



Blue Cross Blue Shield of Michigan

**HIPAA Transaction Standard
Companion Guide**

**American National Standards Institute (ANSI)
ASC X12N 837 (005010X222A1) Professional
Health Care Claim**

Disclosure Statement

This companion document is the property of Blue Cross Blue Shield of Michigan (BCBSM) and is for use solely in your capacity as a trading partner of health care transactions with BCBSM. It is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change.

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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/005010X222 837 Technical Report Type 3 (TR3) for Health Care Claim Payment/Advice and its associated Errata 005010X222A1 - has been established as the standard for electronic professional 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: | LOOP NUMBER: | SEGMENT OR ELEMENT IDENTIFIER: | IMPLEMENTATION NAME: | CODE, QUALIFIER MODIFIER OR OTHER: | BCBSM OR OTHER PAYER SPECIFIC INSTRUCTION: |
| 80 | 1000B | NM103 | Receiver Name | N/A | 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/005010X222 837 TR3, dated May 2006, and the modifications implemented with the adopted Type 1 Errata (X12N/005010X222A1) 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/005010X222– The HIPAA mandated (ANSI) ASC X12N Professional Health Care Claim transaction format.

ASC X12N/005010X222A1 – The Type 1 Errata modifications mandated for use with the ASC X12N/005010X222 837 Professional Health Care Claim transaction format.

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.

BCBSA – An acronym for Blue Cross Blue Shield Association

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

BCN – An acronym for Blue Care Network

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

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 005010X222A1 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.

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.

2.1.3 ERA ENROLLMENT Completion of an ERA Enrollment form

The ERA 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.

4.2 TESTING OVERVIEW

Prior to submission of electronic 837 claims transactions to BCBSM, there is a two-step test process that software must pass:

1. 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.
2. 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:

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

4.2.2 SOFTWARE VENDOR, CLEARINGHOUSE OR SERVICE BUREAU

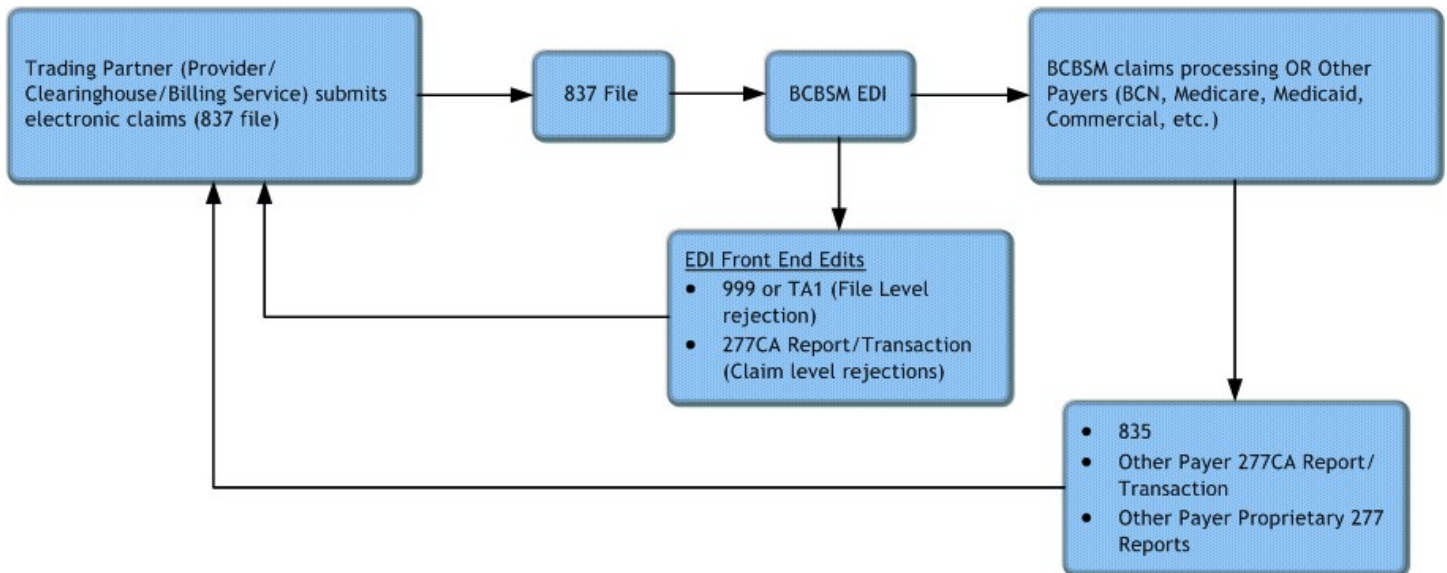
You must meet our testing requirements and follow these steps:

1. Visit <https://editest.bcbsm.com/spokelogon.html>
2. 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:



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 1-800-524-0945, Opt. #1.

Passwords are required for completion of a Trading Partner Agreement and Provider Authorization. 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:

1. Caller name
2. Name of provider, facility or submitter/software developer office
3. Reason for call
4. Member contract number (if applicable)
5. Name of member (if applicable)
6. 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:

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 PROFESSIONAL HEALTH CARE CLAIM

7.1 GENERAL OVERVIEW

The BCBSM EDI clearinghouse accepts ANSI ASC X12N 837 version 005010X222A1 professional transactions for BCBSM, Medicare Advantage*, BCN†, Blue Cross Complete, Blue Card, FEP, Medicare B, MDHHS (Medicaid) and commercial carriers. 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.

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/005010X222A1 – 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 located in the HIPAA TR3 Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the TR3.

* The term 'Medicare Advantage' hereinafter incorporates by reference Medicare Plus Blue PPO, Medicare Plus Blue Group PPO and Medicare Plus Blue PFFS plans.

† The term 'BCN' hereinafter incorporates by reference BCNHMO plans, BCN Advantage, and BCN Service Company.

The following sections address specific information needed by BCBSM in order to process the ASC X12N/005010X222A1-Professional Health Care Claim Transaction. This information should be used in conjunction with the ASC X12N/005010X222A1 – Professional Health Care Claim TR3.

| Transaction Set | Element | Notes/Comments/Instruction | TR3 Pg# |
|---------------------------------------|---|---|---------|
| Health Care Claim: Professional (837) | ISA05 – Interchange ID Qualifier | Report ZZ. | C.4 |
| Health Care Claim: Professional (837) | ISA06 – Interchange Sender ID | Report the EDI-assigned Billing Location Code of the submitter. | C.4 |
| Health Care Claim: Professional (837) | ISA07 – Interchange ID Qualifier | Report ZZ. | C.5 |
| Health Care Claim: Professional (837) | ISA08 – Interchange Receiver ID | Report 382069753. | C.5 |
| Health Care Claim: Professional (837) | GS02 – Application Sender’s Code | Report the EDI-assigned Billing Location Code of the submitter. | C.7 |
| Health Care Claim: Professional (837) | GS03 – Application Receiver’s Code | Report 382069753. | C.7 |
| Health Care Claim: Professional (837) | GS08 – Version/Release/Industry ID Code | Report 005010X222A1 | C.8 |

PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

9.1 MEDICARE ADVANTAGE CLAIMS

Medicare Advantage Claims:

- Follow Medicare billing instructions
- Loop 2010BC NM109: Report Payer Identification Number *00710*
- 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 *00710*
- 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 *00710*.
- 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 'MB'

9.2 MEDICARE STATUTORILY EXCLUDED SERVICES/USE OF 'GY' MODIFIER

- Medicare statutorily excluded services are billed as a secondary claim to BCBSM or FEP:
 - The payer responsibility code in loop 2000B SBR01 must equal 'S'
 - The source of payment/claim filing indicator in Loop 2000B SBR09 must equal 'BL' or 'FI'
- Medicare is reported as the primary payer:
 - The payer responsibility code in loop 2320 SBR01 must equal 'P'
 - The source of payment/claim filing indicator in loop 2320 SBR09 must equal 'MB'
 - The payer information supplied in loop 2330B must be for Medicare:
NM1*PR*2*WPS - MAC J8 MI PART B*****PI*08202~
N3*P.O. BOX 5533~
N4*MARION,*IL*62959~

