC	CRC02 – Certification Condition Code Applies Indicator	The response answers the question: Was an EPSDT referral given to the patient? 'Y' – Yes 'N' – No
182	2300	CRC	CRC03 – Condition Indicator	'AV' - Available – Not Used  'NU' – Not Used  'S2' - Under Treatment  'ST' - New Services Requested

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
184	2300	HI	HI01-1 – Principal Diagnosis Code Qualifier	'BK' – International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis Required
185	2300	HI	HI01-2 – Principal Diagnosis Code	Required
186	2300	HI	HI01-9 – Present on Admission Indicator	Required as directed by the NUBC billing manual
188	2300	HI	HI01-1 – Admitting Diagnosis Qualifier	'BJ' – International Classification of Diseases Clinical Modification (ICD-9-CM) Admitting Diagnosis Required on Inpatient Claims
188	2300	HI	HI01-2 – Admitting Diagnosis	Required on Inpatient Claims
190	2300	HI	HI01-1 – Patient's Reason for Visit Qualifier	'PR' – International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit
190	2300	HI	HI01-2 – Patient's Reason for Visit	Required on Outpatient Claims
194	2300	HI	HI01-1 – External Cause of Injury Qualifier	'BN' – International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) Required when an external Cause of Injury is needed to describe an injury, poisoning, or adverse effect
194	2300	HI	HI01-2 – External Cause of Injury	Required when an external Cause of Injury is needed to describe an injury, poisoning, or adverse effect
195	2300	HI	HI01-9 – Present on Admission Indicator	Required as directed by the NUBC billing

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
				Manual.
221	2300	HI	HI01-1 – Other Diagnosis Qualifier	'BF' – International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis
221	2300	HI	HI01-2 – Other Diagnosis	
221	2300	HI	HI01-9 – Present on Admission Indicator	Required as directed by the NUBC billing Manual.
240	2300	HI	HI01-1 - Principal Procedure Code Qualifier	'BR' – International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure Codes Required on inpatient claims when a procedure was performed
240	2300	HI	HI01-2 - Other Procedure Code	
243	2300	HI	HI01-1 - Other Procedure Code Qualifier	'BQ' – International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes
243	2300	HI	HI01-2 - Other Procedure Code	ICD-9-CM Other Procedure Codes
284	2300	HI	HI01-1 Code list Qualifier Code	'BE' Value
284	2300	HI	H101-2 Value Code	'80' – covered days '82' – co-insurance days for crossover claims  Value codes are necessary for inpatient & psych hospital, PRTF, nursing facilities, psych distinct part unit & rehab distinct part unit

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
285	2300	HI	HI01-5 Value Code Amount	Number of covered or non-covered days
180	2300	NTE	NTE01 – Note Reference Code	‘ADD’ – Additional Information
180	2300	NTE	NTE02 – Claim Note Text	
<b>Attending Physician Name</b>				
<b>Required when the claim contains any services other than non-scheduled transportation claims</b>				
319	2310A	NM1	NM101 – Entity Identifier Code	‘71’ – Attending Physician
320	2310A	NM1	NM102 – Entity Type Qualifier	‘1’ - Person
320	2310A	NM1	NM103 – Attending Provider Last Name	Required but not used by Kentucky Medicaid for Processing
320	2310A	NM1	NM104 – Attending Provider First Name	Required when the person has a first name Kentucky Medicaid will not use for processing
321	2310A	NM1	NM108 - Identification Code Qualifier	‘XX’ – Centers for Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers
321	2310A	NM1	NM109 - Attending Provider Primary Identifier	‘10 digit’ NPI assigned to the provider
<b>Operating Physician Name</b>				
<b>Required when a surgical procedure code is listed on this claim</b>				
327	2310B	NM1	NM101 – Entity Identifier Code	‘72’ – Operating Physician

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
327	2310B	NM1	NM102 – Entity Type Qualifier	'1' - Person
327	2310B	NM1	NM103 – Operating Physician Last Name	Required but not used by Kentucky Medicaid for Processing
327	2310B	NM1	NM104 – Operating Physician First Name	Required when the person has a first name Kentucky Medicaid will not use for processing
328	2310B	NM1	NM108 - Identification Code Qualifier	'XX' – Medicare and Medicaid Services National Provider Identifier (NPI) for Healthcare Providers
328	2310B	NM1	NM109 - Operating Physician Primary Identifier	'10 digit' NPI assigned to the provider
<b>Rendering Provider Name</b>				
<b>KenPac or Lock-in Information</b>				
<b>KenPac/Lock-in Provider Information MUST be billed in this loop when required for Inpatient/Outpatient Services</b>				
337	2310D	NM1	NM101 – Entity Identifier Code	'82' – Rendering Provider
337	2310D	NM1	NM102 – Entity Type Qualifier	'1' - Person
337	2310D	NM1	NM103 – Rendering Provider Last Name	Required but not used by Kentucky Medicaid for Processing
337	2310D	NM1	NM104 – Rendering Provider First Name	Required when the person has a first name Kentucky Medicaid will not use for processing
338	2310D	NM1	NM108 - Identification Code Qualifier	'XX' – Centers for Medicare and Medicaid Services National Provider Identifier

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
				(NPI) for Healthcare Providers
338	2310D	NM1	NM109 - Rendering Provider Identifier	'10 digit' NPI assigned to the provider
<b>Other Subscriber Information</b>				
355	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 #16 for MCO usage.</i>
355	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 G8 Other Relationship
356	2320	SBR	SBR03 – Insured Group or Policy Number	
356	2320	SBR	SBR09 – Claim Filing Indicator	'CI' – Commercial Insurance Co 'MA' – Medicare Part A 'MB' – Medicare Part B
360	2320	CAS	CAS01 – Claim Adjustment Group Code	CO -Contractual Obligations CR -Correction and Reversals OA -Other adjustments PI -Payor Initiated Reductions PR -Patient Responsibility

