



April 30, 2009

Subject: Changes for the Institutional 837 and 835 transactions

Dear software developer,

A revised, updated copy of the *BCBSM EDI Institutional 837/835 Companion Document* is now online at: [bcbsm.com/pdf/837\\_835\\_institutional\\_companion.pdf](http://bcbsm.com/pdf/837_835_institutional_companion.pdf)

The table below summarizes the changes to 837 and 835 transactions

| Section   | Description of Change | Page |
|---|-----------------------|------|
| <b>Data Clarifications for the Institutional 837 (004010X096) Transaction Set</b> |                       |      |
| Loop 2300, REF01  | Added                 | 25   |

If you have any questions regarding this information, please call our Electronic Data Interchange department at 800-542-0945.

Sincerely,

Wanda Brideau  
Manager, ETP Service and Support  
e-Business Interchange Group

John Bialowicz  
Manager, ETP Contracting and Relations  
e-Business Interchange Group

# **Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document**

American National Standards Institute (ANSI) ASC X12N 837 (004010X096A1) Institutional Health Care Claim and 835 (004010X091A1) Health Care Claim Payment/Advice

Published June 2002



## **Table of Contents**

|   |   |
|---|---|
| Table of Contents.....  | 1 |
| Introduction .....  | 2 |
| ANSI ASC X12N Institutional 837 (004010X096A1) – Reporting Instruction Clarifications ..... | 2 |
| General Overview.....   | 2 |
| Hierarchical Structure.....   | 2 |
| Maximums/Limitations .....  | 2 |
| Institutional Electronic Claim Exclusions .....   | 2 |
| Character Set Requirement.....  | 2 |
| Provider Identification Numbers .....   | 2 |
| National Identifiers .....  | 2 |
| National Provider Identifier (NPI).....   | 2 |
| Claim Editing.....  | 2 |
| MDCH Modulus Eleven Check-Digit Routine.....  | 2 |
| Coordination of Benefits (COB).....   | 2 |
| BCBSM .....   | 2 |
| BCN.....  | 2 |
| ANSI ASC X12N Institutional 835 (004010X091A1) – Remittance Clarifications .....            | 2 |
| 835 Balancing.....  | 2 |
| Maximums/Limitations .....  | 2 |
| Unique Receiver Identification (URI) .....  | 2 |
| Provider Identification Numbers .....   | 2 |
| Payee Identification .....  | 2 |
| Claim and Service Level Information.....  | 2 |
| Bundling and Unbundling.....  | 2 |
| Claim/Service Adjustments .....   | 2 |
| Claim Interest and Prompt Payment Discounts .....   | 2 |
| Reversals and Corrections .....   | 2 |
| TA1 Interchange Acknowledgements .....  | 2 |
| 997 Functional Acknowledgements.....  | 2 |
| Unsolicited Claim Status (277).....   | 2 |
| Data Clarifications for the Institutional 835 (004010X098A1) Transaction Set .....          | 2 |
| Pertinent information regarding Loop 2100 REF01*CE/Type of Payment Indicator .....          | 2 |
| Accommodation Codes.....  | 2 |
| Voucher Codes .....   | 2 |
| DRG-PPA Process Indicator (Method of Reimbursement) .....                                   | 2 |
| Provider Contract Indicator .....   | 2 |

Special Use Indicator..... 2  
Institutional 837 and 835 Interchange Envelope and Functional Group Structure ..... 2  
Data Clarifications for the Institutional 837 (004010X096) Transaction Set ..... 2  
General EDI Terminology ..... 2

## **Introduction**

This document is the property of Blue Cross Blue Shield of Michigan (BCBSM) and is for use solely in your capacity as a trading partner exchanging health care transactions with BCBSM.

This document provides information related to specific elements within the addenda version of the ANSI ASC X12N 837 transaction, but does not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.<sup>1</sup>

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N Institutional 837 and 835 transaction set addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, companion documents, institutional manuals, and/or other billing guidelines published by our clearinghouse payers, including BCBSM. Implementation Guides can be purchased from the Washington Publishing Company web site at [www.wpc-edi.com](http://www.wpc-edi.com). Copyright (c) 2000, Data Interchange Standards Association on behalf of ASC X12.Format (c) 2000, Washington Publishing Company. All Rights Reserved.

This document 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. Changes will be communicated in future letters and on the BCBSM web site: [www.bcbsm.com](http://www.bcbsm.com).

Appropriate steps must be taken before submitting production addenda ANSI ASC X12N transactions, such as testing, completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please contact the EDI Help Desk at 800-542-0945.

---

<sup>1</sup>Standards for Electronic Transactions, *Federal Register*, Vol. 65, No. 160, August 17, 2000 pg. 50368

## **ANSI ASC X12N Institutional 837 (004010X096A1) – Reporting Instruction Clarifications**

### **General Overview**

The Health Insurance Portability and Accountability Act (HIPAA) require that all health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The addenda version of the ANSI ASC X12N 837 transaction set has been selected as the format to meet HIPAA requirements for the electronic submission of institutional health care claims. The BCBSM EDI Clearinghouse accepts ANSI ASC X12N 837 addenda version Institutional transactions for BCBSM (including Blue Card), Medicare Advantage, BCN, BCN Advantage, Federal Employee Program (FEP), Medicare A and Medicaid (MDCH) carriers. Acceptance of 837 and return of 835 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 Implementation Guide.
- BCBSM may reject interchanges, functional groups or transactions that do not follow all HIPAA Implementation Guide 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.

Trading partners should note that if the information associated with any of the claims in the 837 ST-SE batch is not correctly formatted from a syntactical perspective; all claims between the ST-SE would be rejected. Providers should consider this possible response when determining the size of their transactions.

When reporting dollar amounts of zero, report that amount (do not leave blank) in the transaction. If required amount elements are left blank, they will be rejected. When reporting percentages in amount elements, be sure to indicate the percentage as a decimal. For example, 50% would be .5, 25% would be .25.

Segments submitted at the claim level apply to the entire claim unless overridden by information submitted at the service line level.

Medicare Advantage is a coverage that combines an insured's Medicare and BCBSM Supplemental benefits. Claims for Medicare Advantage must be submitted as Medicare claims with the following exceptions:

- The Payer Identification Number, reported in Loop 2010BC NM109, must be equal to 00210.
- The insured's Primary Identification Number reported in Loop 2010BA NM109 must contain the BCBSM assigned contract number for the insured. It is recommended that the alpha-prefix followed by 9 numeric, be reported on all Medicare Advantage claims.

BCN Advantage is a coverage that combines an insured's Medicare and BCN Supplemental benefits. Claims for BCN Advantage should follow BCN reporting guidelines for Claim filing Indicator, Payer ID, Provider ID and the Members' contract number. All other claim/service related information should follow Medicare billing instructions. Refer to Segment/Element reporting instructions for further detail.

## **Hierarchical Structure**

The 837 format incorporates a hierarchical structure to make the submission of health care claims as efficient as possible. A hierarchical structure identifies relationships between the provider, subscriber, and patient and can eliminate repetitious reporting of data. One example of this is the ability to report claims for both the subscriber and dependents without repeating the subscriber information.

A subordinate dependent hierarchical level should not be included when the subscriber is also the patient and no additional claims are being sent for the subscriber's dependents. Additional patient information should be reported at the dependent level when the dependent is the patient or when there is a combination of claims for the subscriber and their dependents. Address and demographic segments are only required for the patient/dependent when there are only dependent claims submitted for a subscriber.

The dependent hierarchical level should be used when there are only claims for dependents or claims for both the subscriber and dependents. To ensure correct processing of Blue Care Network claims, it is important to report the correct loops and relationship code of the patient to the insured.

## **Maximums/Limitations**

- Report a maximum of 99 services per claim for BCBSM, BCN and FEP.
- Report a maximum of 450 services per claim for Medicare A and Medicare Advantage.
- Report a maximum of 50 services per claim for MDCH.
- Report up to 100 claims per subscriber/patient combination.
- Submit a maximum of 5,000 claims per transaction set.
- Up to ten other payers can be identified in addition to the destination payer.
- Decimal data reported in data element 782 (Monetary Amount) is limited to a maximum length of ten 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.

## **Institutional Electronic Claim Exclusions**

Please note the list below regarding claims that cannot be submitted in the Institutional 837 to BCBSM EDI until further notice:

- Commercial payers
- Medicare A bill types 33X (Home Health), 81X (Inpatient Hospice, Non Hospital based) and 82X (Inpatient Hospice Hospital based) for Medicare
- Medicare Advantage bill types 81X (Inpatient Hospice, Non Hospital based) and 82X (Inpatient Hospice Hospital based)
- BCN and FEP when billing Tertiary payer COB claims
- FEP Bill types XX7 and XX8
- Out-of-State hospitals (Non-par) for Blue Cross, BCN and FEP
- BCN Secondary payer when billing Type of Bill XX7 and XX8
- BCN ESRD claims

**Character Set Requirement**

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field. **All transactions must be submitted in upper-case characters.**

|       |       |   |   |   |   |   |   |       |
|-------|-------|---|---|---|---|---|---|-------|
| A...Z | 0...9 | ! | “ | & | , | ( | ) | +     |
| '     | -     | . | / | ; | ? | = | @ | Space |

**Provider Identification Numbers**

NPI is the primary identifier for providers. Secondary identifiers are the Provider Taxonomy Codes which are required, as applicable. Refer to the data clarifications section for payer specific reporting requirements.

**National Identifiers**

National Plan ID (Qualifier XV) is not used at this time.