- Report Medicare non-paid services only. Paid and non-paid services cannot be reported on the same claim.
- All services on the claim must contain a GY modifier. You can report other modifiers, but GY is required.
 - For example: Loop 2400 SV1:
SV1*HC:70010:GY*40*UN*1*11**1:2:3:4~

9.3 BLUE CROSS COMPLETE CLAIMS

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
- Professional claims must report payer ID 00710 in loop 2010BB NM109

9.4 MAXIMUMS/LIMITATIONS

- Report up to 100 claims per subscriber/patient combination.
- Submit a maximum of 5,000 claims per transaction set.
- Decimal data reported in data element 782 (Monetary Amount) is limited to a maximum length of 10 characters including reported or implied place for cents (implied value of 00 after the decimal point). Note: the decimal point and leading sign, if sent, are not part of the character count.

9.5 REPORTING COMMERCIAL PAYER IDS AND CLAIM OFFICE NUMBERS

For proper routing of commercial payer claims, the appropriate Payer ID must be reported in loop 2010BB, NM109, and the corresponding Claim Office Number, when applicable, must be reported in loop 2010BB, REF02 (Qualifier FY).

Reference the EDI Commercial Payer Listing for payer identification and claims office numbers used in claims submitted through the BCBSM clearinghouse. The Commercial Payer Listing can be downloaded from **bcbsm.com**.

- If the Claim Office Number shown for a payer is blank, a REF02 segment should not be reported.
- If the Claim Office Number shown for a payer is a 4-digit numeric code, for example “1234”, then report “1234” in the REF02 segment (Qualifier FY).
- The Commercial Payer Listing contains a column labeled “Type”:
 - “E” indicates that electronically submitted claims for that payer are processed electronically.
 - “D” indicates that the claim is submitted directly to the payer by BCBSM EDI.
- If you have questions regarding which Payer ID or Claim Office number to report, contact the EDI Helpdesk at 800-542-0945.

9.6 PROFESSIONAL ELECTRONIC CLAIM EXCEPTIONS

Please note that for proper adjudication, BCBSM recommends hard copy claim submission for:

- FEP and BCN claims requiring hardcopy documentation
- BCBSM COB that are auto or employment related

ACKNOWLEDGEMENTS AND/OR REPORTS

10.1 BCBSM RETURNS THE FOLLOWING ACKNOWLEDGEMENTS:

- Health Care Claim Acknowledgment - 277CA transactions and reports
- Implementation Acknowledgment For Health Care Insurance - 999 transactions
- TA1 Interchange Acknowledgments

Transaction and report examples are included in our BCBSM V5010 Acknowledgements document available on bcbsm.com.

TRANSACTION SPECIFIC INFORMATION

11.1 ASC X12N/005010X222A1 – 837 TRANSACTION

DATA CLARIFICATIONS FOR THE PROFESSIONAL 837 (005010X222A1) TRANSACTION SET

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions |
|---------|---------|-------------|---|-------|--|
| 75 | 1000A | NM109 | Submitter Identifier | | Report the BCBSM EDI-assigned billing location code of the submitter. |
| 80 | 1000B | NM103 | Receiver Name | | Report BCBSM as the receiver name. |
| 80 | 1000B | NM109 | Receiver Primary Identifier | | Report 00710 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer. |
| 83 | 2000A | PRV segment | 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. |
| 103 | 2010AB | N3, N4 All | Pay-To Address Pay-To Address City, State, Zip Code | | BCBSM, Medicare Advantage (including DME), BCN and FEP – If reported, the Pay-to provider address will not be recognized/used. Payments are directed to the provider address indicated in corporate provider databases. |

