Blue Cross Blue Shield of Michigan

HIPAA Transaction Standard Companion Guide

American National Standards Institute (ANSI) ASC X12N 837 (005010X223A2) Institutional Health Care Claim

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Disclosure Statement

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Preface

The Health Insurance Portability and Accountability Act-Administration Simplification (HIPAA-AS) requires BCBSM and all other covered entities to comply with the electronic data interchange standards for health care as established by the Department of Health and Human Services. The ASC X12N/005010X223 837 Technical Report Type 3 (TR3) for Health Care Claim Payment/Advice and its associated Errata 005010X223A2 - has been established as the standard for electronic institutional health care claim transactions and are available at **www.wpc-edi.com**.

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INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table.

The tables contain a row for each segment that BCBSM has something additional, over and above, the information in the IGs. That information can:
1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with BCBSM

In addition to the row for each segment, one or more additional rows may be used to describe BCBSM's usage for composite and simple data elements and for any other information.

TR3 Pg #	837 Loop ID	837 Segment/ Element Reference	Industry/ Data Element Name	Codes	Notes/Comments/Instruction
TR3 PAGE NUMBER: 77	LOOP NUMBER: *1000B*	SEGMENT OR ELEMENT IDENTIFIER: *NM103*	IMPLEMENTATION NAME: *Receiver Name*	CODE, QUALIFIER MODIFIER OR OTHER: *N/A*	BCBSM OR OTHER PAYER SPECIFIC INSTRUCTION: *Report BCBSM as the receiver name.*

1.1 SCOPE/OVERVIEW

This document is intended for use as a companion to the HIPAA-mandated ASC X12N/005010X223A2 837 TR3, dated May 2006, and the modifications implemented with the adopted Type 1 Errata (X12N/005010X223A2) dated June 2010. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the noted HIPAA TR3 and the adopted Type 1 Errata published by Washington Publishing Company.

1.2 REFERENCES

To obtain any or all of the HIPAA mandated 005010 ASC X12 TR3s, please visit X12's website: **http://store.x12.org/store/**, or Washington Publishing Company's website: **www.wpc-edi.com**

To obtain Health Care Code Lists, please refer to Washington Publishing Company's website: **http://www.wpc-edi.com/reference/**.

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1.3 GENERAL EDI TERMINOLOGY

Addenda – Refers to a version of the HIPAA mandated transaction sets that corrects identified implementation issues noted in the original TR3.

ASC X12N/005010X223 – The HIPAA mandated (ANSI) ASC X12N Institutional Health Care Claim transaction format.

ASC X12N/005010X223A2 – The Type 2 Errata modifications mandated for use with the ASC X12N/005010X223 837 Institutional Health Care Claim transaction format.

BCBSA – An acronym for Blue Cross Blue Shield Association

BCBSM or FEP Supplemental – BCBSM or FEP is being billed as the secondary payer and the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO.

BCC – An acronym for Blue Cross Complete of Michigan, a Medicaid managed care plan

BCN – An acronym for Blue Care Network

BlueCard – A BCBSA process through which HIPAA claim transactions for members from all other Blue Cross and/or Blue Shield plans that are governed by the BCBSA can be accepted by a local host plan (the plan that delivers the benefits to a member) and routed to the home plan (the plan that covers the member) for processing. This includes claims for out of state Medicare Advantage.

BlueExchange – A BCBSA process through which non-claim HIPAA transactions for members from all other Blue Cross and/or Blue Shield plans that are governed by the BCBSA can be accepted by a local host plan (the plan that delivers the benefits to a member) and routed to the home plan (the plan that covers the member) for processing.

Data Segment – Corresponds to a record in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12N). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

Data Element – Corresponds to a field in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are defined in Appendices B of the TR3.

Delimiter – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI – An acronym for Electronic Data Interchange.

Electronic Data Interchange – The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value-added network or value-added service provider.

FEP – Federal Employee Program

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Home Plan – The Blue Cross Blue Shield plan that holds a member's contract.

Host Plan – The Blue Cross Blue Shield plan that delivers the service. For example, if a Michigan member receives services from a BCBS participating physician in another state, the physician would bill the BCBS plan [host plan] located in that state.

Interface – The point at which two systems connect to pass data.

Loops – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Medicare Beneficiary Identifier (MBI) – an eleven-character alpha numeric identification number issued by the Center for Medicare Services, which replaces the Medicare Health Insurance Claim Number (HICN).

NASCO – The National Account Service Company connects several Blue Cross and Blue Shield plans across the country through a common automated system to administer health benefit programs.
Routing – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Technical Reports Type 3 (TR3s) – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA TR3s on their web site: **http://store.x12.org/store/**

Trading partners – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Transaction Set – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.

X12N – An Accredited Standards Committee commissioned by the American National Standards Institute to develop standards for Electronic Data Interchange. While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

GETTING STARTED

2.1 WORKING WITH BCBSM

Appropriate steps must be taken before you can submit production 005010X223A2 837 transactions or receive ASC X12N 835 005010X221A1 Health Care Claim Payment/Advice transactions. BCBSM requires:

- Completion of an EDI Trading Partner Agreement,
- Completion of a Provider Authorization,
- Completion of an ERA Enrollment form.

