Blue Cross Blue Shield of Michigan

HIPAA Transaction Standard Companion Guide – Batch Transactions

Refers to the Implementation Guides Based on ASC X12 version 005010 for:

- 837 Professional Health Care Claim (005010X222A1)
- 837 Institutional Health Care Claim (005010X223A2)
- 837 Dental Health Care Claim (005010X224A2)
- 835 Health Care Claim Payment/Advice (005010X221A1)

January 2025

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. All instructions were written as known at the time of publication and are subject to change.

Blue Cross Blue Shield of Michigan maintains **bcbsm.com.** Blue Cross does not control any other websites referenced in this publication or endorse their general content.

IMPORTANT

Beginning August 1, 2023, all batch electronic data exchange services will transition to BCBSM's clearinghouse partner, Availity®[1]. This information applies to claims and remittance for the following BCBSM and Blue Care Network health plans:

- Blue Cross commercial, including the Federal Employee Program®
- Medicare Plus Blue, the Blue Cross Medicare Advantage PPO plan
- Blue Care Network commercial
- BCN Advantage, the BCN Medicare Advantage HMO and POS plans
- Blue Cross Complete, the Blue Cross Medicaid plan

BCBSM will no longer accept professional or institutional claims for:

- Other commercial carriers
- Medicare (non-Blue)
- Medicaid (non-Blue)

To learn more on getting ready with Availity, go to www.availity.com/bcbsm-edi.

[1] *Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.*

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 Technical Reports Type 3 (TR3), also referred to as the ASC X12N Implementation Guides, have been established as the standard for electronic health care transactions and are available for purchase at https://x12.org/products/licensing-program[2].

[2] *BCBSM does not control this website or endorse its general content.*

EDITOR'S NOTE:
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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 Blue Cross Blue Shield of Michigan 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 Blue Cross Blue Shield of Michigan

The following table example specifies the columns used by BCBSM for the detailed description:

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:
193	*2300*	*REF02*	*Referral Number*	*Qualifier 9F*	***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.***

SCOPE/OVERVIEW

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Blue Cross Blue Shield of Michigan and Blue Care Network. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

REFERENCES

To purchase any or all of the HIPAA mandated 005010 ASC X12N TR3s, visit X12's website: https://x12.org/products/licensing-program**.**

ADDITIONAL INFORMATION

GENERAL EDI TERMINOLOGY

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

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.

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

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

ASC X12N/005010X221– The HIPAA mandated (ANSI) ASC X12N Health Care Claim Payment/Advice transaction format.

ASC X12N/005010X221A1 – The Type 1 Errata modifications mandated for use with the ASC X12N/005010X221 835 Health Care Claim Payment/Advice transaction format.

ASC X12N/005010X224 – The HIPAA mandated (ANSI) ASC X12N Dental Health Care Claim transaction format.

ASC X12N/005010X224A2 – The Type 2 Errata modifications mandated for use with the ASC X12N/005010X224 837 Dental 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 plan.

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

BlueCard - a BCBSA program which supports processing of out-of-area claims. The program enables members to obtain healthcare services while traveling or living in another Plan's service area and take advantage of local provider networks and savings. BlueCard claims are submitted to the local Blue Plan in the state where services were performed.

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) – X12 copyrighted Implementation Guide documents that standardize data structure requirements and content for a specific electronic business exchange. Information regarding the purchase of these Implementation Guides is available at https://x12.org/products/licensing-program**.**

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 business task group within the X12N subcommittee responsible for the development of business requirements defined in the health care insurance TR3s/Implementation Guides.

GETTING STARTED

WORKING WITH BLUE CROSS BLUE SHIELD OF MICHIGAN

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

FOR PROVIDERS:

- Providers must be registered with BCBSM's Provider Enrollment and Data Management department.
    - To register, call Blue Cross Provider Enrollment and Data Management at 1-800-822-2761.
- All providers who submit transactions through Availity must have a registered Availity account.
    - If you're new to Availity, go to availity.com** and click Register.
- If applicable, work with your vendor to ensure software is configured to send and receive transactions via Availity using FTP.
    - Reference *Availity's EDI Companion Guide*[3] for FTP specifications.
- If applicable, work with your vendor to ensure that batch files generated by the software include proper Availity Sender and Receiver information.
- Contact your billing service, clearinghouse or service bureau to confirm if they currently receive your ERA (835) files.

FOR BILLING SERVICES, SOFTWARE VENDORS OR CLEARINGHOUSES:

- Register directly with Availity.
- Advise your providers if they need to complete enrollment with Availity to set up the electronic remittance advice, ERA (835), routing.
- Review Availity's EDI Companion Guide and EDI Connectivity Guide. Contact Availity with questions.

[3] *While Blue Cross Blue Shield of Michigan and Blue Care Network recommend this website and we're responsible for its Blue Cross and BCN-specific content, we don't own or control this website.*

TRADING PARTNER REGISTRATION

- BCBSM and BCN do not require completion of a BCBSM Trading Partner Agreement or Provider Authorization for batch transactions.
- To exchange electronic batch transactions with BCBSM and BCN, trading partners must be registered with Availity. If you're new to Availity, go to availity.com** and click Register.