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions |
|---------|---------|-----------|-----------------------------|---|--|
| 118 | 2000B | SBR09 | Claim Filing Indicator Code | Qualifier BL, CI, HM, MB, MC, TV, 11, FI | <p>Claim Filing Indicator Codes are used by the EDI Clearinghouse to route claims to a destination payer. Report the code that corresponds to the destination payer ID reported in loop 2010BB. For proper claim routing and adjudication use only the following codes:</p> <p>BL Blue Cross Blue Shield of MI (including Blue Card and Blue Card Medicare Advantage claims) CI Commercial payers identified on BCBSM's Commercial Payer List. See Section 9.5 of this companion document for more information. HM Blue Care Network, Blue Cross Complete and BCN Advantage MB Medicare B and Medicare Advantage (including DME). MC MDCH (Medicaid) TV Title V 11 State Medical Plan (Other Non-Federal) FI Federal Employee Program (FEP)</p> <p>Note: BCN Report BL for routine vision services. Medical vision and all other services for BCN members should be billed under HM (BCN). 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.</p> |
| 122 | 2010BA | NM103 | Subscriber Last Name | | See Appendix B for additional instructions |
| 122 | 2010BA | NM104 | Subscriber First Name | | BCBSM, BCN, MDHHS and Medicare – Subscriber first name must be at least <u>one</u> character. See Appendix B for additional instructions |