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All three of these forms are completed online at **https://editest.bcbsm.com/tpalogon.html.** Instructions for completing the forms are available at the bottom of the log in screen.

- Go to **bcbsm.com.**
- Click on *Providers* above the blue banner bar.
- Click the *Quick Links* box.
- From the Quick Links list, click *Electronic Connectivity (EDI)*.
- From the *EDI agreements* section, click *Complete the Trading Partner Agreement.*
- To review the instructions document, click *Download step-by-step instructions for completing the TPA (PDF)* located under **Questions? We can help!**

To begin this process, receive more information or ask questions, please contact the EDI Help Desk at 1-800-542-0945.

2.1.1 TRADING PARTNER REGISTRATION

Completion of an EDI Trading Partner Agreement

Providers must complete a BCBSM Trading Partner Agreement (TPA) and complete a Provider Authorization to register their National Provider Identifier (NPI) with EDI.

TPA not completed:

Providers that have **not** completed a TPA must follow these steps prior to submitting 837 batch claim transactions:

- Obtain the submitter ID from your EDI submitter, service bureau or software vendor;
- Contact the EDI Helpdesk at 1-800-542-0945, opt. #3, or email EDISupport@bcbsm.com, to obtain a BCBSM User ID and Password. Providers will need to supply their NPI, and specify if they are Institutional, Professional, or Dental.
- A User ID and Password will be assigned and provided via fax or email. This process should take no more than 24 hours.
- Follow the instructions in the fax or email to access and complete the TPA online.
- Once the TPA is completed, providers must complete the Provider Authorization and ERA Enrollment Forms.

2.1.2 PROVIDER AUTHORIZATION

Completion of Provider Authorization

The Provider Authorization should only be completed once you have verified with your EDI submitter, service bureau or software vendor that they have tested with BCBSM and are approved for electronic submission.

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2.1.3 ERA ENROLLMENT

Completion of an ERA Enrollment form

The Electronic Remittance Advice Enrollment form should be completed if a trading partner wants to receive 835 transactions. Review the TPA and Provider Authorization *Step-by-step instructions document* or our 835 companion guide available on **bcbsm.com** for more information.

2.2 EDI INFORMATION SHEET – vendors or self-developers only

Software vendors, or electronic submitters who have developed their own software, must complete an EDI Information Sheet prior to submitting an 837 file. If an Information Sheet is not completed for each new submitter, 837 files will reject using a TA1 acknowledgement. For more information about TA1s, review the 5010 Acknowledgments Reference Document available on **bcbsm.com**.

Visit **https://editest.bcbsm.com/spokelogon.html** to complete or update the Information Sheet. The *Information Sheet Instructions (PDF)* document is located on the log in screen under **Questions? We can help!**

TRADING PARTNER AGREEMENTS

Our Trading Partner Agreement follows HIPAA guidelines for transactions, medical code sets, privacy and security. The TPA is a contract that must be completed by all providers and submitters who trade health care information electronically with us.

3.1 TRADING PARTNERS

An EDI Trading Partner is defined as any BCBSM customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Blue Cross Blue Shield Michigan.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

TESTING WITH THE PAYER

4.1 CERTIFICATION

BCBSM does not require or provide certification for its trading partners.

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4.2 TESTING OVERVIEW

Prior to submission of electronic claims and non-claims transactions to Blue Cross Blue Shield of MI (BCBSM), there is a two-step testing process that software must pass:

- Test in Validator: a self-testing tool that checks compliance Levels 1-6 based on requirements from the ANSI ASC X12N Technical Report Type 3 (TR3/Implementation Guide) for the specific 5010 Errata version transactions to be tested.
- Test in Subsystem: a Level 7 compliance check based on specific requirements outlined in the appropriate BCBSM Companion Document for the ANSI ASC X12N transactions being tested.

4.2.1 DEVELOPED YOUR OWN ELECTRONIC BILLING SOFTWARE?

To become an approved submitter, you must meet our testing requirements and complete these steps:

- Visit **https://editest.bcbsm.com/spokelogon.html**
- Review the self-testing user guide available on the log in screen.