**National Provider Identifier (NPI)**

The National Provider Identifier (NPI) must be reported as the primary identifier for a health care provider. NPIs should be reported as the provider identifier in all applicable elements. A qualifier of XX is reported in NM108 of applicable provider loops to indicate that a NPI is present in NM109.

NPIs are validated by BCBSM EDI for accuracy and that a match is made to a value registered in the EDI Provider Authorization database. To ensure that there is no interruption in receiving 835 remittance advice transactions, it is essential that when you add your NPI to the EDI Provider Authorization database that you also include your Unique Receiver ID (URI) by source of payment.

**Hospital psychiatric and rehabilitation units** – Many hospitals are enumerating their Medicare-exempt psychiatric and rehabilitation units separately from the hospital. Currently, BCBSM pays for psychiatric and rehabilitation services under the hospital’s facility code. If hospitals have obtained separate NPIs for these units, they must register those NPIs with our Provider Contracting department and with EDI.

Health care providers who have obtained fewer national provider identifiers than BCBSM provider ID numbers must submit taxonomy codes on electronic claims. BCBSM also requests that taxonomy codes be reported on claims billed to Medicare to support the processing of Medicare crossover claims for providers who have obtained fewer NPIs than BCBSM IDs.

**Claim Editing**

All institutional claims are validated based on HIPAA, medical code set and payer specific requirements. These requirements have been identified in the comment area of each affected field within the data clarification section.

The following types of codes will be validated:

- ICD-9-CM (Volume 1 & 2) – diagnosis codes
- ICD-9-CM (Volume 3) – procedure codes
- HCPCS (Level 1 – CPT-4) – procedure codes
- HCPCS (Level 2) – procedure codes
- Modifiers (CPT)
- Modifiers (HCPCS)
- Revenue Codes

Information regarding claims generating these edits will be returned in either an X12N Unsolicited 277 transaction or report file and affected claims will not be forwarded to the destination payer for processing. Edit messages and an example of the report are available in the Unsolicited 277 Companion document on the BCBSM web site at: [www.bcbsm.com](http://www.bcbsm.com)

### **MDCH Modulus Eleven Check-Digit Routine**

MDCH requires Recipient IDs to pass a Modulus Eleven Check Digit Routine. To calculate this check-digit:

- a) Begin with a seven-digit core number.

Examples: 0000123, 0000124, 0000125, 0000126, 0000127, 0000128, 0000129

- b) Multiply digit by position from right and total.

Examples:

$$0000123 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (3*1) = 10$$

$$0000124 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (4*1) = 11$$

$$0000125 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (5*1) = 12$$

$$0000126 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (6*1) = 13$$

$$0000127 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (7*1) = 14$$

$$0000128 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (8*1) = 15$$

$$0000129 - (0*7) + (0*6) + (0*5) + (0*4) (1*3) + (2*2) + (9*1) = 16$$

- c) Divide total by 11 giving a remainder.

Examples:

$$0000123 \ 10/11 = 0 \text{ remainder } 10$$

$$0000124 \ 11/11 = 1 \text{ remainder } 0$$

$$0000125 \ 12/11 = 1 \text{ remainder } 1$$

$$0000126 \ 13/11 = 1 \text{ remainder } 2$$

$$0000127 \ 14/11 = 1 \text{ remainder } 3$$

$$0000128 \ 15/11 = 1 \text{ remainder } 4$$

$$0000129 \ 16/11 = 1 \text{ remainder } 5$$

- d) Create 8<sup>th</sup> digit. Subtract remainder from 11 to get last digit. If it is a 10, do not use that number. If it is an 11, change it to zero.

Examples:

|                      |  |
|----------------------|--|
| 00000123 11 - 10 = 1 | ID number 00001231                         |
| 00000124 11 - 0 = 11 | ID number 00001240 (11 is changed to zero) |
| 00000125 11 - 1 = 10 | No ID number (10's are not used)           |
| 00000126 11 - 2 = 9  | ID number 00001269                         |
| 00000127 11 - 3 = 8  | ID number 00001278                         |
| 00000128 11 - 4 = 7  | ID number 00001287                         |
| 00000129 11 - 5 = 6  | ID number 00001296                         |

- e) To calculate second possible check digit for recipient ID, if 8<sup>th</sup> digit is greater than 4, subtract 5, or, if 8<sup>th</sup> digit is less than 5, add 5.

Examples:

00001231 + 5 becomes 00001236  
00001240 + 5 becomes 00001245  
0000125 is not used  
00001269 - 5 becomes 00001264  
00001278 - 5 becomes 00001273  
00001287 - 5 becomes 00001282  
00001296 - 5 becomes 00001291

- f) Note: For the first example, the core number 0000123 results in two (2) valid recipient numbers - 00001231 and 00001236 which will be assigned to recipients.

## **Coordination of Benefits (COB)**

### **BCBSM**

BCBSM EDI now accepts and processes electronically submitted BCBSM secondary and tertiary COB claims.

The 837 transaction set contains numerous loops of data that must be completed accurately and reported in the correct sequence to ensure proper adjudication of a COB claim. Some data elements may already be required, but contain different values on COB claims or may be in addition to regularly required elements.

Loops 2000B, 2010BA and 2010BB are used to provide information regarding the secondary insured and destination payer. Loops 2300, 2330A through H and 2430 are used to provide information about the primary insured, payer and claim/service adjudication information.

Report the Estimated responsibility in Loop 2300 AMT01 C5 qualifier. When billing secondary and/or tertiary Blue Cross report the applicable prior payment amount in Loop 2320 AMT01 C4/N1 qualifier

**Medicare Advantage** - It is recommended that claim adjustments be reported in the CAS segments.

### **BCN**

- BCBSM EDI accepts and processes BCN secondary electronic claims. Tertiary BCN claims remain an exclusion.
- BCN requires usage of claim adjustment information at the claim (Loop2320) and/or service (Loop 2430) level for secondary claims. If your system has the capability of reporting prior payer adjustments in the CAS segments, make appropriate changes to begin reporting in that manner. You may continue to report applicable value and occurrence code information; however, it is no longer necessary if reporting CAS data. For submitters that do not have the capability to report claim adjustments in CAS segments, BCBSM EDI will convert reported value and occurrence information into CAS data. For BCN secondary claims, if CAS data cannot be reported, a value code qualifier of 'BE' (Loop 2300 HI01-1 to HI12-1) and value code of 'B3' (Loop 2300 HI01-2 to HI12-2) must be present. The value code amount (Loop 2300 HI01-5 to HI12-5) must be equal to or less than the total claim amount (Loop 2300 CLM02).
- A BCN claim is categorized as 'supplemental' when Medicare is the primary payer. When reporting a BCN supplemental claim, the allowed amount should equal the sum of the prior payment, copay and/or deductible. If the allowed amount does not equal the total of these items, the claim will edit.

## **ANSI ASC X12N Institutional 835 (004010X091A1) – Remittance Clarifications**

The addenda version of the ANSI ASC X12N 835-transaction set has been selected as the format to meet HIPAA requirements for the return of health care remittance advice. One 835 transaction set reflects a single check or non-payment notice. Multiple claims can be referenced within one 835. This document refers only to 835's for BCBSM, BCN, FEP/NASCO and Medicare Advantage, but does not reflect what Medicare or MDCH will return. BCBSM is not performing electronic funds transfer at this time.

### **835 Balancing**

Three levels of balancing occur within the 835 transaction:

- Transaction Set Balancing – The total payment equals the sum of claim payments minus the sum of provider level adjustments.
- Claim Level Balancing – The total claim payment equals the submitted claim charge minus the sum of claim and service adjustments.

---

General Information for BCBSM, BCN and FEP. Information for other payers may vary.

Published June 2002  
Last Revised 2<sup>nd</sup> Qtr 2009

- **Service Level Balancing** – The service line payment equals the submitted service line charge minus the sum of service line adjustments. Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments (CAS) or Provider Adjustment Segments (PLB) decrease the payment when the adjustment amount is positive, and increase the payment when the adjustment amount is negative.

Service detail will be reported in the 835 for institutional claims when payment adjustments are related to specific line items from the original submitted claim. If any service detail is reported in the claim payment, all services for the claim payment will be reported.

All reductions are documented at either the service or claim level. They may also be used to differentiate between the units that were reported and the actual units that were used to adjudicate the claim/service. The adjustment group is also indicated. The nature of the adjustment is identified by a standard list of adjustment reason codes published by the Washington Publishing Company [www.wpc-edi.com](http://www.wpc-edi.com).

Provider level adjustments include remittance information that is not specific to the claim(s)/ service(s) contained in the prior level of the 835 transaction. These provide for reporting increases or reductions to the amount remitted. Reference numbers are used for further identification and reconciliation.

The total payment will agree with the remittance detailing that payment.

### **Maximums/Limitations**

The total payment amount will not exceed ten numeric characters (99999999.99). The 835 will not be issued for less than zero dollars. There is a recommended maximum of 10,000 claim payment segments per transaction set.

### **Unique Receiver Identification (URI)**

NPI is the primary ID returned in the PE segment in the 835. To continue receiving your 835 remittance without disruption, please be sure that your EDI provider authorizations and unique receiver IDs have been updated to include your NPI.

### **Provider Identification Numbers**

NPI is the primary identifier for providers.

### **Payee Identification**

BCBSM may not return the Payee Address information (Loop 1000B, Segments N3 and N4).