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|-------------------------------|---|-------------------------------|--------------|---|--------------|-------------------------------|-------------------------|------------------------------------|----|-------|------------|----|-------|---------------------------|----|-------|--|----|-------|-------------------------------|----|-------|-------------------|----|---|-----------------|----|-------|-----------------------|----|-------|-------------------------|----------------|--------|
| 123 | 2010BA | NM109 | Subscriber Primary Identifier | Qualifier MI | <p>All BCBSM (including Blue Card), BCN and Medicare Advantage – Report the subscriber’s identification number, including the prefix, without embedded spaces or special characters.</p> <p>Blue Cross Complete – See Section 9.3 of this Companion Guide for reporting instructions.</p> <p>FEP – Report R followed by eight digits.</p> <p>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.</p> <p>MDHHS (Medicaid) – Report the member ID number assigned by MDHHS (Medicaid).</p> <p>Medicare and MDHHS (Medicaid) – For Indian Health Services, report the 3-digit tribe ID followed by the 7-digit residency code. These numbers are obtained from the authorizing service that referred the patient for services.</p> <p>Format as:</p> <ul style="list-style-type: none"> • Community – 3 digits • County – 2 digits • State – 2 digits <p>Commercial – Either loop 2010BA/NM109 or 2010CA/NM109 must be present.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 134 | 2010BB | NM109 | Payer Identifier | Qualifier PI | <p>The Payer Identifier must correspond to the Claim Filing Indicator reported in SBR09 of loop 2000B.</p> <table border="1"> <thead> <tr> <th><i>Payer</i></th> <th><i>If 2000B SBR09 Equals:</i></th> <th><i>Report Payer ID:</i></th> </tr> </thead> <tbody> <tr> <td>BCBSM (including Blue Card)</td> <td>BL</td> <td>00710</td> </tr> <tr> <td>FEP</td> <td>FI</td> <td>00710</td> </tr> <tr> <td>Medicare Advantage</td> <td>MB</td> <td>00710</td> </tr> <tr> <td>BCN/Blue Cross Complete/BCN Advantage</td> <td>HM</td> <td>00710</td> </tr> <tr> <td>Medicare Advantage DME</td> <td>MB</td> <td>00710</td> </tr> <tr> <td>Commercial</td> <td>CI</td> <td>See “Section 9.5 Reporting Commercial Payer IDs and Claim Office Numbers”</td> </tr> <tr> <td>Medicare</td> <td>MB</td> <td>08202</td> </tr> <tr> <td>Medicare DMERC</td> <td>MB</td> <td>17013</td> </tr> <tr> <td>MDHHS (Medicaid)</td> <td>MC TV 11</td> <td>D00111</td> </tr> </tbody> </table> | <i>Payer</i> | <i>If 2000B SBR09 Equals:</i> | <i>Report Payer ID:</i> | BCBSM (including Blue Card) | BL | 00710 | FEP | FI | 00710 | Medicare Advantage | MB | 00710 | BCN/Blue Cross Complete/BCN Advantage | HM | 00710 | Medicare Advantage DME | MB | 00710 | Commercial | CI | See “Section 9.5 Reporting Commercial Payer IDs and Claim Office Numbers” | Medicare | MB | 08202 | Medicare DMERC | MB | 17013 | MDHHS (Medicaid) | MC TV 11 | D00111 |
| <i>Payer</i> | <i>If 2000B SBR09 Equals:</i> | <i>Report Payer ID:</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BCBSM (including Blue Card) | BL | 00710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEP | FI | 00710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare Advantage | MB | 00710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BCN/Blue Cross Complete/BCN Advantage | HM | 00710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare Advantage DME | MB | 00710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Commercial | CI | See “Section 9.5 Reporting Commercial Payer IDs and Claim Office Numbers” | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare | MB | 08202 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare DMERC | MB | 17013 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MDHHS (Medicaid) | MC TV 11 | D00111 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 136 | 2010CA | NM103 | Patient Last Name | | See Appendix B for additional instructions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 136 | 2010CA | NM104 | Patient First Name | | BCBSM, BCN, MDHHS and Medicare – Patient first name must be at least <u>one</u> character. See Appendix B for additional instructions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions |
|---------|---------|---------------------------|--|----------------------------------|--|
| 196 | 2300 | REF02 | Original Reference Number/Payer Claim Control Number (ICN/DCN) | Qualifier F8 | <p>BCBSM and FEP When required, report the 14- or 17-digit Internal Control Number of the original claim.</p> <p>Medicare Advantage (including DME) – Report an original claim DCN when loop 2300/CLM05-3 is 7.</p> <p>BCN – Report the original claim reference number ICN/DCN (must start with an E, M, or 0 (zero) followed by 11 digits) in REF02 when loop 2300/CLM05-3 is 7 or 8.</p> <p>MDHHS (Medicaid) – Report the 10-digit Claim Reference Number assigned by MDHHS (Medicaid) to the last approved claim when loop 2300/CLM05-3 is 7 or 8.</p> <p>Blue Cross Complete – Report the original claim reference number ICN/DCN (12 numeric) when loop 2300/CLM05-3 is 7 or 8. Limit of 12 characters.</p> |
| 182 | 2300 | PWK02 | Report Transmission Code | Qualifier BM, FX | <p>BCBSM and Medicare Advantage: Report qualifier BM – By Mail or FX – By Fax only.</p> |
| 193 | 2300 | REF02 | Referral Number | Qualifier 9F | <p>BCBSM – For Hearing Services, report the referral number assigned to the hearing evaluation date which is a prerequisite for receiving hearing benefits. The referral number assigned by BCBSM is HED CCYYMMDD when CCYYMMDD is the date of the hearing evaluation.</p> |
| 226 | 2300 | HI Segment Diagnosis Code | Health Care Diagnosis Codes | | <p>All Payers – Report diagnosis codes (without decimal points) to the highest specificity available. Use the diagnosis code pointer in loop 2400 to relate the diagnosis to specific service lines.</p> <p>BCBSM, Medicare Advantage (including DME), BCN and FEP – Diagnosis codes will be validated for reported dates relating to the service. At this time, only one diagnosis code will be referenced per service line.</p> <p>Medicare – Report up to eight diagnosis codes per claim.</p> <p>Medicare DMERC – Only the first four diagnosis codes will be considered for claim processing on Medicare DMERC claims.</p> <p>MDHHS (Medicaid) – Report at least one diagnosis code on every claim.</p> <p>Commercial – Some payers may only recognize up to four diagnosis codes.</p> |
| 258 | 2310A | NM101 | Entity Identifier Code | Qualifier DN Qualifier P3 | <p>BCBSM and FEP: Report Qualifier DN for the referring/ordering physician in all cases when a patient was referred for services. This includes services ordered/referred by another physician or self-referral/no referral services. If more than one iteration of this loop is being reported DN is used to report the actual provider referring services.</p> <p>Report Qualifier P3:</p> <ul style="list-style-type: none"> • when reporting the initial PPO network provider, • in a second iteration of this loop for services that were performed by an out-of-network provider (in order to avoid patient sanctions), or • in a second iteration of this loop when reporting a Primary Care Provider in addition to the actual referring provider |

