



Kentucky Health Cooperative

**ANSI ASC X12N 837I
Health Care Claim: Institutional
Companion Guide**

January 2014

Introduction

The Kentucky Health Cooperative (KYHC) is publishing this *Electronic Data Interchange (EDI) 837I Institutional Transaction Companion Guide (Companion Guide)* to accompany the *ASC X12 Standards for Electronic Data Interchange Institutional Technical Report Type 3 (Technical Report Type 3)* for the *ASC X12N Health Care Claims Institutional (837) Transaction Set*.

The *Technical Report Type 3* provides general information about EDI transmission, such as delimiters, enveloping and related topics. This Kentucky Health Cooperative *Companion Guide* will not duplicate these efforts.

HIPAA *Technical Report Type 3* is available through Washington Publishing, Inc. at: <http://www.wpc-edi.com/>

If you are using an EDI clearing house, they will have access to the WPC HIPAA *Technical Report Type 3*. Please contact your clearing house if you have any questions on the use of the WPC HIPAA *Technical Report Type 3*.

Preferences and Conventions

1. Trading Partner Agreements specify the terms and conditions by which transactions are exchanged electronically with the Co-op. This *Companion Guide* may be an addendum to a new or existing Trading Partner Agreement.
2. It is recommended in the *Technical Report Type 3* that each transaction (ST-SE envelope) be limited to a maximum of 5000 claims.
3. While all of the characters in the extended character set are supported, it is recommended that incoming 837 claim data use the basic character set as defined in *Appendix B of the Technical Report Type 3*.
4. The subscriber hierarchical level (HL segment) must be in order from one, in increments of one (+1), and must be numeric.
5. Trading Partners cannot send test and production information within the same transaction file, regardless of the transaction. Test data and production data must be submitted in separate files.
6. Only multiple data loops or segments should be populated with the first occurrence, and each loop or segment populated consecutively thereafter. There should be no loops or segments without valid data.
7. Delimiters must be consistently applied throughout the transmissions. The following are the delimiters to use when submitting files:
 - Data Element Separator Delimiter [] *
 - Sub Element Separator Delimiter [] :
 - Segment Terminator Delimiter [] ~
8. The submitter's Organization/User ID, which also can be found in ISA06 and GS02, must be included in the filename. Example: <submitter_ID>_837I_KY_<yyyymmdd>_<counter>.837
9. Payer response file naming conventions are as follows:
 - List File Name: 837I_KY_Optum.277
 - List File Name: 837I_KY_Optum.999

Privacy and Security Protection

The Kentucky Health Cooperative complies with the privacy and confidentiality requirements as outlined in the *HIPAA Privacy and Security* regulations regarding the need to protect health information. All Trading Partners are also expected to comply with these regulations.

Loop 2010BB – 837 Institutional

The following table details segment specifics and data elements that require specific information for processing by the Kentucky Health Cooperative.

837 Health Care Claim: Institutional – Payer Level Detail			
This table includes only data elements requiring specific information for KY Co-op processing			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to KY Co-op
Loop 2010BB			
NM1 Payer Name REQUIRED	NM101 – Entity Identifier Code	<i>PR</i>	Payer
NM1 Payer Name REQUIRED	NM102 – Entity Type Qualifier	<i>2</i>	Non-Person Entity
NM1 Payer Name REQUIRED	NM103 – Name Last or Organization Name		"KENTUCKY HEALTH COOPERATIVE"
NM1 Information Source Code REQUIRED	NM108 – Entity Identifier Code	<i>PI</i>	Payer Identification
NM1 Information Source Code REQUIRED	NM109 – Identification Code		"77894"

Additional Information

Taxonomy Code

The Kentucky Health Cooperative highly recommends that the submitter sends in the Provider Taxonomy code in the PRV Segment at either the 2000A Loop or the 2310A Loop. This is not required; however, if the Co-op is required to perform specialty type validation for specific payers, thus requiring the need for this information, a generic value will be assigned if the claim is sent in without this data.