CERTIFICATION AND TESTING OVERVIEW

BCBSM and BCN do not require certification or testing for batch transactions. Contact Availity if you'd like to conduct testing or have questions.

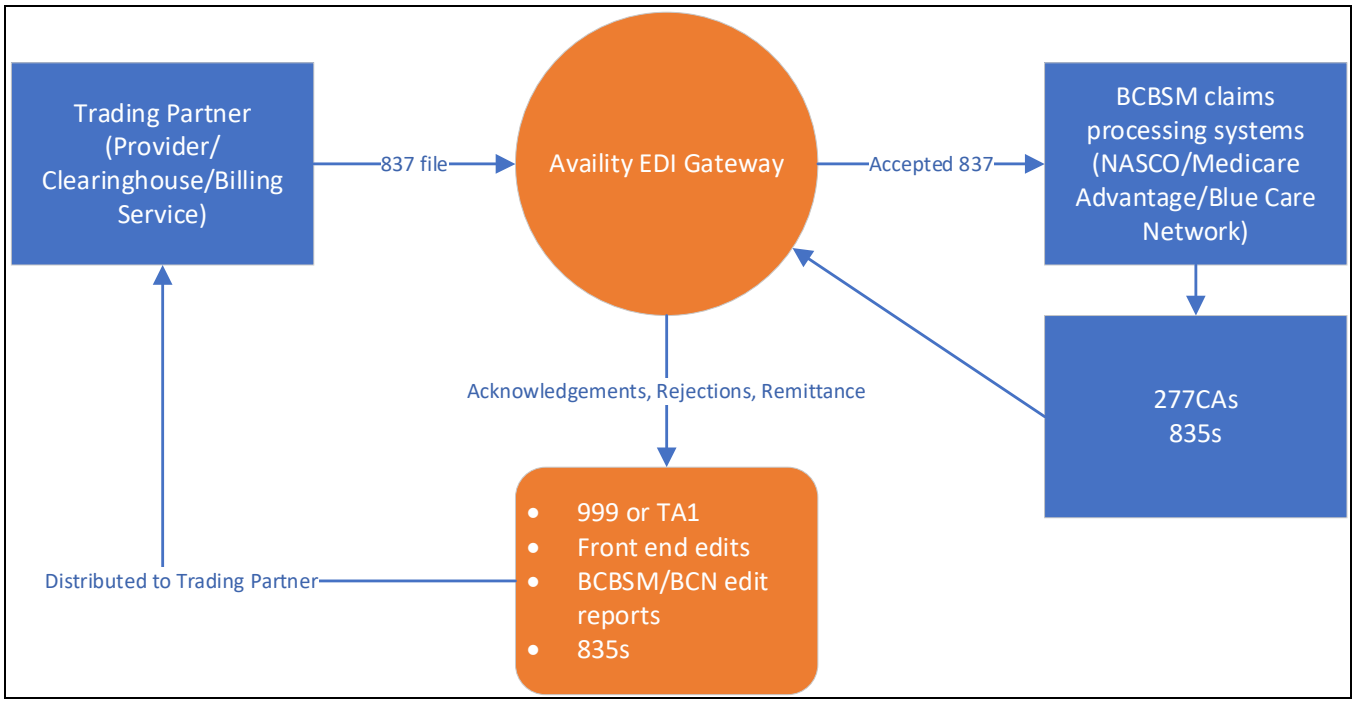
CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

For information regarding transmission administrative procedures, re-transmission procedures, communication protocols/specification and passwords:

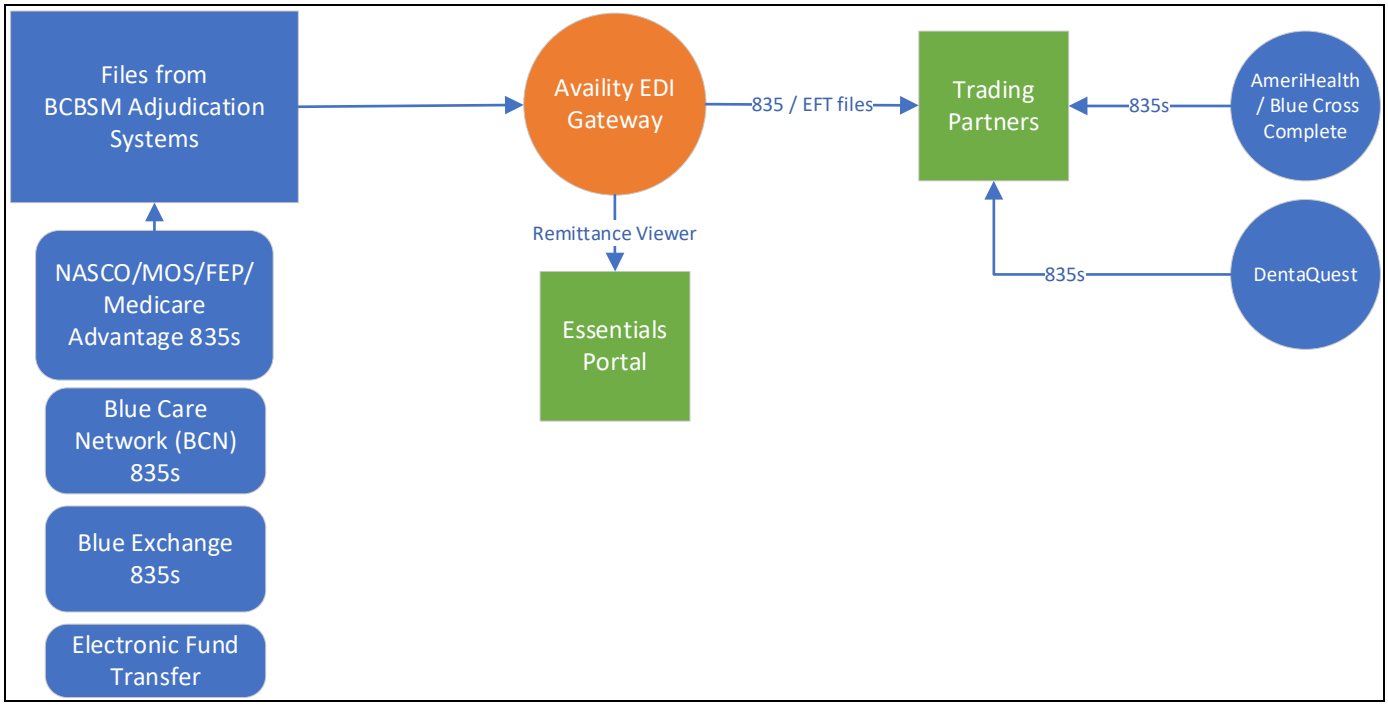
- Review Availity's EDI Connection Guide.
- Contact Availity: Visit Availity.com or contact Availity Client Services at 1-800-AVAILITY (282-4548).

PROCESS FLOWS

837 CLAIMS:



835 REMITTANCE:



CONTACT INFORMATION

EDI CUSTOMER SERVICE

- Contact Availity: Visit Availity.com or contact Availity Client Services at 1-800-AVAILITY (282-4548).

EDI TECHNICAL ASSISTANCE

- Contact Availity: Visit Availity.com or contact Availity Client Services at 1-800-AVAILITY (282-4548).

PROVIDER SERVICE NUMBERS

- BCBSM Provider Enrollment and Data Management department
  - 1-800-822-2761
- BCBSM Provider Inquiry department and Provider Consultants
  - Visit For Providers: Contact us | BCBSM
- Visit Availity.com or contact Availity Client Services at 1-800-AVAILITY (282-4548)

APPLICABLE WEBSITES

- For Providers: EDI paperless | BCBSM
- Availity.com

FEDERAL EMPLOYEE PROGRAM INFORMATION

- Patient benefits, eligibility and claims: Call 1-800-840-4505

CONTROL SEGMENTS/ENVELOPES ISA -IEA

Loop	Field	Field Description	837 Professional	837 Institutional	837 Dental*
Header	ISA05	Sender ID Qualifier	ZZ	ZZ	ZZ
Header	ISA06	Sender ID	AV09311993<+5 spaces>	AV09311993<+5 spaces>	AV09311993<+5 spaces>
Header	ISA07	Receiver ID Qualifier	01	01	01
Header	ISA08	Receiver	030240928<+6 spaces>	030240928<+6 spaces>	030240928<+6 spaces>
Header	GS02	Application Sender Code	AV01101957 or assigned vendor ID	AV01101957 or assigned vendor ID	AV01101957 or assigned vendor ID
Header	GS03	Application Receiver Code	030240928	030240928	030240928
2010BB	NM109	Payer ID	00710	00210	382069753

* BCBSM only accepts ANSI ASC X12N 837 dental transactions for the Federal Employee Program (FEP).

For additional information, review Availity's Batch Electronic Data Interchange (EDI) Standard Companion Guide (availity.com)

PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Refer to each transaction specific section of this guide for rules and limitations.

ACKNOWLEDGEMENTS AND/OR REPORTS

For additional information, review Availity's Batch Electronic Data Interchange (EDI) Standard Companion Guide (availity.com)

- 999 Acknowledgement: Availity notifies you when it receives the transmission file and notes whether it had X12 or HIPAA syntax errors.
- Edit reports: Availity proprietary reports have replaced BCBSM EDI 277CA edit reports.

TRADING PARTNER AGREEMENTS

TRADING PARTNERS

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

BCBSM does not require Trading Partner Agreements or Provider Authorizations.

All BCBSM Trading Partners must be registered with Availity.