### **Claim and Service Level Information**

- A Claim Status Code is used to identify the status of the entire claim as assigned by the payer. Possible status codes describe the following conditions: processed as primary, processed as secondary, processed as tertiary, denied, reversal of previous payment, predetermination pricing only, processed as primary, secondary or tertiary and forwarded to additional payer(s) and not our claim, forwarded to additional payer(s).
- Patient Responsibility Amount will balance to supporting claim/service level adjustments.

- The individual claim payment may be zero or less than zero, but the 835 total payment will not be issued for less than zero dollars.
- DRG Related Group Code and Weight will be present when adjudication considered the DRG.
- Corrected insured name or identification number is provided when available.
- The status of a non-adjudicated claim will be returned in an Unsolicited 277 Health Care Claim Status Notification Transaction Set. This transaction is not mandated by HIPAA legislation.
- When the current payer believes that another payer has priority for making a payment, the name and ID number of that payer, may be returned, if available. The ID number returned is an internal number BCBSM uses to recognize a payer or in some cases could be the payer's name.

### **Bundling and Unbundling**

Bundled and unbundled information will be reported back if applicable. When codes are bundled, the code submitted, adjudicated code and total payment amount would be reported on the first line. All subsequent lines will contain the code submitted, adjudicated code and payment amount of \$0.

### **Claim/Service Adjustments**

- For 835's coming from other payers, both the Claim Adjustment and Service Adjustment Segments will provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s).
- The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim.
- Service level adjustments are not repeated at the claim level.
- A standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. These codes provide the 'explanation' for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835.
- A Claim Adjustment Group Code categorizes the adjustment reason codes that are contained in a particular adjustment segment. Up to six different adjustments related to a particular Claim Adjustment Group may be reported per segment.
- Remark codes (MIA, MOA or LQ segment) further describe reasons for an adjustment to the charge when applicable.

### **Claim Interest and Prompt Payment Discounts**

Payer-provider level interest and prompt payment discounts refer to adjustments that specific payer and provider contractual agreements require. Such adjustments are financially independent from the formula for determining benefit payments and are reported at the provider adjustment level. This information will also be provided in an amount segment at the claim level without affecting balancing.

### **Reversals and Corrections**

Reversals and corrections will be handled by reversing the original claim payment and re-sending the corrected data.

## Additional Information

### TA1 Interchange Acknowledgements

Interchange Acknowledgements are used to reply to an interchange or transmission that has been sent. This acknowledgement provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure and verifies the envelope information. It may also be used by EDI to identify a duplicate file or other file level rejections. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the TA1 Interchange Acknowledgement. Interchange acknowledgement (TA1) transactions are only provided when requested in the Interchange Control Header, to identify interchange control structure errors or to identify duplicate interchanges.

### 997 Functional Acknowledgements

Functional Acknowledgements are used to facilitate control of EDI. Segments within the 997 are used to identify the acceptance or rejection of functional groups, transaction sets or segments. Data elements in error can also be identified. The sending trading partner can determine if the receiving trading partner has received the transaction sets that they sent. Use of this process is essential for successful reconciliation and follow-up of EDI. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the 997 Functional Acknowledgement.

Please note that BCBSM will be returning 997 functional acknowledgements upon receipt of files from trading partners and expects to receive 997 functional acknowledgements from trading partners to acknowledge receipt of files that BCBSM has sent to them. Such usage of the 997 is necessary for reconciliation purposes.

### Unsolicited Claim Status (277)

The Unsolicited Claim Status (277) transaction or a report file (U277A, U277F or U277I) will be used by EDI to notify submitters of front end claim editing conditions encountered on claims submitted within the 837 transaction. An EDI companion document for this transaction and the EDI user guide which contain edit lists are available on our web site [www.bcbsm.com](http://www.bcbsm.com). The Standard Implementation Guide for 003070 Unsolicited 277 and Standard Health Care Claim Status Codes will be used in the Unsolicited 277 are available from the Washington Publishing Company web site [www.wpc-edi.com](http://www.wpc-edi.com).

### Data Clarifications for the Institutional 835 (004010X098A1) Transaction Set

| Loop | Segment/Element | Instruction   | Industry/Element Name                |
|------|-----------------|---|--------------------------------------|
|      | BPR01           | BCBSM – H will be returned for non-payment and I will be returned for payment/remittance information.   | Transaction Handling Code            |
|      | BPR02           | This amount will balance to the total of all claim payments minus any provider level adjustments.   | Total Actual Provider Payment Amount |
|      | BPR04           | BCBSM – CHK will be returned for payment/remittance information. NON will be returned for nonpayment and BIP Hospitals.   | Payment Method Code                  |
|      | TRN02           | The check number that was issued to the provider.<br>BCBSM, NASCO and Medicare Advantage – For remittance files containing all non-paid claims or a provider withhold adjustment, a unique generated check number will be returned. | Trace Number                         |

Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document  
 American National Standards Institute (ANSI) ASC X12N 837 (004010X096A1) Institutional Health Care Claim  
 and 835 (004010X091A1) Health Care Claim Payment/Advice

| Loop  | Segment/Element | Instruction  | Industry/Element Name              |
|-------|-----------------|--|------------------------------------|
|       | TRN03           | <b>BCBSM and NASCO</b> – 1382069753 will be returned<br><b>BCN FACETS</b> – 1382359234 will be returned  | Payer Identifier                   |
|       | REF02           | <b>BCN</b> – 382069753   | Receiver Identification            |
| 1000A | N102            | <b>MOS, BCBSM and NASCO</b> – BCBSM will be returned.<br><b>Medicare Advantage</b> – Blue Cross Blue Shield Michigan will be returned.<br><b>BCN</b> – Blue Care Network of Michigan   | Payer Name                         |
| 1000A | N301            | <b>MOS, BCBSM and NASCO</b> – 600 E. Lafayette will be returned<br><b>Medicare Advantage</b> – 600 Lafayette Blvd will be returned<br><b>BCN</b> – 25925 Telegraph Road will be returned.  | Payer Address                      |
| 1000A | N401            | <b>MOS, BCBSM and NASCO and Medicare Advantage</b> – Detroit will be returned.<br><b>BCN</b> – Southfield will be returned.  | Payer City                         |
| 1000A | N402            | <b>BCBSM, NASCO and BCN</b> – MI will be returned.   | Payer State                        |
| 1000A | N404            | <b>MOS, BCBSM and NASCO</b> – 48226 will be returned<br><b>Medicare Advantage</b> – 482262998 will be returned.<br><b>BCN</b> – 48034 will be returned.  | Payer Zip Code                     |
| 1000A | REF01/REF02     | <b>BCBSM</b> – REF01 will contain 2U and REF02 will contain 00210.<br><b>MOS and NASCO</b> – REF01 will contain 2U and REF02 will contain 710.<br><b>BCN</b> – Not used.<br><b>Medicare Advantage</b> – REF01 will contain 2U and REF02 will contain 210 | Additional Payer ID                |
| 1000A | PER03/PER04     | <b>BCN</b> – PER03 will contain TE and PER04 will contain 2483547450. This is the telephone number for BCN provider inquiry.   | Payer Contact Communication Number |
| 1000B | N1 Segment      | <b>All Payers</b> – Qualifier PE followed by payee name and NPI.   | Payee Identification               |
| 1000B | N301/N302       | <b>BCBSM</b> – May contain payee address information in N301.<br><b>MOS, NASCO, and Medicare Advantage</b> – Not used.<br><b>BCN</b> – N301 and N302 will contain payee address information.   | Payee Address                      |
| 1000B | N401-N403       | <b>BCBSM and BCN</b> – will be returned<br><b>NASCO, Medicare Advantage</b> – Not used.  | Payee City, State and Zip Code     |
| 1000B | REF01/REF02     | <b>All Payers</b> – REF01 will contain XX and REF02 will contain the BCBSM NPI of the payee.   | Additional Payee Identifier        |
| 2100  | CLP01           | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – If available, the provider-assigned patient control number will be returned. When not available, a value of 0 will be returned.  | Patient Control Number             |
| 2100  | CLP02           | <b>BCBSM, NASCO and BCN</b> – Code values of 1, 2, 3, 4 or 22 will be returned.  | Claim Status Code                  |
| 2100  | CLP06           | <b>BCBSM</b> – Code values of 12 (par) or 15 (non-par) will be returned.<br><b>NASCO</b> – Code values of 12 (PPO), 13 (POS) or 15 (Indemnity) will be returned.<br><b>BCN</b> – HM will be returned.  | Claim Filing Indicator Code        |
| 2100  | CAS Segment     | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – Adjustments that are applicable to the claim level will be returned.   | Claim Adjustment (Claim Level)     |
| 2100  | NM103           | <b>BCBSM</b> – Some names may be truncated to five positions.  | Patient First Name                 |
| 2100  | NM108/NM109     | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – NM108 will contain MI and the member ID number will be returned.   | Patient Contract Number            |

General Information for BCBSM, BCN and FEP. Information for other payers may vary.