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
360	2320	CAS	CAS02 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.  All denied encounters must submit value 'A1'.
360	2320	CAS	CAS03 – Adjustment Amount	Adjustment Amount  For denied encounters this amount will equal the Total Charge Amount in CLM02 in Loop 2300
360	2320	CAS	CAS04 – Adjustment Quantity	Adjustment Quantity
360	2320	CAS	CAS05 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.
360	2320	CAS	CAS06 – Adjustment Amount	Adjustment Amount
361	2320	CAS	CAS07 – Adjustment Quantity	Adjustment Quantity
361	2320	CAS	CAS08 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.
361	2320	CAS	CAS09 – Adjustment Amount	Adjustment Amount
361	2320	CAS	CAS10 – Adjustment Quantity	Adjustment Quantity
362	2320	CAS	CAS11 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.
362	2320	CAS	CAS12 – Adjustment Amount	Adjustment Amount

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
362	2320	CAS	CAS13 – Adjustment Quantity	Adjustment Quantity
362	2320	CAS	CAS14 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.
362	2320	CAS	CAS15 – Adjustment Amount	Adjustment Amount
362	2320	CAS	CAS16 – Adjustment Quantity	Adjustment Quantity
363	2320	CAS	CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed except for denied encounters.
363	2320	CAS	CAS18 – Adjustment Amount	Adjustment Amount
363	2320	CAS	CAS19 – Adjustment Quantity	Adjustment Quantity
364	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
364	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
<b>Other Insurance Coverage Information</b>				
367	2320	OI	OI03 – Benefits Assignment Certification Indicator	'Y' - Yes
368	2320	OI	OI06 – Release of Information Code	'Y' - Yes
<b>Other Subscriber Name</b>				
378	2330A	NM1	NM101 – Entity Identifier Code	'IL' – Insured or Subscriber

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
378	2330A	NM1	NM102 – Entity Type Qualifier	'1' – Person '2' – Non-Person Entity
378	2330A	NM1	NM103 – Other Insured Last Name	
378	2330A	NM1	NM104 – Other Insured First Name	Required when NM102 = 1 and the person has a first name
379	2330A	NM1	NM108 – Identification Code Qualifier	'MI' – Member Identification Number
379	2330A	NM1	NM109 – Other Insured Identifier	
<b>Other Payer Name</b>				
<b>Note: 2330B DTP or 2430 DTP segment required for Encounters. 2330B REF segment required for Encounters.</b>				
384	2330B	NM1	NM101 – Entity Identifier Code	'PR' – Payer
384	2330B	NM1	NM102 – Entity Type Qualifier	'2' – Non-Person Entity
385	2330B	NM1	NM103 – Other Payer Last or Organization Name	
385	2330B	NM1	NM108 – Identification Code Qualifier	'PI' – Payer Identification
385	2330B	NM1	NM109 – Other Insured Payer Primary Identifier	<b>For ENCOUNTER only.</b> Use MCO or Passport 10 digit trading partner ID when NM101 PR represents MCO or Passport as the payer.
389	2330B	DTP	DTP01 - Date/Time Qualifier	'573' - Other Payer or MCO Claim Paid Date
389	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)

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Page	Loop	Segment	Data Element	Comments
389	2330B	DTP	DTP03 – Adjudication or Payment Date	TPL or MCO Paid Date (CCYYMMDD)
<b>Service Line Number</b>				
423	2400	LX	LX01 – Assigned Number	The Service Line LX segment must begin with one and is incremented by one for each additional service line of a claim.
424	2400	SV2	SV201 – Service Line Revenue Code	See Code Source 132: National Uniform Billing Committee (NUBC) Codes.
426	2400	SV2	SV202-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
426	2400	SV2	SV202-2 – Procedure Code	
427	2400	SV2	SV202-7 – Description	Will be returned on 835 if submitted
427	2400	SV2	SV203 – Line Item Charge Amount	
428	2400	SV2	SV204 – Unit or Basis for Measurement Code	'DA' – Days 'UN' - Unit
428	2400	SV2	SV205 – Service Unit Count	
428	2400	SV2	SV207 - Line Item Denied Charge or Non0Covered Charge Amount	Service Line Non-Covered Charge Amount
435	2400	REF	REF01 – Reference Identification Qualifier	'6R' – Provider Control Number
435	2400	REF	REF02 – Line Item Control Number	Will be returned on 835 if submitted
441	2400	NTE	NTE01 – Note Reference Code  Third Party Organization Notes	'TPO'

**837 Institutional Health Care Claim and Encounter Claims**

Page	Loop	Segment	Data Element	Comments
441	2400	NTE	NTE02 – Line Note Text	'A1'
<b>Drug Identification</b>				
451	2410	LIN	LIN02 – Product/Service Id Qualifier	N4 – National Drug Code
451	2410	LIN	LIN03 – National Drug Code	National Drug Code
452	2410	CTP	CTP04 – National Drug Unit Count	
453	2410	CTP	CTP05-1 Unit or Basis for Measurement Code	F2 - International Unit GR - Gram ME - Milligram ML - Milliliter UN - Unit
454	2410	REF	REF01 – Reference Identification Qualifier	VY - Link Sequence Number XZ - Pharmacy Prescription Number
455	2410	REF	REF02 – Prescription Number	