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions |
|---------|---------|-------------|--|--|--|
| 259 | 2310A | NM109 | Referring Provider Identifier | | <p>BCBSM and FEP: Report the NPI of the referring/ordering physician in all cases when a patient was referred for services. This includes services ordered/referred by another physician or self-referral/no referral services. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop.</p> <p>BCBSM PPO: Report the NPI of the PPO Physician referring services in order to receive full payment on all out-of-panel referrals. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop. If the Billing NPI is used, this may impact adjudication. Report in either loop 2310A or 2420F.</p> |
| 265 | 2310B | PRV segment | Rendering Provider Specialty Information | | <p>BCBSM and Medicare Crossover only - Required when the billing provider is not the rendering provider. If the NPI reported in Loop 2010AA NM109 belongs to a multi-part group with uniquely enumerated subparts, report the BCBSM-assigned taxonomy code of the rendering provider that links that provider to the group NPI.</p> |
| 295 | 2320 | SBR09 | Claim Filing Indicator Code | | <p>BCBSM and FEP supplemental claims: For proper claim adjudication, report MB when the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO.</p> |
| 362 | 2400 | PWK02 | Report Transmission Code | Qualifier BM, FX | <p>BCBSM and Medicare Advantage: Report qualifier BM – By Mail or FX – By Fax only.</p> |
| 353 | 2400 | SV101-3 | Procedure Modifier | Qualifier GY | <p>Report Medicare statutorily excluded services following the requirements identified in Section 9.2 in Payer Specific Rules and Limitations.</p> |
| 355 | 2400 | SV103 | Unit or Basis for Measurement Code | Qualifier MJ (Minutes) Qualifier UN (Units) | <p>All BCBSM (including Blue Card), BCN and Medicare Advantage:</p> <p>Qualifier MJ is required for time-based anesthesia procedure codes without a time period in the code description.</p> <p>Anesthesia procedure codes that are not time-based must use the qualifier UN, Units.</p> <p>Anesthesia procedure codes with specified time periods including, but not limited to “daily” or “15 minutes” must be reported using the qualifier UN.</p> |

| TR3 Pg# | Loop ID | Reference | Industry/Element Name | Codes | Notes/Comments/Instructions |
|---------|---------|-------------|--|--|--|
| 427 | 2410 | CTP05-1 | Unit or Basis for Measurement Code | National drug code (NDC) unit or basis for measurement code (code qualifier) | To ensure correct processing, Blue Cross Blue Shield of Michigan requests that the national drug code (NDC) unit or basis for measurement code (code qualifier) reported in Loop 2410 CTP05-1 for source of payment BL be one of the following: <ul style="list-style-type: none"> • Report UN (unit) for drugs that come in a vial in powder form that need to be reconstituted before administration • Report ML (milliliter) for drugs that come in a vial in a liquid form • Report GR (gram) for topical forms of medicine (e.g., cream, ointment and bulk powder in a jar) International units should be converted to standard measurements (UN). |
| 433 | 2420A | PRV segment | Billing Provider Specialty Information | | Required when adjudication is known to be impacted by the provider taxonomy (type) code and the billing provider is not the rendering provider and this code is different than reported at the claim level. |
| 466 | 2420F | NM101 | Entity Identifier Code | Qualifier DN Qualifier P3 | BCBSM and FEP: Report Qualifier DN for the referring/ordering physician in all cases when a patient was referred for services. This includes services ordered/referred by another physician or self-referral/no referral services. If more than one iteration of this loop is being reported DN is used to report the actual provider referring services. Report Qualifier P3: <ul style="list-style-type: none"> • when reporting the initial PPO network provider, • in a second iteration of this loop for services that were performed by an out-of-network provider (in order to avoid patient sanctions), or • in a second iteration of this loop when reporting a Primary Care Provider in addition to the actual referring provider |
| 467 | 2420F | NM109 | Referring Provider Identifier | | BCBSM and FEP: Report the NPI of the referring/ordering physician in all cases when a patient was referred for services. This includes services ordered/referred by another physician or self-referral/no referral services. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop. BCBSM PPO: Report the NPI of the PPO Physician referring services. In order to receive full payment on all out-of-panel referrals. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop. If the Billing NPI is used, this may impact adjudication. Report in either loop 2310A or 2420F. |