TRANSACTION SPECIFIC INFORMATION – 837 PROFESSIONAL CLAIMS

PAYER SPECIFIC RULES AND LIMITATIONS: 837P CLAIMS

MEDICARE ADVANTAGE / MEDICARE PLUS BLUE CLAIMS:

- Follow Medicare billing instructions
- Loop 2000B SBR09: Report Claim Filing Indicator *MB*
- 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 plan.
  - 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'

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~

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

PROFESSIONAL MAXIMUMS/LIMITATIONS

- Report up to 100 claims per subscriber/patient combination.
- Submit a maximum of 5,000 claims per transaction set.
- Do not report leading or trailing zeros for Monetary Amounts.

PROFESSIONAL ELECTRONIC CLAIM EXCEPTIONS

- FEP and BCN claims requiring hardcopy documentation.
-

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.

ASC X12N/005010X222A1 – 837P TRANSACTION DATA CLARIFICATIONS FOR THE PROFESSIONAL 837 (005010X222A1) TRANSACTION SET

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837P
75	1000A	NM109	Submitter Identifier		Report the Customer ID assigned by Availity.
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 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, email the EDI Helpdesk at edisupport@bcbsm.com

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837P
103	2010AB	N3, N4 All	Pay-To Address Pay-To Address City, State, Zip Code		**BCBSM, Medicare Advantage / Medicare Plus Blue** (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.
118	2000B	SBR09	Claim Filing Indicator Code	Qualifier BL, HM, MB, FI	Claim Filing Indicator Codes are used 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: **BL** Blue Cross Blue Shield of MI (including Blue Card and Blue Card Medicare Advantage claims) **HM** Blue Care Network, Blue Cross Complete and BCN Advantage **MB** Medicare Advantage / Medicare Plus Blue (including DME). **FI** Federal Employee Program (FEP) **Note:** **BCN** Report BL for routine vision services. Medical vision and all other services for BCN members should be billed under HM (BCN).
122	2010BA	NM103	Subscriber Last Name		**All Payers**: Name must start with an alpha character (A..Z). Names cannot contain: • Special characters, other than a hyphen or space • Consecutive spaces • Consecutive hyphens • Numbers
122	2010BA	NM104	Subscriber First Name		**All Payers:** Name must start with an alpha character (A..Z). Names cannot contain: • Special characters, other than a hyphen or space • Consecutive spaces • Consecutive hyphens • Numbers
123	2010BA	NM109	Subscriber Primary Identifier	Qualifier MI	**All BCBSM (including Blue Card and** Blue Card Medicare Advantage**), BCN, BCN Advantage and Medicare Advantage / Medicare Plus Blue** –Report the subscriber's identification number, including the prefix, without embedded spaces or special characters. **Blue Cross Complete** – • For members with an enrollee ID beginning with XYU, report the entire contract number including the prefix • For members with a 10-digit Medicaid recipient ID, report the full 10 digits without spaces or special characters **FEP** – Report R followed by eight digits.

<table>
<tr><th>TR3 Pg#</th><th>Loop ID</th><th>Reference</th><th>Industry/Element Name</th><th>Codes</th><th>Notes/Comments/Instructions – 837P</th></tr>
<tr><td>134</td><td>2010BB</td><td>NM109</td><td>Payer Identifier</td><td>Qualifier PI</td><td>The Payer Identifier must correspond to the Claim Filing Indicator reported in SBR09 of loop 2000B.
<table>
<tr><th>Payer</th><th>If 2000B SBR09 Equals:</th><th>Report Payer ID:</th></tr>
<tr><td>BCBSM (including Blue Card and Blue Card Medicare Advantage</td><td>BL</td><td>00710</td></tr>
<tr><td>FEP</td><td>FI</td><td>00710</td></tr>
<tr><td>Medicare Advantage/ Medicare Plus Blue, including DME</td><td>MB</td><td>00710</td></tr>
<tr><td>BCN/Blue Cross Complete/BCN Advantage</td><td>HM</td><td>00710</td></tr>
</table></td></tr>
<tr><td>136</td><td>2010CA</td><td>NM103</td><td>Patient Last Name</td><td></td><td>All Payers: Name must start with an alpha character (A..Z). Names cannot contain:
Special characters, other than a hyphen or space
Consecutive spaces
Consecutive hyphens
Numbers</td></tr>
<tr><td>136</td><td>2010CA</td><td>NM104</td><td>Patient First Name</td><td></td><td>All Payers: Name must start with an alpha character (A..Z). Names cannot contain:
Special characters, other than a hyphen or space
Consecutive spaces
Consecutive hyphens
Numbers</td></tr>
<tr><td>196</td><td>2300</td><td>REF02</td><td>Original Reference Number/Payer Claim Control Number (ICN/DCN)</td><td>Qualifier F8</td><td>BCBSM and FEP When required, report the 14- or 17-digit Internal Control Number of the original claim.
Medicare Advantage / Medicare Plus Blue (including DME) – Report an original claim DCN when loop 2300/CLM05-3 is 7 or 8.
BCN and BCN Advantage – 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.
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.</td></tr>
<tr><td>182</td><td>2300</td><td>PWK02</td><td>Report Transmission Code</td><td>Qualifier BM, FX</td><td>BCBSM and Medicare Advantage/ Medicare Plus Blue: Report qualifier BM – By Mail or FX – By Fax only.</td></tr>
<tr><td>193</td><td>2300</td><td>REF02</td><td>Referral Number</td><td>Qualifier 9F</td><td>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.</td></tr>
</table>