Published June 2002  
 Last Revised 2<sup>nd</sup> Qtr 2009

| Loop | Segment/Element | Instruction  | Industry/Element Name                    |
|------|-----------------|--|--|
| 2100 | NM1 Segment     | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – This information will be returned when available if applicable.  | Corrected Patient/Insured Name           |
| 2100 | NM1 Segment     | <b>BCBSM</b> – Not used<br><b>NASCO, Medicare Advantage</b> – When present, NM108 will contain FI and NM109 will contain the Rendering Provider's Federal Tax ID Number.<br><b>BCN</b> – When present, NM108 will contain FI, BS or SL and NM109 will contain the assigned number.   | Service Provider Name/ID                 |
| 2100 | NM1 Segment     | <b>BCBSM, NASCO and BCN</b> – Returned if applicable.  | Corrected Priority Payer Name            |
| 2100 | REF01/REF02     | <b>BCBSM and NASCO</b> – 1L or CE will be returned.<br><ul style="list-style-type: none"> <li>• IF CE IS RETURNED PLEASE SEE THE END OF THIS DOCUMENT FOR DETAILED INFORMATION</li> </ul> <b>BCN</b> – 1L, SY, A6, BB, or EA will be returned.<br><b>Medicare Advantage</b> – REF02 MA will be returned.                     | Other Claim Related ID                   |
| 2100 | DTM01           | <b>BCBSM, BCN and NASCO</b> – DTM will contain 050, 232 and/or 233<br><b>Medicare Advantage</b> - DTM will contain 050   | Claim Date Qualifier                     |
| 2100 | AMT01           | <b>BCBSM, NASCO and BCN</b> – AMT01 will contain AU when applicable to report contract charges.  | Claim Supplemental Amount Qualifier Code |
| 2110 | SVC01-1         | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – HC or NU will be returned.<br><b>NASCO</b> – ID may be returned in some cases, otherwise HC will be returned.<br><b>Medicare Advantage</b> – Service information may not be available where the entire charge is applied to the deductible or if the claim is paid in full | Product or Service ID Qualifier Code     |
| 2110 | SVC06-1         | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – HC will be returned when applicable.   | HCPCS Code (qualifier)                   |
| 2110 | SVC07           | <b>BCBSM</b> – A quantity will be returned on pay-subscriber remittances.  | Original Units of Service Count          |
| 2110 | CAS Segment     | <b>BCBSM, NASCO and BCN</b> – Adjustments that are applicable to the service level will be returned.   | Service Adjustment (Service Level)       |
| 2110 | REF01           | <b>BCBSM, NASCO and BCN</b> – REF01 will contain 6R and REF02 will contain the provider control number when applicable.<br><b>Medicare Advantage</b> – A sequential number will be returned at this time.  | Service Provider ID                      |
| 2110 | AMT01           | <b>NASCO, BCN and Medicare Advantage</b> – AMT01 will contain B6 when applicable.  | Service Supplemental Amount              |
| 2110 | LQ01, LQ02      | <b>BCBSM, BCN and Medicare Advantage</b> – LQ01 will contain HE and LQ02 will contain the Claim Payment Remark Code.   | Claim Payment Remark Code                |
| 2110 | PLB Segment     | <b>BCBSM, NASCO, BCN and Medicare Advantage</b> – Used when applicable   | Provider Level Adjustment                |

## **BCBSM and NASCO**

### **Pertinent information regarding Loop 2100 REF01\*CE/Type of Payment Indicator**

#### **Accommodation Codes**

- 0 BC-65 Outpatient Complementary
- 1 Regular Inpatient Hospital Admission
- 2 BC-65 Inpatient Hospital Admission, Full Days; admission out of country, Canada and after ninety-first day in U.S. hospitals, subsequent admission
- 3 Regular Outpatient
- 4 BC-65 Inpatient Hospital Admission, Full Days; admission out of country, Canada and after ninety-first day in U.S. hospitals, continuous admission
- 5 BC-65 Inpatient Deductible
- 6 BC-65 Inpatient Coinsurance and/or Lifetime Reserve Days Coinsurance
- 7 BC-65 Deductible/Coinsurance and/or Lifetime Reserve Days Coinsurance
- 8 BC-65 Skilled Nursing Facility Coinsurance
- B Freestanding Physical Therapy Facility
- D Substance Abuse, Inpatient
- P Skilled Nursing Facility, Full Days (Patient over 65) non-Medicare Admission
- T Outpatient Psychiatric Facility
- W Regular Home health Care Program
- E Substance Abuse, Outpatient
- H BC-65 Home Health
- K Ambulatory Surgical Facility
- M Skilled Nursing Facility, Full Days (Patient over 65) Admitted under Medicare
- N Skilled Nursing Facility

### **Voucher Codes**

|   |   |
|---|---|
| 1 | Inpatient Regular                               |
| 2 | Out-of-State and Michigan Non-Par               |
| 3 | Outpatient Regular                              |
| 4 | Bank Home, ITS Home and Bank Home Complementary |
| 5 | BC Complementary Inpatient                      |
| 6 | BC Complementary Outpatient                     |
| 7 | Home Health Complementary                       |
| 8 | Skilled Nursing Facility (SNF)                  |
| 9 | Pay Subscriber (Modes)                          |
| A | Bank Host Regular Inpatient                     |
| B | Bank Host Inpatient Complementary               |
| F | Serviced Inpatient/Outpatient                   |
| G | Equalized Inpatient/Outpatient                  |
| H | Home Care Agency                                |
| J | Home Care Hospital                              |
| K | Ambulatory Surgical Facilities                  |

### **DRG-PPA Process Indicator (Method of Reimbursement)**

|   |   |
|---|---|
| B | Blue Care Network                                       |
| C | PHA Controlled Cost                                     |
| D | Old de-par DRG  |
| G | Old DRG Gain/loss pilot                                 |
| H | Local Out of network claim. Pays at 100%                |
| I | ITS Home  |
| J | BCN Outpatient Peer group 5, Ratio Cost to Change       |
| K | Trust/PPO Outpatient Peer group 5, Ratio Cost to Change |
| L | PHA Lower of Cost to Charge                             |
| M | Psych Managed Care                                      |
| N | PHA new DRG   |
| P | PPO/Trust   |
| R | PHA Per Diem  |
| S | Ford flat rate/price                                    |

T Case Management/CCM extra contractual  
U BCN Inpatient Total contract charge  
V Traditional Inpatient total contract charge  
W Trust/PPO Inpatient total contract charge  
X POS or CCP extra contractual

**Provider Contract Indicator**

Blank PHA  
B Blue Care Network  
F Psych Managed Care (network 556)  
M Community Care Partnership - in network  
N Community Care Partnership - out of network  
P POS  
S Psych Manager Care (network 557)  
T Trust/PPO

**Special Use Indicator**

% Percent of PHA  
A Mid Michigan

## **Institutional 837 and 835 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 (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for transmitting to BCBSM EDI are:

| <b>Transaction Set</b>                             | <b>Element</b>                          | <b>Instruction</b>   | <b>Pg#</b> |
|--|---|--|------------|
| Institutional 837 Health Care Claim                | ISA05 – Interchange ID Qualifier        | Report ZZ.   | B.4        |
| Institutional 837 Health Care Claim                | ISA06 – Interchange Sender ID           | Report the Federal Tax ID of the submitter. Must be registered with BCBSM EDI.   | B.4        |
| Institutional 837 Health Care Claim                | ISA07 – Interchange ID Qualifier        | Report ZZ.   | B.4        |
| Institutional 837 Health Care Claim                | ISA08 – Interchange Receiver ID         | Report 382069753.  | B.5        |
| Institutional 837 Health Care Claim                | GS02 – Application Sender’s Code        | Report the Federal Tax ID of the submitter. Must be registered with BCBSM EDI.   | B.8        |
| Institutional 837 Health Care Claim                | GS03 – Application Receiver’s Code      | Report 382069753.  | B.8        |
| Institutional 837 Health Care Claim                | GS08 – Version/Release/Industry ID Code | Report 004010X096A1.   | B.8        |
| <b>Separator</b>                                   |   |  |            |
| Institutional 835 Health Care Claim Payment Advice | ISA05 – Interchange ID Qualifier        | ZZ will be returned from EDI.  | B.4        |
| Institutional 835 Health Care Claim Payment Advice | ISA06 – Interchange Sender ID           | 382069753 will be returned from EDI.   | B.4        |
| Institutional 835 Health Care Claim Payment Advice | ISA07 – Interchange ID Qualifier        | ZZ will be returned from EDI.  | B.4        |
| Institutional 835 Health Care Claim Payment Advice | ISA08 – Interchange Receiver ID         | The URI (Unique Receiver ID), designated by the provider based on source of payment will be returned.  | B.5        |
| Institutional 835 Health Care Claim Payment Advice | GS02 – Application Sender’s Code        | One of the following application system identifiers will be reported for BCBSM-related 835 functional groups:<br>Institutional NASCO and FEP: BCBSM NASCO<br>Institutional BCBSM: BCBSM LOCAL INS<br>Institutional BCN: FACETSTHG<br><br>Medicare Advantage: MED ADVANTAGE<br>MOS: BCBSM MOS<br>Medicaid: D00111 | B.8        |
| Institutional 835 Health Care Claim Payment Advice | GS03 – Application Receiver’s Code      | The payer assigned ID will be returned from EDI.   | B.8        |
| Institutional 835 Health Care Claim Payment Advice | GS08 – Version/Release/Industry ID Code | 004010X096A1 will be returned.   | B.8        |