APPENDICES

A. 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.
- ✓ Contact the EDI help desk at 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

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 |

C. CHANGE SUMMARY

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 information. | 10 | Feb 2020 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION | Changed loop 2300, REF02 to match 837 Institutional. | 18 | 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 Advantage 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). | 5 | Nov 2019 |
| 9.1 MEDICARE ADVANTAGE, BCN ADVANTAGE AND BLUE CARD MEDICARE ADVANTAGE CLAIMS | Added instructions for: Medicare Advantage Claims, BCN Advantage claims, Blue Card Medicare Advantage claims, and BCBSM or FEP Supplemental. | 13 | Nov 2019 |
| 9.5 REPORTING COMMERCIAL PAYER IDS AND CLAIM OFFICE NUMBERS | <ul style="list-style-type: none"> Updated Claim Office reference to numeric only. Removed print mail reference. | 14 | Nov 2019 |
| 9.6 PROFESSIONAL ELECTRONIC CLAIM EXCEPTIONS | <ul style="list-style-type: none"> Removed print mail reference. | 14 | Nov 2019 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION | <ul style="list-style-type: none"> Updated loop 2010BA, removing reference to Medicare Health Insurance Claim Number (HICN). Added loop 2320, Claim Filing Indicator Code: BCBSM and FEP supplemental claims: For proper claim adjudication, report MB when the primary payer is original Medicare or any type of Medicare Advantage or Medicare Advantage HMO. | 19 | Nov 2019 |

| Section | Description of Change | Page | Date |
|--|--|------|---------------|
| | <ul style="list-style-type: none"> Removed loop 2010AA regarding Cofinity. | | |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION | Added the following for loop 2410 CTP05-1 for source of payment BL be one of the following: <ul style="list-style-type: none"> Report UN (unit) for drugs that come in a vial in powder form that need to be reconstituted before administration Report ML (milliliter) for drugs that come in a vial in a liquid form Report GR (gram) for topical forms of medicine (e.g., cream, ointment and bulk powder in a jar) International units should be converted to standard measurements (UN). | 19 | Aug 2018 |
| 11.1 ASC X12N/005010X222A1 – 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 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION | Added the following for loop 2400, PWK02: BCBSM and Medicare Advantage: Report qualifier BM – By Mail or FX – By Fax only. | 19 | April 2018 |
| 9.6 Professional Electronic Claim Exceptions | Removed reference to BCBSM in regard to claims requiring hard copy documentation. | 14 | February 2017 |
| 9.1 MEDICARE ADVANTAGE CLAIMS | Removed “alpha” from “alpha prefix”. | 13 | November 2016 |
| 9.3 BLUE CROSS COMPLETE CLAIMS | Removed “alpha” from “alpha prefix”. | 13 | November 2016 |
| 9.6 PROFESSIONAL ELECTRONIC CLAIM EXCEPTIONS | Removed reference to tertiary claims. | 14 | November 2016 |

| Section | Description of Change | Page | Date |
|--|--|------|---------------|
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION - Revise instructions for 2010BA NM109 | Removed “alpha” from “alpha prefix”. | 16 | November 2016 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION - Revise 2010BB NM109 | Updated Medicare DMERC Payer ID to 17013. | 17 | August 2016 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION - Revise instructions for 2010BA NM109 | Added: Blue Cross Complete – See Section 9.3 of this Companion Guide for reporting instructions. | 16 | August 2016 |
| 11.1 ASC X12N/005010X222A1 – 837 TRANSACTION - Revise instructions for Loops 2000A taxonomy statements | 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. | 15 | August 2016 |
| 9.3 Blue Cross Complete claims | Added Blue Cross Complete claims guidelines | 13 | August 2016 |
| 9.4 Maximums/Limitations | Removed Claim Office Number of “0000”. | 13 | August 2016 |
| All | Published document in new format | | Nov. 2015 |