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837P
226	2300	HI Segment Diagnosis Code	Health Care Diagnosis Codes		**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. **BCBSM, Medicare Advantage / Medicare Plus Blue** (including DME), **BCN, BCN Advantage 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.
258	2310A	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: • 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
259	2310A	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.
265	2310B	PRV segment	Rendering Provider Specialty Information		**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.

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837P
295	2320	SBR09	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 plan
362	2400	PWK02	Report Transmission Code	Qualifier BM, FX	**BCBSM and Medicare Advantage / Medicare Plus Blue:** Report qualifier BM – By Mail or FX – By Fax only.
353	2400	SV101-3	Procedure Modifier	Qualifier GY	Report Medicare statutorily excluded services following the requirements identified in the **Payer Specific Rules and Limitations** outlined above this section.
355	2400	SV103	Unit or Basis for Measurement Code	Qualifier MJ (Minutes) Qualifier UN (Units)	**All BCBSM (including Blue Card and Blue Card Medicare Advantage), BCN, BCN Advantage and Medicare Advantage / Medicare Plus Blue:** Qualifier MJ is required for time-based anesthesia procedure codes without a time period in the code description. Anesthesia procedure codes that are not time-based must use the qualifier UN, Units. Anesthesia procedure codes with specified time periods including, but not limited to “daily” or “15 minutes” must be reported using the qualifier UN.
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: •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.

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837P
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: • 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.

TRANSACTION SPECIFIC INFORMATION – 837 INSTITUTIONAL CLAIMS

PAYER SPECIFIC RULES AND LIMITATIONS: 837I CLAIMS

MEDICARE ADVANTAGE / MEDICARE PLUS BLUE CLAIMS:

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

BCN ADVANTAGE CLAIMS:

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

BLUE CARD MEDICARE ADVANTAGE CLAIMS:

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

BCBSM OR FEP SUPPLEMENTAL:

- When BCBSM or FEP is billed as the secondary payer and the primary payer is original Medicare or any type of Medicare Advantage plan.
  - The payer responsibility code in loop 2000B, SBR01 must equal 'S'
  - The claim filing indicator/source of payment in loop 2000B, SBR09 must equal "BL' or 'FI'
- Medicare is reported as the primary payer:
  - The payer responsibility code reported in loop 2320, SBR01 must equal 'P'
  - The claim filing indicator/source of payment in loop 2320, SBR09 must equal 'MA'

INSTITUTIONAL MAXIMUMS/LIMITATIONS

- Report a maximum of 99 services per claim for BCBSM.
- Report a maximum of 450 services per claim for Medicare Advantage/Medicare Plus Blue.
- Do not report leading or trailing zeros for Monetary Amounts

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
- Institutional claims must report payer ID 00210 in loop 2010BB NM109

INSTITUTIONAL ELECTRONIC CLAIM EXCEPTIONS
- For more information, refer to applicable Provider Manuals located in the Provider Resources section of the Availity portal.

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.

ASC X12N/005010X223A2 – 837 TRANSACTION DATA CLARIFICATIONS FOR THE INSTITUTIONAL 837 (005010X223A2) TRANSACTION SET

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837I
72	1000A	NM109	Submitter Identifier	Qualifier 46	Report the Customer ID assigned by Availity.
77	1000B	NM103	Receiver Name		Report BCBSM as the receiver name.
77	1000B	NM109	Receiver Primary Identifier		Report 00210 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer.
78	2000A	All	Billing Provider Hierarchical Level Loop		**BCBSM, BCN and FEP** – Any entity reported other than the billing provider will not be recognized. Payments will be directed to the provider indicated in corporate provider databases. If reported, the Pay-to provider will not be recognized/used.
80	2000A	PRV01	Billing Provider Specialty Information		**BCBSM and Medicare Crossover only -** Required when adjudication is known to be impacted by the provider taxonomy (type) code and a rendering provider will not be reported in loop 2310B NM109. Certain BCBSM provider types must report a taxonomy code at billing provider level, e.g. durable medical equipment suppliers and laboratories.
109	2000B	SBR01	Payer Responsibility Sequence Number Code	Qualifier P, S, T	**BCBSM and FEP** – Can be P, S or T.
110	2000B	SBR09	Claim Filing Indicator Code	Qualifier BL, HM, MA, FI	Claim Filing Indicator Codes determine the destination payer to whom the claim will be routed. The code must correspond to the destination payer ID reported in loop 2010BB. For proper claim routing and adjudication use only the following codes: **BL** Blue Cross (including Blue Card and Blue Card Medicare Advantage claims) **HM** Blue Care Network, Blue Cross Complete and BCN Advantage **MA** Medicare Advantage/Medicare Plus Blue **FI** Federal Employee Program (FEP)