## Data Clarifications for the Institutional 837 (004010X096) Transaction Set

| Loop   | Segment/Element       | Instruction   | Industry/Element Name                               |
|--------|-----------------------|---|---|
| Header | BHT04                 | Must be less than or equal to the current date.   | Transaction Set Creation Date                       |
| 1000A  | NM103                 | The submitter name is required.   |   |
| 1000A  | NM109<br>Qualifier 46 | Report the Federal Tax ID of the submitter.   | Submitter Primary ID Number                         |
| 1000B  | NM103                 | Report BCBSM as the receiver name.  | Name Last/Org Name                                  |
| 1000B  | NM109                 | Report 00210 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer.  | ID Code   |
| 2000A  | All                   | <p>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.</p> <p>The Billing/Pay-to 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.</p> <p><b>BCBSM and FEP</b> – Required when adjudication is known to be impacted by the provider taxonomy code, and the Service Facility Provider is the same entity as the Billing. In these cases, the Billing Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310E is not used.</p> <p><b>BCBSM, BCN and FEP</b> – Any entity reported other than the billing provider will not be recognized. 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.</p> <p><b>Medicare Advantage</b>-If reported then secondary identifiers will be validated.</p> | Billing/Pay-to Provider Hierarchical Level Loop     |
| 2000A  | PRV01                 | <b>All Payers</b> – Health care providers who have obtained fewer national provider identifiers than BCBSM provider ID numbers must submit taxonomy codes on electronic claims. BCBSM also requests that taxonomy codes be reported on claims billed to Medicare to support the processing of Medicare crossover claims for providers who have obtained fewer NPIs than BCBSM IDs.  | Billing/Pay-To Provider Specialty Information       |
| 2000A  | CUR                   | <b>All Payers</b> – For proper adjudication, we recommend not reporting a CUR segment. Foreign currency claims should be reported using a paper submission.   | Currency Segment                                    |
| 2010AA | NM103                 | Provider name is required.  | Billing Provider Name                               |
| 2010AA | NM108/NM109           | <p><b>All Payers:</b></p> <ul style="list-style-type: none"> <li>• Report NM108 qualifier=XX then NM109 must contain the 10 digit NPI.</li> <li>• NM109- Report 10 digit NPI.</li> <li>• The EIN or SSN of the Billing provider must be reported in the REF01/REF02 of this loop.</li> <li>•</li> </ul>   | Billing Provider ID, Billing Provider Secondary ID. |
| 2010AA | REF01/REF02           | <b>All Payers</b> – Credit/Debit card information may not be used to bill any insurance payer.  | Credit/Debit Card Billing Information               |

| Loop   | Segment/Element         | Instruction   | Industry/Element Name                     |
|--------|-------------------------|---|---|
| 2010AA | REF01/REF02             | <p>Required when a secondary identification number is necessary to identify the entity. The primary identification number must be reported in NM108/NM109 in this loop.</p> <p>BCBSM EDI and/or the destination payer will validate the Billing Provider's Secondary Identification Number. To avoid unnecessary claim rejections, report all applicable identification numbers associated with the claims submitted in this transaction set.</p> <p><b>All Payers – NPI requirements</b> – Refer to the section titled '<b>National Provider Identifier (NPI)</b>' on page 6 for NPI specifications. All payers must report qualifier EI (employer identification number) or SY (social security number).</p> <p>If additional numbers are needed the REF segment can be repeated up to 8 times.</p> | Billing Provider Secondary ID Segment     |
| 2010AB | NM108/NM109             | <p><b>All Payers:</b></p> <ul style="list-style-type: none"> <li>• NM108 – Report applicable qualifier (24=EIN, 34=SSN, XX=NPI).</li> <li>• If NM108 qualifier=XX then NM109 must contain the 10 digit NPI.</li> <li>• NM109 – Report either the 9 digit Employer Identification Number (EIN), Social Security Number (SSN) or 10 digit NPI.</li> <li>• If NPI is reported then either the EIN or SSN of the Billing provider must be reported in the REF01/REF02 of this loop.</li> </ul> <p><b>BCBSM, BCN and FEP</b> – If reported, the Pay-to Provider will not be used.</p>  | Pay-to Provider Segment                   |
| 2010AB | REF01/REF02             | <p><b>All Payers – NPI requirements</b> – Refer to the section titled '<b>National Provider Identifier (NPI)</b>' on page 6 for NPI specifications.</p>   |   |
| 2000B  | SBR01                   | <p><b>BCBSM, Medicare Advantage and MDCH</b> – Can be P, S or T.<br/> <b>BCN, FEP</b> – Can be P or S.<br/> <b>MDCH</b>– Use P if MDCH is the only payer, S if there is one other payer primary to MDCH or T if there are two or more other payers primary to MDCH.</p>   | Payer Responsibility Sequence Number Code |
| 2000B  | SBR02                   | <p><b>Medicare, Medicare Advantage and MDCH</b>– For Medicare and MDCH, the subscriber is always the same as the patient. SBR02 must equal 18.<br/> <b>BCN</b> – To ensure proper processing only report when the insured is the patient.</p>   | Relationship Code                         |
| 2000B  | SBR03                   | <p><b>BCN</b> – Report the group number as shown on the subscriber's ID card.</p>   | Subscriber Group Number                   |
| 2000B  | SBR09<br>(Qualifier MI) | <p>Claim Filing Indicators determine the destination payer by the EDI Clearinghouse. For proper claim routing and adjudication use only the following codes:<br/>                     BL – Blue Cross<br/>                     HM – Blue Care Network /BCN Advantage<br/>                     MA – Medicare A and Medicare Advantage<br/>                     MC – MDCH<br/>                     TV – Title V<br/>                     11 – State Medical Plan (Other Non-Federal)<br/>                     OF – Federal Employee Program (FEP)<br/> <b>MDCH</b> – 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>   | Claim Filing Indicator                    |

| Loop   | Segment/Element              | Instruction   | Industry/Element Name              |
|--------|------------------------------|---|------------------------------------|
| 2010BA | NM1                          | <b>Medicare, Medicare Advantage and MDCH</b> – The subscriber is always the patient.  | Subscriber loops                   |
| 2010BA | NM103                        | <b>BCBSM, BCN, BCN Advantage, FEP, Medicare Advantage/ Medicare Plus Blue, MDCH</b> – Do not report numbers, special characters or embedded spaces. Must be alphabetic.<br><b>Medicare</b> –Do not report special characters  | Subscriber Last Name               |
| 2010BA | NM104                        | <b>All Payers</b> – Do not report numbers or special characters. Must be alphabetic. Do not report numbers, embedded spaces or special characters   | Subscriber First Name              |
| 2010BA | NM109                        | <b>All Payers</b> – NM109 is required for reporting the subscriber’s identification number. Use qualifier MI in NM108.<br><b>BCBSM</b> (including Blue Card claims), <b>Medicare Advantage</b> – Submit the contract number as reported on the members ID card. Must contain 9 numeric or if first two positions are XY, position three must be alpha and positions 4-12 must be numeric or if the first position is alpha, position two and three must be alpha and position four must be present with no embedded spaces or special characters.<br><b>BCN/BCN Advantage</b> – Submit the contract number as reported on the members ID card. Must contain at least 9 digits.<br><b>FEP</b> – Must be an R followed by eight digits.<br><b>Medicare</b> – Enter the patient’s Medicare Health Insurance Claim Number (HICN). | Subscriber Identification          |
| 2010BA | N301/N302/N401/<br>N402/N403 | <b>FEP</b> – For proper adjudication, report these elements if the patient is not the same as the subscriber.<br><b>Medicare and MDCH</b> – Required on all claims.   | Subscriber Address.                |
| 2010BA | DMG segment                  | <b>All Payers</b> – Required when the patient is the same as the subscriber.  | Subscriber Demographic Information |
| 2010BA | DMG02                        | <b>BCN</b> – When present must be a valid date. Cannot be greater than the system date.<br><b>Medicare and MDCH</b> – Must be a valid date. Cannot be greater than the system date.   | Subscriber Birth Date              |
| 2010BA | DMG03                        | <b>BCN</b> – When present must be M or F.<br><b>Medicare and MDCH</b> – Must be a valid code.   | Subscriber Gender Code             |
| 2010BB | NM101 through<br>NM109       | <b>All Payers</b> – Credit/Debit card information may not be used to bill any insurance payer.  | Credit/Debit Card Holder Name      |
| 2010BC | NM103                        | <b>BCBSM and Medicare Advantage</b> – Enter BCBSM.<br><b>BCN</b> – Enter BCN<br><b>FEP</b> – Enter BCBSM-FEP<br><b>Medicare</b> – Enter MEDICARE.<br><b>MDCH</b> – Enter MEDICAID   | Payer Name                         |
| 2010BC | NM108                        | <b>All Payers</b> – Enter PI.   | Qualifier                          |
| 2010BC | NM109<br>(Qualifier PI)      | <b>BCBSM, FEP, Medicare Advantage, BCN and BCN Advantage</b> – This element must equal 00210 when the Claim Filing Indicator (2000B-SBR09) is BL (Blue Cross), HM (BCN and BCN Advantage) OF (FEP) or MA (Medicare Advantage). When the claim is for a Blue Card member, report the Payer ID as indicated on the member’s insurance card (Blue Card 00210). If the Blue Card members’ card doesn’t include a Plan Code, use 00210.<br><b>Medicare</b> – This element must equal 00452 when the Claim Filing Indicator Code (2000B-SBR09) is MA (Medicare) and will be transferred to NGS.<br><b>MDCH</b> – This element must equal D00111 when the Claim Filing Indicator Code (2000B-SBR09) is MC (MDCH), TV (Title V) or 11 (State Medical Plan).   | Payer ID                           |