4.2.2 SOFTWARE VENDOR, CLEARINGHOUSE OR SERVICE BUREAU

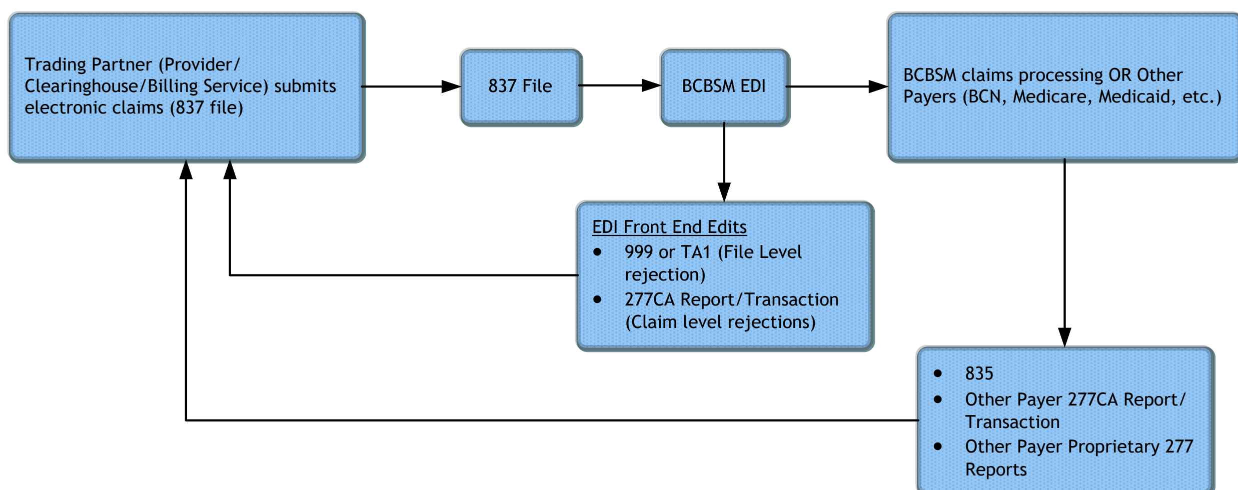
You must meet our testing requirements and follow these steps:

- Visit **https://editest.bcbsm.com/spokelogon.html**
- Review the self-testing user guide available on the log in screen.

CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

5.1 PROCESS FLOWS

Process flows for HIPAA Transactions Sets are located in the front matter of the applicable TR3 implementation guides. BCBSM'S 837 process includes:



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5.2 COMMUNICATION PROTOCOL SPECIFICATIONS

5.2.1 CONNECTION INSTRUCTIONS

BCBSM utilizes SFTP as the connection protocol for 837 transactions. If you are experiencing connectivity issues or need more information email EDISupport@bcbsm.com or contact our Help Desk at 1-800-542-0945.

It is recommended that you read the tutorial for the product you select. BCBSM cannot assist with setup issues on your system; please contact your vendor or technical staff.

5.3 PASSWORDS

SFTP users can obtain a password by contacting the EDI Help Desk at 1-800-542-0945, Opt. #1.

Passwords are required for completion of a Trading Partner Agreement, Provider Authorization or ERA Enrollment Form. Contact the EDI Helpdesk at 1-800-542-0945, Opt. #3, or email EDISupport@bcbsm.com, to obtain a BCBSM User ID and Password.

CONTACT INFORMATION

6.1 EDI CUSTOMER SERVICE: 1-800-542-0945.

The EDI Help Desk is available 8:00 am to 4:30 pm M-F.

When you contact the EDI Help Desk, we need to make sure of your identity before we can release any sensitive data, such as membership, benefit or claim information. BCBSM will request the following information from you to verify your identity and ensure the privacy and confidentiality of health care data of our members and providers:

- Caller name
- Name of provider, facility or submitter/software developer office
- Reason for call
- Member contract number (if applicable)
- Name of member (if applicable)
- Providers, submitters and software developers:

Professional (includes vision and hearing):	Billing NPI and BCBSM-assigned submitter ID
Facility:	Billing NPI or Federal tax identification number
Dental:	Federal tax identification number

6.1.1 Electronic Data Interchange Department Contacts

Customer inquiries should be made to the EDI Help Desk at 1-800-542-0945. The following telephone prompts should be followed:

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Option 1: Questions on transaction edits, remittances, Internet claim tool support, SFTP Password resets and connections, transmission issues, recreates and Payer ID listings.

Option 2: New customers or vendors who wish to obtain Submitter ID or electronic submission information

Option 3: Trading Partner Agreement and NPI or Provider Number Authorization questions including TPA and Authorization Login and Password IDs.

For general information or other questions, please email EDISupport@bcbsm.com

6.2 EDI TECHNICAL ASSISTANCE

For technical information or other questions, email EDISupport@bcbsm.com.

6.3 APPLICABLE WEBSITES/E-MAIL

Visit **bcbsm.com** and click *Contact Us* for a complete listing of contact information.

BCBSM GENERAL 837 INSTITUTIONAL HEALTH CARE CLAIM

7.1 GENERAL OVERVIEW

The BCBSM EDI clearinghouse accepts ANSI ASC X12N 837 version 005010X223A2 institutional transactions for BCBSM, Medicare Advantage, BCN, Blue Cross Complete, Blue Card, FEP, Medicare A, and MDHHS (Medicaid). Acceptance of 837 transactions will occur in batch mode and will not be accommodated in the real-time environment.

- BCBSM may edit data submitted beyond the requirements defined in the HIPAA TR3.
- BCBSM may reject interchanges, functional groups or transactions that do not follow all HIPAA TR3 and BCBSM Companion Document requirements.
- BCBSM will reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.
- BCBSM will reject a file that is determined to be a duplicate of a previously submitted file.

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7.2 COORDINATION OF BENEFITS

TR3 front matter Sections 1.4.4 and 1.4.5 provide examples and detailed information regarding claim balancing and allowed/approved amount calculations.