<table>
<tr><th>TR3 Pg#</th><th>Loop ID</th><th>Reference</th><th>Industry/Element Name</th><th>Codes</th><th>Notes/Comments/Instructions – 837I</th></tr>
<tr><td>96</td><td>2010AB</td><td>N3, N4
All</td><td>Pay-To Address City, State, Zip Code</td><td></td><td>BCBSM, Medicare Advantage/Medicare Plus Blue, BCN and FEP – Payments will be directed to the provider address indicated in corporate provider database files. If reported, the Pay-to provider address will not be used to direct payment.</td></tr>
<tr><td>113</td><td>2010BA</td><td>NM103</td><td>Subscriber Last Name</td><td></td><td>All Payers: Name must start with an alpha character (A..Z). Names cannot contain:
Special characters, other than a hyphen or space
Consecutive spaces
Consecutive hyphens
Numbers</td></tr>
<tr><td>113</td><td>2010BA</td><td>NM104</td><td>Subscriber First Name</td><td></td><td>All Payers: Name must start with an alpha character (A..Z). Names cannot contain:
Special characters, other than a hyphen or space
Consecutive spaces
Consecutive hyphens
Numbers</td></tr>
<tr><td>114</td><td>2010BA</td><td>NM109</td><td>Subscriber Primary Identifier</td><td></td><td>All BCBSM (including Blue Card and Blue Card Medicare Advantage), BCN, BCN Advantage and Medicare Advantage/Medicare Plus Blue – NM109 is required. Report the subscriber’s identification number, including the prefix, without embedded spaces or special characters.
Blue Cross Complete –
For members with an enrollee ID beginning with XYU, report the entire contract number including the prefix
For members with a 10-digit Medicaid recipient ID, report the full 10 digits without spaces or special characters.
FEP – Must be R followed by eight digits.</td></tr>
<tr><td>123</td><td>2010BB</td><td>NM109</td><td>Payer Identifier</td><td></td><td>The Payer Identifier must correspond to the Claim Filing Indicator reported in SBR09 of loop 2000B.
<table>
<tr><th>Payer</th><th>If Claim Filing Indicator Equals:</th><th>Report Payer ID:</th></tr>
<tr><td>BCBSM (including Blue Card & Blue Card Medicare Advantage)</td><td>BL</td><td>00210</td></tr>
<tr><td>FEP</td><td>FI</td><td>00210</td></tr>
<tr><td>Medicare Advantage/ Medicare Plus Blue</td><td>MA</td><td>00210</td></tr>
<tr><td>BCN
Blue Cross Complete
BCN Advantage</td><td>HM</td><td>00210</td></tr>
</table></td></tr>
</table>

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837I
136	2010CA	NM103	Patient Last Name		**All Payers**: Name must start with an alpha character (A..Z). Names cannot contain: • Special characters, other than a hyphen or space • Consecutive spaces • Consecutive hyphens • Numbers
136	2010CA	NM104	Patient First Name		**All Payers**: Name must start with an alpha character (A..Z). Names cannot contain: • Special characters, other than a hyphen or space • Consecutive spaces • Consecutive hyphens • Numbers
145	2300	CLM05-1	Facility Type Code		BCBSM accepts all valid NUBC bill type codes. Please refer to the NUBC manual or visit www.nubc.org for a list of valid values.
145	2300	CLM05-3	Claim Frequency Code		BCBSM accepts all valid NUBC claim frequency type codes. Please refer to the NUBC manual or visit www.nubc.org for a list of valid values.
153	2300	CL103	Patient Status Code		**All Payers** – Must be 30 when billing interim claims bill type XX2 or XX3.
154	2300	PWK02	Report Transmission Code	Qualifier BM, FX	**BCBSM and Medicare Advantage/Medicare Plus Blue:** Report qualifier BM – By Mail or FX – By Fax only.
166	2300	REF02	Original Reference Number (ICN/DCN)	Qualifier F8	**BCBSM and FEP**: When required, report the 14- or 17-digit Internal Control Number of the original claim. **BCN, BCN Advantage**: Limit of 12 characters. When required, report 'E', 'M', or '0' (zero), followed by 11 numeric. **Blue Cross Complete**: Limit of 12 characters. When required, report 12 numeric.
284	2300	HI01-2 through HI12-2	Value Codes	Qualifier BE	**BCBSM** – For proper adjudication on all BCBSM and FEP claims, a value code for estimated responsibility is needed – report A3, B3 or C3 as applicable. Value code 01 or 02 is required on inpatient claims. Value codes 01 and 02 are not allowed on the same claim. Report all other value codes as applicable.
285	2300	HI01-5 through HI12-5	Value Code Amount	Qualifier BE	**BCBSM and FEP** – When the type of bill is XX8, the value amount for A3, B3 or C3 must be zero.
294	2300	HI01-2 through HI12-2	Condition Code	Qualifier BG	**BCBSM and FEP** – Only condition codes reported in HI01-2 through HI07-2 will be referenced by adjudication. Any additional conditions codes reported will not be used by adjudication.
354	2320	SBR09	Claim Filing Indicator Code		**BCBSM and FEP supplemental claims:** For proper claim adjudication, report MA when the primary payer is original Medicare or any type of Medicare Advantage plan
429	2400	PWK02	Report Transmission Code	Qualifier BM, FX	**BCBSM and Medicare Advantage/Medicare Plus Blue:** Report qualifier BM – By Mail or FX – By Fax only.