| Loop   | Segment/Element        | Instruction   | Industry/Element Name         |
|--------|------------------------|---|-------------------------------|
| 2000C  | All                    | <b>Medicare, Medicare Advantage and MDCH</b> – The subscriber is always the same as the patient; therefore, the Patient Hierarchical Level (2000C) is <b>not</b> used.<br><b>BCBSM, BCN and FEP</b> – Required if the patient is not the subscriber.  | Patient Hierarchical Level    |
| 2010CA | NM103                  | <b>BCBSM, BCN</b> – Must contain at least two alpha characters. Do not include special characters or embedded spaces.   | Patient Last Name             |
| 2010CA | NM104                  | <b>BCBSM, BCN, MDCH and Medicare</b> – Patient first name must be at least <u>one</u> character. Do not include special characters or embedded spaces.  | Patient First Name            |
| 2010CA | NM109<br>Qualifier MI  | <b>Required <u>only</u> if the patient identifier is different than the subscriber ID reported in loop 2010BA.</b>  | Patient Primary Identifier    |
| 2010CA | DMG02                  | <b>BCBSM, BCN and FEP</b> – Must be less than or equal to admission date (2300, DTP03, Qualifier 435).  | Patient Birth Date            |
| 2010CA | DMG03                  | <b>BCN</b> – When present, must equal M or F.   | Patient Gender Code           |
| 2300   | CLM02                  | <b>All Payers</b> – Total submitted charges must equal the sum of the line item charge amounts (2400/SV203). Negative values are not valid for this element and could result in the claim being rejected.   | Total Claim Charge Amount     |
| 2300   | CLM05-1                | <b>BCBSM</b> – Must equal 11-14, 16, 18, 21-23, 33, 71, 76, 81-83, 85-86.<br><b>BCN</b> – Must equal 11-13, 21-23, 33, 72-75, 81-83, 85, 86.<br><b>Medicare</b> – Must equal 11-14, 18, 21-23, 26, 71-76, 83, 85-86 or 89.<br><b>Medicare Advantage</b> – Must equal 11,-14, 18, 21-23, 26, 32- 34, 71-76, 83, 85-86 or 89.<br><b>MDCH</b> – Must equal 11-14, 18, 21- 23, 26, 33, 71-75, 81-83, 85, 86 or 89.<br><b>FEP</b> – Must equal 11-13, 14, 18, 21-23, 33-34, 71-76, 79, 81-86, 89<br><b>BCBSM</b> – If the type of bill equals 81X or 82X, the claims will process as inpatient<br><b>BCN</b> – If the type of bill equals 81X, the claim will process as outpatient.<br><b>FEP</b> – If the type of bill equals 81X, 82X, 84X or 89X and if an accommodation revenue code 0100-0219, 0655, 0656, 0658 or 1000-1005 is reported, the claim will process as outpatient | Facility Type Code            |
| 2300   | CLM05-3                | Must be a valid National Uniform Billing committee (NUBC) frequency code. Valid codes are 1-5, 7, 8, 9 or 0. Must be a valid bill type and frequency combination. 9 is <b>only</b> valid for Medicare Advantage Home Health claims.<br>When reporting bill types XX7 and XX8, the original document must be reported (Loop 2300/REF01 qualifier F8).<br><b>BCN</b> – When submitting a replacement claim for BCN, report CLM05-3 as a 7 (XX7) when billing Primary Payer.   | Claim Frequency Type Code     |
| 2300   | CLM06                  | <b>Medicare Advantage</b> – Report the provider signature indicator with a ‘ Y’   | Provider Signature Indicator  |
| 2300   | DTP03<br>Qualifier 096 | <b>All Payers</b> – Must be in HHMM format. Required when the Type of Bill is 11X, 18X or 21X. Required on inpatient claims.<br><b>HOSPICE SUBMITTERS: BCBSM</b> – When billing Blue Cross (BL) claims, if the type of bill equals 811 or 814, a <b>discharge hour is required.</b>   | Discharge Hour                |
| 2300   | DTP03<br>Qualifier 434 | <b>All Payers</b> – From and Thru Dates reported cannot be greater than the date the file was created.<br><b>BCN, Medicare and MDCH</b> – Must be greater than or equal to the admission date. Statement from date must be prior to statement thru date.  | Statement From and Thru Dates |
| 2300   | DTP03<br>Qualifier 435 | <b>All Payers</b> – Date and hour reported cannot be later than the date the file was created or the statement from date. Hour must be in HHMM format. Required when the Type of Bill is 11X, 18X or 21X. Required on inpatient claims.<br><b>BCBSM</b> – For proper claims adjudication, required on outpatient claims. If the admission date is not reported, the from date will be used in its place.  | Admission Date and Hour       |
| 2300   | CL101                  | <b>All Payers</b> – Required on inpatient claims.   | Admission Type Code           |

| Loop | Segment/Element       | Instruction   | Industry/Element Name                          |
|------|-----------------------|---|--|
| 2300 | CL102                 | <b>BCN and MDCH</b> – Must equal 1-9 if inpatient.<br><b>Medicare</b> – Must equal 1-9 or A-D if inpatient.   | Admission Source Code                          |
| 2300 | CL103                 | <b>BCBSM, BCN, FEP and Medicare</b> – Required on Inpatient claims<br><b>MDCH</b> – Required for inpatient and outpatient.<br><b>All Payers</b> – Must be 30 when billing interim claims bill type nn2 or nn3.  | Patient Status Code                            |
| 2300 | PWK01/PWK02,          | <b>BCBSM</b> – BCBSM prefers that claim attachments are available on request at provider site (PWK02 qualifier AA).<br><b>Medicare</b> – Any data submitted in the PWK segment may not be considered for processing.  | Paperwork                                      |
| 2300 | K301                  | <b>All Payers</b> – Present on Admission (POA) is required.<br><b>All Payers</b> – It is recommended that this data element be reported for all inpatient hospital claims: <ul style="list-style-type: none"> <li>• Position 1-3 – will contain the value, POA.</li> <li>• Position 4 – POA indicator of the principal diagnosis code.</li> <li>• Position 5 – begins the reporting of POA indicators for all other diagnosis codes (including e-codes), if applicable.</li> <li>• A value of Z or X must be reported to indicate the end of reporting of the POA indicators for the other diagnosis.</li> <li>• The position following the Z or X value represents the POA indicator for a submitted e-code if applicable or can be left blank.</li> </ul>   |  |
| 2300 | NTE01/NTE02           | <b>BCBSM, BCN and FEP</b> – The NTE segment should be used when, in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.<br><b>BCBSM</b> – For proper adjudication, report the following information when applicable to indicate the medical emergency or billing consideration. All medical emergency and billing consideration information are preceded by the letters RMK. Do not include embedded space or special character between RMK and the code.<br>RMKAN = Medical emergency, acute illness.<br>RMKAT = Documentation attached.<br>RMKCN = Medical emergency, chronic illness.<br>RMKEM = Medical emergency, referred.<br>RMKDC = Individual consideration.<br>RMKSC = Status to an original claim.<br>RMKSP = Medical emergency, severe pain.<br><b>MDCH</b> – Report ADD in NTE01 and provide free-text remarks, if needed in REF02. | Billing Notes                                  |
| 2300 | AMT01/AMT02           | <b>All Payers</b> – Credit/Debit card information may not be used to bill any insurance payer.  | Credit/Debit Card Maximum Amount               |
| 2300 | REF02<br>Qualifier F8 | <b>BCN</b> – Required when CLM05-3 is 7 or 8. It must follow the format beginning with ‘E’, ‘M’, ‘G’, ‘V’, ‘0’ (zero), followed by 11 digits.   | Claim Original Reference Number (ICN/DCN)      |
| 2300 | REF02<br>Qualifier G4 | <b>MDCH</b> – Report the 9 digit number assigned by the Admission and Certification Review contractor.  | Peer Review Organization (PRO) Approval Number |