CONTROL SEGMENTS/ENVELOPES

8.1 ISA- IEA: DATA CLARIFICATION

ASC X12N/005010X223A2 – 837 Transaction Interchange Envelope and Functional Group Structure:

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA TR3s in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the TR3s. The interchange cannot contain non-HIPAA version functional groups.

The following sections address specific information needed by BCBSM in order to process the ASC X12N/005010X223A2 837 Institutional Health Care Claim Transaction. This information should be used in conjunction with the ASC X12N/005010X223A2 837 Institutional Health Care Claim TR3.

Transaction Set	Element	Notes/Comments/Instruction	Pg#
Health Care Claim: Institutional (837)	ISA05 – Interchange ID Qualifier	Report ZZ.	C.4
Health Care Claim: Institutional (837)	ISA06 – Interchange Sender ID	Report the Federal Tax ID of the submitter. Must be registered with BCBSM EDI.	C.4
Health Care Claim: Institutional (837)	ISA07 – Interchange ID Qualifier	Report ZZ.	C.5
Health Care Claim: Institutional (837)	ISA08 – Interchange Receiver ID	Report 382069753.	C.5
Health Care Claim: Institutional (837)	GS02 – Application Sender's Code	Report the Federal Tax ID of the submitter. Must be registered with BCBSM EDI.	C.7
Health Care Claim: Institutional (837)	GS03 – Application Receiver's Code	Report 382069753.	C.7
Health Care Claim: Institutional (837)	GS08 – Version/Release/Industry ID Code	Report 005010X223A2	C.8

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PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

9.1 MEDICARE ADVANTAGE, BCN ADVANTAGE AND BLUE CARD MEDICARE ADVANTAGE CLAIMS

Medicare Advantage Claims:

- Follow Medicare billing instructions
- Loop 2010BC NM109: Report Payer Identification Number *00210*
- Loop 2010BA NM109: Report the insured's BCBSM assigned contract number, together with the prefix, as the Primary Identification Number

BCN Advantage claims:

- Follow BCN reporting instructions
- Loop 2000B SBR09: Report Claim Filing Indicator *HM*
- Loop 2010BC NM109: Report Payer Identification Number *00210*
- Loop 2010BA NM109: Report the insured's BCN assigned contract number, together with the prefix, as the Primary Identification Number

Blue Card Medicare Advantage claims:

- Follow Medicare instructions
- Loop 2000B SBR09: Report Claim Filing Indicator *BL*
- Loop 2010BC NM109: Report Payer Identification Number *00210*.
- Loop 2010BA NM109: Report the insured's BCBSM assigned contract number, together with the prefix, as the Primary Identification Number

BCBSM or FEP Supplemental:

- When BCBSM or FEP is billed as the secondary payer and the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO.
  - The payer responsibility code in loop 2000B, SBR01 must equal 'S'
  - The claim filing indicator/source of payment in loop 2000B, SBR09 must equal "BL' or 'FI'

- Medicare is reported as the primary payer:
  - The payer responsibility code reported in loop 2320, SBR01 must equal 'P'
  - The claim filing indicator/source of payment in loop 2320, SBR09 must equal 'MA'

9.2 MAXIMUMS/LIMITATIONS

- Report a maximum of 99 services per claim for BCBSM.
- Report a maximum of 450 services per claim for Medicare A and Medicare Advantage.

9.3 BLUE CROSS COMPLETE CLAIMS

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Blue Cross Complete claims must adhere to specific guidelines. To ensure proper handling of BCC claims, remember these key requirements:

- For members with an enrollee ID beginning with XYU, report the entire contract number including the prefix in loop 2010BA NM109
- For members with a 10-digit Medicaid recipient ID, report the full 10 digits without spaces or special characters in loop 2010BA NM109
- All BCC claims must report a claim filing indicator/source of payment code ‘HM’ in loop 2000B SBR09
- Institutional claims must report payer ID 00210 in loop 2010BB NM109

9.4 INSTITUTIONAL ELECTRONIC CLAIM EXCEPTIONS

BCBSM does not act as a clearinghouse for institutional other commercial payer claims or out-of-State hospital (Non-par) claims for Blue Cross, BCN and FEP. Note: Submit out-of-State claims to the Blues Plan for the state where the services were rendered.

TRANSACTION SPECIFIC INFORMATION

10.1 ASC X12N/005010X223A2 – 837 TRANSACTION

Data Clarifications for the institutional 837 (005010X223A2) Transaction Set

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions
72	1000A	NM109	Submitter Identifier	Qualifier 46	Report the Federal Tax ID of the submitter.
77	1000B	NM103	Receiver Name		Report BCBSM as the receiver name.
77	1000B	NM109	Receiver Primary Identifier		Report 00210 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer.
78	2000A	All	Billing Provider Hierarchical Level Loop		Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider. The Billing Provider HL may also contain information about the pay-to provider entity. If the pay-to provider entity is the same as the billing provider entity, then use loop ID-2010AA. **BCBSM, BCN and FEP** – Any entity reported other than the billing provider will not be recognized.