TRANSACTION SPECIFIC INFORMATION – 837 DENTAL CLAIMS

PAYER SPECIFIC RULES AND LIMITATIONS: 837D CLAIMS

Clearinghouses, service bureaus or providers who want to submit 837 BCBSM FEP dental claims will need to register with Availity.

- Go to www.availity.com and click REGISTER

All other dental claims are being administered by DentaQuest. Please visit their website for additional information: dentaquest.com[4].

BCBSM only accepts ANSI ASC X12N 837 addenda version dental transactions for the Federal Employee Program (FEP). Acceptance of 837 transactions will occur in batch mode and will not be accommodated in the real-time environment.

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.

837D MAXIMUMS/LIMITATIONS

- Report a maximum of 50 services per claim.
- Report up to 100 claims per subscriber/patient combination.
- Do not report leading or trailing zeros for Monetary Amounts

DENTAL ELECTRONIC CLAIM EXCEPTIONS
Note: FEP Out of State claims should be routed to the State Home FEP Payer.

ASC X12N/005010X224A2 – 837 TRANSACTION DATA CLARIFICATIONS FOR THE DENTAL 837 (005010X224A2) TRANSACTION SET

TR3 Pg#	Loop ID	Reference	Industry/Element Name	Codes	Notes/Comments/Instructions – 837D
70	1000A	NM109	Submitter Identifier		Report the Customer ID assigned by Availity.
85	1000B	NM103	Receiver Name		Report **BCBSM** as the receiver name.
85	1000B	NM109	Receiver Primary Identifier		Report **BCBSM**'s Federal Tax ID# 382069753 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer.
98	2010AB	N3, N4 All	Billing Provider Hierarchical Level Loop		**FEP** – If reported, the Pay-to provider address will not be recognized/used. Payments will continue to be directed to the provider address in corporate provider databases.
113	2000B	SBR09	Claim Filing Indicator	FI	Claim Filing Indicators determine the destination payer by the EDI Clearinghouse. For proper claim routing and adjudication use only the following codes: **FEP**: Report FI
116	2010BA	NM109	Subscriber Primary Identifier		**FEP** – Report R following by eight digits.
125	2010BB	NM109	Payer Identifier		Report Payer ID 382069753.

[4] *BCBSM does not control this website or endorse its general content.*

TRANSACTION SPECIFIC INFORMATION – 835 REMITTANCE

PAYER SPECIFIC RULES AND LIMITATIONS: 835 REMITTANCE ADVICE

BCBSM GENERAL 835 HEALTH CARE PAYMENT/ADVICE INFORMATION - 835 files returned by BCBSM:

BCBSM returns the following 835 files:

- **Professional**: BCBSM (FEP, MOS, NASCO), Medicare Advantage/Medicare Plus Blue, and Blue Care Network (includes BCN Advantage).
- **Institutional**: BCBSM (FEP, MOS, NASCO), Medicare Advantage/Medicare Plus Blue, and Blue Care Network (includes BCN Advantage).
- **Dental:** FEP only, DentaQuest 835 files do not route through BCBSM. Non-FEP dental submitters must register with DentaQuest's clearinghouse to receive their commercial dental service 835 files. Registration information for BCBSM dental is available at www.dentaquest.com[1]
- **Blue Cross Complete Professional and Institutional:** BCC submitters can visit www.mibluecrosscomplete.com for more information.
- **Blue Exchange:** Medicare Crossover payment file returned to a provider supplying services to Medicare patients with additional coverage by a Blue Cross and Blue Shield (BCBS) plan other than BCBSM. Blue Exchange 835 files are routed from the BCBS plan to the Blue Cross Blue Shield Association and then to BCBSM for distribution. Refer to EDI Enrollment for BlueExchange Medicare Crossover 835s (bcbsm.com) for more information.
- **Blue Card:** Professional or institutional payment file returned to a provider supplying services to a patient with coverage by a BCBS plan other than BCBSM. Blue Card 835 files are routed from the BCBS plan to BCBSM for distribution.

Distribution of all 835 remittance files to trading partners is based upon the provider's enrollment setup with Availity. Visit Availity.com for more information.