| Loop | Segment/Element                       | Instruction   | Industry/Element Name                                   |
|------|---------------------------------------|---|---|
| 2300 | REF02<br>Qualifier G1                 | <b>BCBSM and BCN</b> – Use qualifier G1 in REF01. Valid code values for REF02 are:<br>CAP – Psychiatric Managed Care Substance Abuse<br>MOT – TRUST University of Michigan Children’s Center<br>REH – TRUST and PHA Medical Rehabilitation Exempt Units<br>EPC – PHA Exempt Psychiatric Care Units<br>ASF – Ambulatory Surgical Facility (hospital based only)<br>AMB – Ambulance Service<br>ERD – End Stage Renal Dialysis Services (Hospital based only)<br>OPT – Outpatient Physical Therapy<br>OPT – Referring Physician PIN Number – PPO Referrals<br>OPT – Psychiatric Authorization Number<br>OPT – Psychiatric Managed Care Substance Abuse (Outpatient)<br><b>MDCH</b> – Report the 9 digit prior authorization number assigned by MDCH. Use qualifier G1. | Prior Authorization Number                              |
| 2300 | REF01<br>Qualifier EA                 | <b>FEP</b> – Required on supplemental claims.   | Medical Record ID Number                                |
| 2300 | HI Segment<br>Diagnosis Code          | <b>All Payers</b> – Diagnosis must be reported to the highest level of specificity.   | Diagnosis Code  |
| 2300 | HI02-2<br>Qualifier BJ                | <b>All Payers</b> – Diagnosis must be reported to the highest level of specificity. Required on inpatient claims.<br><b>Medicare</b> – When reporting revenue codes 450-459, 516 or 526 on outpatient claims, report HI02-1 qualifier ZZ to indicate patient reason for visit.  | Admitting Diagnosis Code                                |
| 2300 | HI03-2<br>Qualifier BK, BN and<br>BF  | <b>BCBSM, BCN and FEP</b> – One principal diagnosis, one admitting and up to eight additional diagnosis codes will be referenced per claim. Additional diagnosis codes will not be referenced.<br><b>BCN, Medicare and MDCH</b> – Cannot be the same as the principal diagnosis code.<br><b>Commercial</b> – Diagnosis must be coded to the highest level of specificity. Duplicate diagnosis codes are not allowed.  | Additional Diagnosis Codes                              |
| 2300 | HI03-2<br>Qualifier BP, BR and<br>BO  | <b>BCBSM, BCN and FEP</b> – One principal and five additional procedure codes can be reported per claim. Additional procedure codes will not be referenced by adjudication.<br><b>BCBSM</b> – If secondary diagnosis code indicates cancelled surgery, then procedure code is not required.<br><b>BCN</b> – Required on inpatient claims when reporting revenue codes 036n, 0490, 0499 or 0723. If secondary diagnosis code indicates cancelled surgery, then procedure code is not required.<br><b>MDCH</b> – Required on inpatient claims when reporting revenue code 036n.<br><b>BCN and MDCH</b> – Must report a valid principal procedure date.  | Principal Procedure Code,<br>Additional Procedure Codes |
| 2300 | HI01-2 through HI12-4<br>Qualifier BI | <b>BCBSM, BCN and FEP</b> – Only codes reported in HI01-2 and HI02-2 will be referenced. Additional occurrence span codes will not be referenced by adjudication.   | Occurrence Span Code                                    |
| 2300 | HI01-4 through HI12-4<br>Qualifier BI | Dates reported must be less than or equal to file submission date.<br><b>BCBSM, BCN and FEP</b> – Only dates reported in HI01-4 and HI02-4 will be referenced. All other occurrence span dates will not be referenced by adjudication.<br><b>BCN</b> – Required if corresponding occurrence span code is reported.  | Occurrence Span From and Thru<br>Dates                  |
| 2300 | HI01-2 through HI12-2<br>Qualifier BH | <b>BCBSM, BCN and FEP</b> – Only codes reported in HI01-2 through HI10-2 will be referenced by adjudication. Additional occurrence codes reported will not be used by adjudication. Required if occurrence date is reported in corresponding occurrence associated date. If present, must be a valid code.  | Occurrence Code   |

| Loop | Segment/Element                       | Instruction  | Industry/Element Name        |
|------|---------------------------------------|--|------------------------------|
| 2300 | REF01, Qualifier 9F                   | <b>BCBSM</b> – To report services referred by a PPO physician, report the referring providers NPI preceded by the letters PPO. This should appear as PPOxxxxxxxxx where the NPI is equal to xxxxxxxxxxx.   | Referral Number              |
| 2300 | HI01-4 through HI10-4<br>Qualifier BH | <b>BCBSM, BCN and FEP</b> – Required if corresponding occurrence code is reported. Only dates in HI01-4 through HI10-4 will be referenced by adjudication. All other occurrence-associated dates will not be referenced. Dates reported must be less than or equal to the file submission date.<br><b>BCBSM</b> – Occurrence code 35 is required to be reported on physical therapy claims.  | Occurrence Code Dates        |
| 2300 | HI01-2 through HI12-2<br>Qualifier BE | Must be a valid code.<br><b>BCBSM, BCN, FEP and MDCH</b> – If corresponding value associated amount is present, value code is required.<br><b>BCBSM</b> – Value code 01 or 02 is required on inpatient claims. Value codes 01 and 02 are not allowed on the same claim. Value code A3, B3 or C3 is required. The related value code associated amount cannot be greater than claim total charges.<br><b>MDCH</b> – When claim is MDCH primary or MDCH secondary to a Medicare primary claim and lifetime reserve days (Loop 2300, QTY01, Qualifier LA) are reported, value code 08 and/or 10 is required.<br><b>Note:</b> The following value codes are valid for paper claims only: 80, 81, 82 and 83. Use quantity segment | Value Codes                  |
| 2300 | HI01-5 through HI12-5<br>Qualifier BE | <b>BCBSM, BCN and FEP</b> – Required if corresponding value code is reported in HI01-2 through HI12-2.<br><b>BCBSM</b> – When the type of bill is XX8, the value amount for A3, B3 or C3 must be zero.<br><b>MDCH</b> – Must be greater than zero if the corresponding value code reported is not 02.  | Value Code Associated Amount |
| 2300 | HI01-2 through HI12-2<br>Qualifier BG | If present, must be a valid code.<br><b>BCBSM, BCN and FEP</b> – 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.   | Condition Code               |

| Loop  | Segment/Element       | Instruction   | Industry/Element Name          |
|-------|-----------------------|---|--------------------------------|
| 2300  | QTY01<br>Qualifier CA | <p><b>BCBSM:</b></p> <ul style="list-style-type: none"> <li>QTY segment is used to report quantities that apply to the entire (applicable) claim.</li> <li>Physical therapy, Occupational therapy or Speech therapy, report the actual number of days you treated the patient during a billing period. Count all therapies performed on the same day as one visit. Do not count an evaluation as a visit.</li> <li>Psych day (partial hospitalization revenue code 0912) covered days report one half of the number of covered psychiatric day care days, rounded up to a whole number, non covered days report the other half of the number of psychiatric day care days, rounded down to a whole number. Service units report the total number of psychiatric day- care days must equal the total of covered and non covered days.</li> </ul> <p><b>BCBSM, BCN and FEP</b> – Report accommodation days covered by the primary payer (inpatient and skilled nursing facility). If Patient Status (CL103) is 30, both the from and thru dates are counted as covered or noncovered days. If CL103 is 01-07 or 20, the thru date is not counted as a covered or noncovered day.</p> <ul style="list-style-type: none"> <li>When the type of bill (CLM05-1 and CLM05-3) is 115 or 855, covered days must be zero. Must be greater than zero if type of bill is 111, 112, 114, 117, 118, 851, 852, 854, 857 or 858.</li> </ul> <p><b>BCBSM/BCN</b> – When the type of bill (CLM05-1 and CLM05-3) is 110-112, 114 or 117-118, covered days must be greater than zero. Covered plus non-covered days must be equal to the accommodations days for accommodations revenue codes 110-169, 171-219, 901 and 912 (912 applies to BCBSM only).</p> <p><b>FEP</b> – The sum of covered plus noncovered days must be equal to the total accommodations days. When the type of bill (CLM05-1 and CLM05-3) is 110-114, covered days must be greater than zero.</p> <p><b>Medicare</b> – Covered days should not exceed 150. Covered days cannot exceed the sum of coinsurance and life reserve days. When covered days are reported, covered charges must be present. When covered days are greater than 60, coinsurance or LTR days must be greater than zero. Covered days are not valid for outpatient claims or the following type of bills: 12n, 22n, 115, 185 or 215. Covered plus noncovered days and total accommodations days must be equal.</p> <p><b>MDCH</b> – Required on inpatient when supplemental to Medicare.</p> <p><b>Medicare Advantage</b> – If QTY is present then at least one occurrence of CA is required</p> | Covered Days                   |
| 2300  | QTY01<br>Qualifier CD | <p><b>BCBSM</b> – Must be greater than zero when the bill type is 11X and value code 9 or 11 is present.</p> <p><b>Medicare</b> – 61<sup>st</sup> through 90<sup>th</sup> day of a benefit period for inpatient, and the 21<sup>st</sup> through the 100<sup>th</sup> day for SNF. For acute care inpatient, must not exceed 30 days or the number of covered days. For SNF inpatient claims, must not exceed 80 days or the number of covered days. For outpatient or if coinsurance days are not being used, must be zero. Required if value codes 9 or 11 are reported.</p> <p><b>MDCH</b> – Required on inpatient when supplemental to Medicare.</p>  | Coinsurance Days               |
| 2300  | QTY01<br>Qualifier LA | <p><b>Medicare</b> – Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.</p> <p><b>BCBSM</b> – Must be greater than zero when the bill type is 11X and value code 8 or 10 is present.</p> <p><b>MDCH</b> – If quantity is greater than zero, value codes 8 or 10 and value amounts are required.</p>   | Lifetime Reserve Days          |
| 2305  | CR701                 | <b>BCBSM</b> – For proper adjudication, submit Home Health and Hospice on the Institutional 837 rather than Professional 837.   | Discipline Type Code           |
| 2310A | NM103                 | <b>MDCH</b> – Required on all claims.   | Attending Physician Last Name  |
| 2310A | NM104                 | <b>Medicare, Medicare Advantage and MDCH</b> – Required on all claims.  | Attending Physician First Name |