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TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions
					Payments will continue to be directed to the provider indicated in corporate provider databases. If reported, the Pay-to provider will not be recognized/used.
80	2000A	PRV01	Billing Provider Specialty Information		**BCBSM and Medicare Crossover only -** Required when adjudication is known to be impacted by the provider taxonomy (type) code and a rendering provider will not be reported in loop 2310B NM109. Certain BCBSM provider types must report a taxonomy code at billing provider level, e.g. durable medical equipment suppliers and laboratories. For assistance with determining if a taxonomy code is required in this loop, contact the EDI Help Desk at 1-800-542-0945.
109	2000B	SBR01	Payer Responsibility Sequence Number Code	Qualifier P, S, T	**BCBSM and FEP** – Can be P, S or T.
110	2000B	SBR09	Claim Filing Indicator Code	Qualifier BL, HM, MA, MC, TV, 11, FI	Claim Filing Indicator Codes determine the destination payer to whom the claim will be routed by the EDI Clearinghouse. The code must correspond to the destination payer ID reported in loop 2010BB. For proper claim routing and adjudication use only the following codes: **BL** – Blue Cross (including Blue Card and Blue Card Medicare Advantage claims) **HM** – Blue Care Network, Blue Cross Complete and BCN Advantage **MA** – Medicare A and Medicare Advantage **MC** – MDHHS (Medicaid) **TV** – Title V **11** – State Medical Plan (Other Non-Federal) **FI** – Federal Employee Program (FEP) **MDHHS (Medicaid)** – In most cases, use MC. TV and 11 also accepted. If recipient qualifies for more than one program, or other Michigan Department of Community Health program not listed, use MC.
96	2010AB	N3, N4 All	Pay-To Address City, State, Zip Code		**BCBSM, Medicare Advantage, BCN and FEP** – Payments will be directed to the provider address indicated in corporate provider database files. If reported, the Pay-to provider address will not be used to direct payment.
113	2010BA	NM103	Subscriber Last Name		See **Appendix B** for additional instructions.
113	2010BA	NM104	Subscriber First Name		**BCBSM, BCN, MDHHS and Medicare** – Patient first name must be at least one character. See **Appendix B** for additional instructions.

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<table>
<tr><th>TR3 Pg#</th><th>Loop ID</th><th>Reference</th><th>Industry/Element Name</th><th>Codes</th><th>Notes/Comments/Instructions</th></tr>
<tr><td>114</td><td>2010BA</td><td>NM109</td><td>Subscriber Primary Identifier</td><td></td><td>All BCBSM (including Blue Card), BCN and Medicare Advantage – NM109 is required. Report the subscriber's identification number, including the prefix, without embedded spaces or special characters.
Blue Cross Complete – See Section 9.3 of this Companion Guide for reporting instructions.
FEP – Must be R followed by eight digits.
Medicare – Report the patient's Medicare Beneficiary Identifier (MBI), eleven alpha numeric characters, no spaces or special characters. Only MBI allowed effective Jan. 1, 2020, with a few exceptions.
MDHHS (Medicaid) – Report the member ID number assigned by MDHHS.</td></tr>
<tr><td>123</td><td>2010BB</td><td>NM109</td><td>Payer Identifier</td><td></td><td>The Payer Identifier must correspond to the Claim Filing Indicator reported in SBR09 of loop 2000B.
<table>
<tr><th>Payer</th><th>If Claim Filing Indicator Equals:</th><th>Report Payer ID:</th></tr>
<tr><td>BCBSM (including Blue Card & Blue Card Medicare Advantage)</td><td>BL</td><td>00210</td></tr>
<tr><td>FEP</td><td>FI</td><td>00210</td></tr>
<tr><td>Medicare Advantage</td><td>MA</td><td>00210</td></tr>
<tr><td>BCN
Blue Cross Complete
BCN Advantage</td><td>HM</td><td>00210</td></tr>
<tr><td>Medicare</td><td>MA</td><td>08201</td></tr>
<tr><td>MDHHS (Medicaid)</td><td>MC
TV
11</td><td>D00111</td></tr>
</table></td></tr>
<tr><td>136</td><td>2010CA</td><td>NM103</td><td>Patient Last Name</td><td></td><td>See Appendix B for additional instructions.</td></tr>
<tr><td>136</td><td>2010CA</td><td>NM104</td><td>Patient First Name</td><td></td><td>BCBSM, BCN, MDHHS and Medicare – Patient first name must be at least one character. See Appendix B for additional instructions.</td></tr>
<tr><td>145</td><td>2300</td><td>CLM05-1</td><td>Facility Type Code</td><td></td><td>The BCBSM clearinghouse accepts all valid NUBC bill type codes. Please refer to the NUBC manual or visit www.nubc.org for a list of valid values.</td></tr>
</table>