| Loop  | Segment/Element                                | Instruction  | Industry/Element Name                    |
|-------|--|--|--|
| 2310A | NM108/NM109                                    | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications.<br><b>All Payers</b> – Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI.   | Attending Physician ID                   |
| 2310A | REF01  | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Attending Physician Secondary Identifier |
| 2310B | NM103/NM104                                    | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications.<br><b>Medicare</b> – Required if Operating Physician Secondary ID is reported.  | Operating Physician First and Last Name  |
| 2310B | NM108/NM109                                    | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications.<br><b>All Payers</b> – Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI .  | Operating Physician ID                   |
| 2310B | REF01  | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.<br><b>Medicare</b> – Required if procedure code is reported and type of bill is 111. Required if HCPCS code is within a range of (10000-36414 and 36416-69999) and type of bill is 13X or 831. | Operating Physician Secondary Identifier |
| 2310C | NM108/NM109                                    | <b>All Payers</b> – If present and 24 or 34 is reported then 9 digit characters must be present.<br>If NM108 qualifier=XX then NM109 must contain the 10 digit numeric NPI.<br>If reporting NPI see REF segment of this loop for further instruction.  | Other Provider ID                        |
| 2310C | REF01  | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Other Provider Secondary ID              |
| 2310E | NM108/NM109                                    | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications.<br><b>All Payers</b> – If present and 24 or 34 is reported then 9 numeric characters must be present.<br>If NM108 qualifier=XX then NM109 must contain the 10 digit NPI.  | Service Facility ID                      |
| 2310E | PRV  | <b>BCBSM and FEP</b> – Required when the Service Facility Provider is a different entity than the Billing Provider and the taxonomy code is needed to identify the provider. This PRV segment applies to the entire claim.   | Service Facility Specialty Information   |
| 2310E | REF01/REF02                                    | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Service Facility Secondary ID            |
| 2320  | SBR Segment<br>Other Subscriber<br>Information | <b>All Payers</b> – Required if other payers could potentially be involved in payment of this claim.<br>SBR01 is used to identify the payment responsibility of the other payer.   | Other Subscriber Information<br>Segment  |
| 2320  | SBR03  | <b>BCN</b> – Required, if applicable.<br><b>MDCH</b> – Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber.  | Other Subscriber Group Number            |
| 2320  | CAS Segment                                    | <b>All Payers</b> – Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.  |  |
| 2320  | OI06   | <b>FEP</b> – For proper adjudication, use code Y.  | Release of Information Code              |
| 2330A | NM103/NM105                                    | <b>BCBSM, BCN and FEP</b> – For proper adjudication, do not report numbers or special characters.<br><b>MDCH</b> – Enter the name of the subscriber as it appears on the files of the other payer.   | Other Insured Name                       |

| Loop  | Segment/Element       | Instruction  | Industry/Element Name          |
|-------|-----------------------|--|--------------------------------|
| 2330A | NM109<br>Qualifier MI | <b>All Payers</b> – Use the unique number assigned to the subscriber by the other payer indicated in loop 2330B.   | Other Insured Primary ID       |
| 2330B | NM103                 | <b>All Payers</b> – If other payer information is known, report Other Payer Names as follows:<br><b>BCBSM</b> – Enter BCBSM<br><b>BCN</b> – Enter BCN<br><b>FEP</b> – Enter BCBSM-FEP<br><b>Medicare</b> – Enter MEDICARE<br><b>MDCH</b> – Enter MEDICAID<br><b>Other Payer</b> – Report the Insurance Name  | Other Payer Name               |
| 2330B | NM109                 | <b>MDCH</b> – Use qualifier PI and enter the eight-digit carrier code assigned by MDCH. See the MDCH web site for a listing of carrier codes.  | Other Payer Primary Identifier |
| 2400  | LX01                  | <b>BCBSM, BCN and FEP</b> – For optimal adjudication of your claims, report no more than 99 service lines per claim.<br><b>Medicare</b> – Report 450 or less service lines on each institutional claim.<br><b>MDCH</b> – Report 50 or less service lines on each institutional claim. Claims submitted with more than 50 service lines may be subject to processing delays.  | Service Line Counter           |
| 2400  | SV201                 | <b>BCBSM</b> – For Acute Hospitals and ASF's, if billing TOB 13X and 83X and reporting one or more of the following revenue codes: 260- 264, 331, 332, 335, 339, 450, 456, 480-483, 489, 510, 515-517, 519, 636, 730, 731, 739, 740, 749, 762, 920-922 and 929 then a HCPCS code is required.<br><b>BCBSM, BCN FEP</b> – If revenue code 0260, 0262, 0331, 0332, 0335 or 0636 is reported, the following segments are required: SV205 and SV206.   | Service Line Revenue Code      |
| 2400  | SV202-1/SV202-2       | Required for outpatient claims when an appropriate HCPCS exists for the service line item.<br><b>BCBSM and FEP</b> – Continue to report J procedure codes for injections and chemotherapy drugs.<br><b>BCN</b> – Report modifier 50 and units in SV205 for lab, radiology or surgical procedures.  | Product/Service ID Qualifier   |
| 2400  | SV203                 | <b>BCBSM</b> – Type of bill 74X. For service dates 3/1/08 and greater, when billing physical therapy, occupational therapy or speech therapy, report the actual number of visits for revenue codes 420, 430 or 440 as applicable.<br><b>BCN, FEP and Medicare</b> – 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).<br><b>BCN, Medicare and MDCH</b> – If SV201 equals 0100 through 0999, must be greater than zero. Sum of all service level charges must equal claim total charges (loop 2300/CLM02).<br><b>Medicare and Medicare Advantage</b> – A zero must be reported for revenue codes 0022 and 0024.<br><b>MDCH</b> – Zero charge amounts are not accepted. | Service Line Charge Amount     |
| 2400  | SV205                 | <b>BCN</b> – If loop 2300/QTY01 equals CA or NA, QTY02 must equal the sum of all loop 2400/SV205 if SV201 equals 0100-0169 or 0171-0219. Must be greater than zero if HCPCS code (SV202) is present. Report modifier 50 in SV202 and units in SV205 for lab, radiology or surgical procedures.<br><b>BCBSM</b> – If loop 2300/QTY02 equals CA or NA, QTY02 must equal the sum of all loop 2400/SV205 if SV201 equals 0100-0169, 0171-0219 or 0901, 0912 and 1000-1005.<br><b>BCN, Medicare and MDCH</b> – If SV201 equals 0100 through 0219, must be greater than zero.  | Service Line Units             |

| Loop  | Segment/Element | Instruction  | Industry/Element Name                  |
|-------|-----------------|--|--|
| 2400  | SV206           | <b>All Payers</b> – Required when associated revenue code is 0100-0219.<br><b>BCBSM and BCN</b> – If multiple room rates fall within the same accommodation code billed on a claim, indicate the highest rate in this element.<br><b>MDCH</b> – Must be present. Zero is an acceptable rate. | Service Line Rate                      |
| 2400  | SV207           | <b>BCN, Medicare and MDCH</b> – Must not be greater than SV203.  | Service Line Non-covered Charge Amount |
| 2400  | PWK             | <b>BCBSM</b> – BCBSM prefers that claim attachments are available on request at provider site (PWK02 qualifier AA).<br><b>Medicare</b> – Any data submitted in the PWK segment may not be considered for processing.   | Paperwork                              |
| 2410  | LIN Segment     | <b>MDCH</b> – Will only recognize the first repeat of this segment. All additional repeats will be ignored.  | Drug Identification Segment            |
| 2420A | NM108/NM109     | If NM108 qualifier=XX then NM109 must contain the 10 digit numeric NPI.  | Attending Physician                    |
| 2420A | REF01           | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Attending Physician Secondary ID       |
| 2420B | NM108/NM109     | If NM108 qualifier=XX then NM109 must contain the 10 digit NPI.  | Operating Physician                    |
| 2420B | REF01           | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Operating Physician Secondary ID       |
| 2420C | NM108/NM109     | If NM108 qualifier=XX then NM109 must contain the 10 digit NPI.  | Other Physician                        |
| 2420C | REF01           | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Other Physician Secondary ID           |
| 2420D | NM108/NM109     | If NM108 qualifier=XX then NM109 must contain the 10 digit NPI.  | Referring Provider Name                |
| 2420D | REF01           | <b>All Payers – NPI requirements</b> – Refer to the section titled ‘ <b>National Provider Identifier (NPI)</b> ’ on page 6 for NPI specifications. Report qualifier EI or SY.  | Referring Provider ID                  |
| 2430  | All             | <b>MDCH</b> – MDCH expects this loop for each prior payer identified in loop 2320, except when that payer has adjudicated the claim at the claim level.  | Service Line Adjudication Information  |
| 2430  | CAS Segment     | <b>All payers – Required when the prior payment had service line adjustments reported on a remittance.</b>   |  |
| 2430  | CAS02           | <b>Medicare Advantage, MDCH</b> – A Claim Adjustment Reason Code is required for each payer identified in loop 2320, except when that payer has adjudicated the claim at the claim level.  | Claim Adjustment Reason Code           |

## **General EDI Terminology**

**Addenda** – Refers to a version of the HIPAA mandated transaction sets which correct identified implementation issues noted in the original implementation guides.

**ANSI X12N 835 v4010** – HIPAA standardized ANSI X12N transaction format for claims remittance data.

**ANSI X12N 837 v4010** – HIPAA standardized ANSI X12N transaction format for claims submission data.

**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. Each data element is 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:

|    |  |
|----|--|
| Nn | Numeric (with an assumed number of decimal positions)    |
| R  | Decimal Real Number (including decimal or negative sign) |
| ID | Identifier   |
| AN | Alphanumeric string                                      |
| DT | Date   |
| TM | Time   |

**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.

**CMS** – Centers for Medicare and Medicaid Services.

**Implementation Guides** – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: [www.wpc-edi.com](http://www.wpc-edi.com).

**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.

**Routing** – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

**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.

**Translation Software** – Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

**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. For example, one 837-transaction set is equivalent to one claim file.

**X12N** – An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). 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.

**BlueExchange** – A Blue Cross Blue Shield Association process through which non-claim HIPAA transactions for members from all other Blue Cross and/or Blue Shield plans can be accepted by a local host plan and routed to the home plan for processing. It also allows for receipt of 835 transactions for crossover remittances from other Blue Cross Blue Shield plans.