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TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions
145	2300	CLM05-3	Claim Frequency Code		The BCBSM clearinghouse accepts all valid NUBC claim frequency type codes. Please refer to the NUBC manual or visit www.nubc.org for a list of valid values.
153	2300	CL103	Patient Status Code		**All Payers** – Must be 30 when billing interim claims bill type XX2 or XX3.
154	2300	PWK02	Report Transmission Code	Qualifier BM, FX	**BCBSM and Medicare Advantage:** Report qualifier BM – By Mail or FX – By Fax only.
166	2300	REF02	Original Reference Number (ICN/DCN)	Qualifier F8	**BCBSM and FEP**: When required, report the 14- or 17-digit Internal Control Number of the original claim. **BCN, BCN Advantage** and **MIChild**: Limit of 12 characters. When required, report ‘E’, ‘M’, or ‘0’ (zero), followed by 11 numeric. **Blue Cross Complete**: Limit of 12 characters. When required, report 12 numeric.
284	2300	HI01-2 through HI12-2	Value Codes	Qualifier BE	**BCBSM** – For proper adjudication on all BCBSM and FEP claims, a value code for estimated responsibility is needed – report A3, B3 or C3 as applicable. Value code 01 or 02 is required on inpatient claims. Value codes 01 and 02 are not allowed on the same claim. Report all other value codes as applicable.
285	2300	HI01-5 through HI12-5	Value Code Amount	Qualifier BE	**BCBSM and FEP** – When the type of bill is XX8, the value amount for A3, B3 or C3 must be zero.
294	2300	HI01-2 through HI12-2	Condition Code	Qualifier BG	**BCBSM and FEP** – Only condition codes reported in HI01-2 through HI07-2 will be referenced by adjudication. Any additional conditions codes reported will not be used by adjudication.
354	2320	SBR09	Claim Filing Indicator Code		**BCBSM and FEP supplemental claims:** For proper claim adjudication, report MA when the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO.
429	2400	PWK02	Report Transmission Code	Qualifier BM, FX	**BCBSM and Medicare Advantage:** Report qualifier BM – By Mail or FX – By Fax only.
424	2400	SV201	Service Line Revenue Code		**BCBSM** – For dates of service on or after October 1, 2013, see **Appendix A** – OUTPATIENT REPORTING.

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TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions
425	2400	SV202-1 SV202-2	Product Service ID Qualifier		Required for outpatient claims when an appropriate HCPCS exists for the service line item. **All Payers** – Report qualifier HP when billing HIPPS/RUGGS codes with revenue codes 0022 - 0024. **BCBSM** – For dates of service on or after October 1, 2013, see **Appendix A** – OUTPATIENT REPORTING. **BCBSM, BCN, FEP** – If bill type is 13X or 83X and multiple surgical HCPCS (range 10,000 through 69,999) are reported, the second and subsequent surgical HCPCS codes can be reported with a zero-charge amount (do not leave element blank to indicate zero charges).

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APPENDICES

A. INSTITUTIONAL OUTPATIENT REPORTING

Healthcare Common Procedure Coding System codes updated for revenue code chart

Effective Oct. 1, 2013 BCBSM implemented reporting changes on all outpatient institutional claims. These changes are for Blue Cross claims only (Claim filing indicator BL) and applicable to dates of service on or after Oct. 1, 2013.
The changes include:

- Reporting appropriate revenue codes for each date of service;
- Reporting of HCPCS procedure codes for each date of service. (Loop 2400, SV202-2);
- Dialysis claims containing Revenue Codes 0821, 0841 and 0851 must have the appropriate condition code for each date of service;
- Freestanding Outpatient Physical Therapy Facilities can no longer report Revenue Code 420, 430 and 440. (Loop 2400, SV201); and
- Value Code 80 is no longer required on outpatient therapy claims. (Loop 2300, HI01-1 BE qualifier).
- As of Dec. 13, 2013, Health Care Procedure Coding System codes were no longer required on hospital outpatient facility claims when revenue codes 0251-0254, 0256-0259, 0370, 0379 or 0637 were reported on the claim lines. On surgery claims, these service lines will continue to be bundled with surgery services.
  BCBSM made some changes to a table listing revenue codes and a description of the service categories they represent. We're providing the updated chart below for your reference. The revenue codes and HCPCS requirements listed below are effective Oct. 1, 2013.
  Changes to the table include:
- Revenue codes marked with a single asterisk won't always have CPT or HCPCS codes that can be reported with them. For example, there are no CPT or HCPCS codes available for certain medical supplies. Just use the appropriate revenue code for the medical supplies dispensed.

Description	Revenue codes that require HCPCS codes
Surgery (including maternity)	0360, 0361, 0369, 0490, 0499, 0700, 0750, 0769, 0790 Codes that require a surgical HCPCS if surgery is performed in this room: 0450, 0451, 0452, 0456, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0519, 0761
Laboratory – clinical/anatomical	0300, 0301, 0302, 0303, 0304, 0305, 0306, 0307, 0309, 0310, 0311, 0312, 0314, 0319, 0923, 0924, 0925
Other	0270*, 0271*, 0272*, 0279*, 0280, 0289, 0370*, 0379*, 0380, 0381, 0382, 0383, 0384, 0385, 0386, 0387, 0389, 0390, 0391, 0392, 0399, 0410, 0412, 0413, 0419, 0450, 0451, 0452, 0456, 0459, 0460, 0469, 0470, 0471, 0472, 0479, 0480, 0481, 0482, 0483, 0489, 0500, 0509, 0510, 0511, 0512, 0514, 0515, 0516, 0517, 0519, 0530, 0531, 0539, 0540, 0545, 0621, 0622, 0623, 0730**, 0731, 0732, 0739, 0740, 0780, 0920, 0921, 0922, 0929, 0940, 0942, 0943, 0949, 0951, 0952, 2101, 2105, 2106

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Description	Revenue codes that require HCPCS codes
Durable Medical Equipment/Prosthetic & Orthotic	0274, 0291, 0292, 0293, 0946, 0947
Drug Administration	0260, 0331, 0332, 0335, 0771
Drug/Pharmacy	0250*, 0251*, 0252*, 0253*, 0254*, 0256*, 0257*, 0258*, 0259*, 0262, 0631, 0632, 0633, 0634, 0635, 0636, 0637*
Radiopharmaceutical	0255, 0343, 0349
Radiology	0255, 0320, 0321, 0322, 0323, 0324, 0329, 0330, 0333, 0339, 0340, 0341, 0342, 0343, 0344, 0349, 0350, 0351, 0352, 0359, 0400, 0401, 0402, 0403, 0404, 0409, 0610, 0611, 0612, 0614, 0615, 0616, 0618, 0619, 0860, 0861
Emergency room & trauma	0450, 0451, 0452, 0459, 0681, 0682, 0683, 0684, 0689
Surgery (Maternity)	Refer to "Surgery"
Treatment Room	0761
Observation Room	0762
Physical Therapy, Occupational Therapy, Speech and Language Pathology Evaluation	0424, 0434, 0444
Physical Therapy, Occupational Therapy, Speech and Language Pathology Visit	0421, 0431, 0441

**This code may not have a HCPCS code that can be reported with it.

**Ambulatory surgery facilities must report the applicable EKG HCPCS code when reporting revenue code 0730. Other applicable revenue codes and HCPCS code information for laboratory, radiology and surgery services are included above.

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B. TRANSACTION EXAMPLES

Reporting subscriber and/or patient first and last names

- Loop 2010BA NM103 and NM104 example:

  NM1*IL*1*LAST NAME*FIRST NAME****MI*XXX123456789~

- Loop 2010CA NM103 and NM104 example:

  NM1*QC*1*LAST NAME*FIRST NAME~

Guidelines	Correct	Incorrect
Names should not contain any special characters, other than a dash	ABC-E	ABC&%
Names should not contain more than three spaces between the first and last character	A<space>C<space>E<space>G	A<space>C<space>E<space>G<space>I
Name should not contain more than three dashes between the first and last character	A-C-E-G	A-C-E-G-I
Names should not contain a combination of more than three dashes and spaces between the first and last character	A-C<space>E-G	A-C<space>E-G<space>I
Name should not contain consecutive spaces	A<space>C<space>E<space>G	A<space><space>DE
Name should not contain consecutive dashes	A-C-E-G	A—DE
Names should not contain a consecutive space and dash, in any combination	A-C<space>E-G	A<space>-DE Or A-<space>DE

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C. IMPLEMENTATION CHECKLISTS:

Providers:

- ✓ Did you complete a Provider Authorization for the Trading Partner?
  - This must be completed if you are not currently sending other transactions to BCBSM under another ID.

- ✓ Reminder: Terms of the Trading Partner Agreement require you to notify BCBSM of any changes in your trading partner information.
  - If you switch service bureaus (clearinghouses), software vendors, billing services, or the recipient for your 835 files, you must update your Provider Authorization form.
    - Keep these items in mind when changes occur. You should review your Provider Authorization information if you've:
    - Changed tax identification numbers
    - Added new NPIs
    - Hired a new billing service
    - Started submitting claims through a clearinghouse or you've changed clearinghouses
    - Decided you no longer want to receive 835 remittance files
    - Selected a new destination for your 835s

- ✓ Contact 1-800-542-0945 for a logon ID and password

Vendors, Software Developers and Self-submitters:

- ✓ Complete an Information Sheet
- ✓ Confirm with Provider that they have completed the Trading Partner Registration and Provider Authorization processes

ERA/835 only setup:

- ✓ Contact 1-800-542-0945 for assistance.

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D. CHANGE SUMMARY

This section describes the differences between the current Companion Guide and previous guide(s)

The table below summarizes the changes to this companion document.

Section	Description of Change	Page	Date
5.2.1 CONNECTION INSTRUCTIONS	Removed SFTP and HTTPS instructions.	11	Feb 2020
1.3 GENERAL EDI TERMINOLOGY	Added the following definitions: **BCBSM or FEP Supplemental** – BCBSM or FEP is being billed as the secondary payer and the primary payer is original Medicare or any type of Medicare Advantage or Medicare HMO. **Medicare Beneficiary Identifier (MBI)** – an eleven-character alpha numeric identification number issued by the Center for Medicare Services, which replaces the Medicare Health Insurance Claim Number (HICN).	6	Nov 2019
9.1 MEDICARE ADVANTAGE, BCN ADVANTAGE AND BLUE CARD MEDICARE ADVANTAGE CLAIMS	Added the following: **BCBSM or FEP Supplemental** • When BCBSM or FEP is billed as the secondary payer and the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO. o The payer responsibility code in loop 2000B, SBR01 must equal 'S' o The claim filing indicator/source of payment in loop 2000B, SBR09 must equal "BL' or 'FI' • Medicare is reported as the primary payer: o The payer responsibility code reported in loop 2320, SBR01 must equal 'P' o The claim filing indicator/source of payment in loop 2320, SBR09 must equal 'MA'	14	Nov 2019

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10.1 ASC X12N/005010X223A2 – 837 TRANSACTION	• Updated loop 2010BA, removing reference to Medicare Health Insurance Claim Number (HICN). • Added the following for loop 2320, SBR09: Report Claim Filing Indicator MA when the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO.	18	Nov 2019
9.2 MAXIMUMS/LIMITATIONS	Removed reference to "FEP" from the following sentence: Report a maximum of 99 services per claim for BCBSM.	14	April 2018
10.1 ASC X12N/005010X223A2 – 837 TRANSACTION	Added the following for loop 2300, PWK02: BCBSM and Medicare Advantage: Report qualifier BM – By Mail or FX – By Fax only.	17	April 2018
10.1 ASC X12N/005010X223A2 – 837 TRANSACTION	Added the following for loop 2400, PWK02: BCBSM and Medicare Advantage: Report qualifier BM – By Mail or FX – By Fax only.	18	April 2018
All sections	Changed reference to "alpha prefix" to "prefix".		June 2017
10.1 ASCX12N/005010X223A2 – Data Clarifications for the 837 Transaction set	Removed: 2300, HI01-2 through HI12-2: Added clarification regarding value code 80.	18	August 2016
10.1 ASCX12N/005010X223A2 – Data Clarifications for the 837 Transaction set	2000A: BCBSM and Medicare Crossover only - Required when adjudication is known to be impacted by the provider taxonomy (type) code and a rendering provider will not be reported in Loop 2310B NM109. Certain BCBSM provider types must report a taxonomy code at billing provider level, e.g. durable medical equipment suppliers and laboratories. For assistance with determining if a taxonomy code is required in this loop, contact the EDI Help Desk at 1-800-542-0945.	14	July 2016
10.1 ASCX12N/005010X223A2 – Data Clarifications for the 837	Added: Blue Cross Complete – See Section 9.3 of this	14	July

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Transaction set	Companion Guide for reporting instructions.		2016
9.3 Blue Cross Complete claims	Added Blue Cross Complete claims guidelines	13	July 2016
All	Published document in new format		March 2016
1.3 General EDI Terminology	Added Medicare Advantage Out of State to Blue Card description.	5	March 2016
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Loop 2000B SBR09: Added Medicare Advantage Out of State BlueCard to claims included under Source of Payment BL	14	March 2016
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Loop 2300 CLM05-1: Removed ***BCBSM*** *For dates of service prior to Jan. 1, 2016: When Reporting revenue codes 0901 or 0912, use type of bill 11.*	15	March 2016
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Loop 2300 HI01-2 through HI12-2: Added instruction ***BCBSM*** *- Effective for dates of service May 1, 2016 and greater, when billing physical, occupational or speech therapy on a 13x or 74x type of bill and reporting revenue 0421, 0431, 0441 a value code 80 will be required to report the total number of days.*	16	March 2016
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Loop 2400 SV202-1 and SV202-2: Added instructions ***BCBSM*** *– For dates of service on or after October 1, 2013, see* ***Appendix A*** *– OUTPATIENT REPORTING.* ***BCBSM, BCN, FEP*** *– If bill type is 13X or 83X and multiple surgical HCPCS (range 10,000 through 69,999)*	16	March 2016

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	are reported, the second and subsequent surgical HCPCS codes can be reported with a zero charge amount (do not leave element blank to indicate zero charges).		
Appendix C. IMPLEMENTATION CHECKLISTS	Revised instructions	20	March 2016
1.3 General EDI Terminology	Added 'BlueCard'	5	Dec. 2015
9.2 Maximums/Limitations	Removed two bullets: ✓ Report a maximum of 999 services per claim for BCN Decimal data reporting	13	Dec. 2015
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Removed entry: Loop 2010BB NM103 Payer Name Removed entry: Loop 2300 DTP03 Admission Date/Hour Removed entry: Loop 2300 HI02-3 Principle Procedure Code/Other Procedure Code Removed entry: Loop 2300 HI01-4 through HI10-4 Occurrence Code Removed entry: Loop 2330B NM103 Other Payer Name	13-16	Dec. 2015
10.1 ASC X12N/005010x223A2 – 837 Transaction - Data Clarifications for the Institutional 837 Transaction Set	Revised instructions: Loop 2300 CLM05-1 Facility Type Code Revised instructions: Loop 2400 SV201 Service Line Revenue Code Revised instructions: 2400 SV202-1/SV202-2 Product Service ID Qualifier Revised instructions: Loop 2400 SV203 Line Item Charge Amount	13-16	Dec. 2015

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