835 DISTRIBUTION SCHEDULE

BCBSM bulking time is 8 PM EST	**Availity distribution is within 3 hours of receipt**	
BCBSM MOS:	**Distribution**	**Check/EFT date**
Facility	Friday	Thursday
Professional	Saturday	Friday
BCBSM NASCO:	**Distribution**	**Check/EFT date**
Facility	Friday	Friday
Professional	Saturday	Friday
Blue Care Network (includes BCN Advantage)	**Distribution**	**Check/EFT date**
Facility and Professional	Tuesday	Check date: Previous Monday EFT date: Following Friday

BCBSM bulking time is 8 PM EST	**Availity distribution is within 3 hours of receipt**	
Medicare Advantage / Medicare Plus Blue	**Distribution**	**Check/EFT date**
Facility and Professional	Saturday	Check date: Previous Tuesday EFT date: Following Tuesday
Blue Exchange – Crossover	**Distribution**	**Check/EFT date**
Facility and Professional	Daily	Same day

ONLINE REMITTANCE ADVICE Vouchers:
BCBSM, BCN/BCNA, and Medicare Advantage/Medicare Plus Blue remittance advice vouchers are viewable online through the Availity portal.

EFT-ERA Operating Rules
Blue Cross Blue Shield of Michigan is required under the federally mandated EFT-ERA Operating Rules to advise health care providers to notify their financial institution or bank that they have enrolled to use EFT. In addition:

- Providers should request that their financial institution or bank return a health plan payment reassociation number to them in CCD+ format.
- When addressing this with your financial institution, it's recommended that you speak with the branch manager about obtaining the reassociation number.
- The reassociation number, located in the addenda record of the banking EFT CCD+ data elements, is necessary for reassociation or tracing of the EFT to ERA in a provider's accounts receivable or practice management system.

835 ISA- IEA: Data Clarification

ASC X12N/005010X221A1 – 835 Transaction Interchange Envelope and Functional Group Structure:

Transaction Set	Element	Instruction	TR3 Pg #
Professional, Institutional and FEP Dental 835 Health Care Claim Payment Advice	ISA05 – Interchange ID Qualifier	ZZ will be returned.	C.4
Professional, Institutional and FEP Dental 835 Health Care Claim Payment Advice	ISA06 – Interchange Sender ID	382069753 will be returned.	C.4
Professional, Institutional and FEP Dental 835 Health Care Claim Payment Advice	ISA07 – Interchange ID Qualifier	ZZ will be returned.	C.5

Transaction Set	Element	Instruction	TR3 Pg #
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: NASCO and FEP: BCBSM NASCO BCN: FACETSTHG Medicare Advantage / Medicare Plus Blue: MED ADVANTAGE MOS: BCBSM MOS	C.7
Professional 835 Health Care Claim Payment Advice	GS02 – Application Sender's Code	One of the following application system identifiers will be returned for BCBSM-related 835 functional groups: NASCO and FEP: BCBSM NASCO MOS: BCBSM MOS BCN: FACETSTHG Medicare Advantage / Medicare Plus Blue: MED ADVANTAGE	C.7
Professional, Institutional and FEP Dental 835 Health Care Claim Payment Advice	GS08 – Version/Release/Industry ID Code	005010X0221A1 will be returned	C.8

MISSING/LATE ERA (835 TRANSACTION)
After completing the ERA/835 setup if your practice or facility also receives payment by EFT and these are not received within 4 business days of each other:

- Contact your clearinghouse when a clearinghouse is used to receive your ERA/835.
- Contact Blue Cross Complete. Visit www.mibluecrosscomplete.com for more information.
- For dental (non-FEP) 835/ERA issues, contact DentaQuest at 1-888-826-8152.
- For all others, contact Availity Client Services at 1-800-AVAILITY (282-4548).

ASC X12N/005010X221A1 – 835 Transaction
This information should be used in conjunction with the ASC X12N/005010X221A1 – 835 TR3. BCBSM returns professional, institutional and dental 835 files only. NOTE: Dental 835s are returned for FEP Dental claims only.

The addenda version of the ANSI ASC X12N 835 transaction set has been selected as the format to meet HIPAA requirements for the electronic return of health care remittance advice. One 835 transaction set reflects a single payment advice or check. Multiple claims can be referenced within one 835. The 835 may or may not contain responses for all services submitted within an individual claim and depends on how the claim is split by the adjudication system. This document refers only to 835s for BCBSM (FEP, MOS and NASCO), BCN (including BCN Advantage), and Medicare Advantage (Medicare Plus Blue).

The 835 remittance advice contains information on the final disposition of a claim that is processed by the payer. The output file will also include some claims that were previously pended and subsequently paid or rejected.

Loop	Segment/ Element	Instruction - 835	Industry/ Data Element Name	TR3 Pg #
1000A	N102	Professional and Institutional 835 files only will return the following: **BCBSM, MOS and NASCO (**includes FEP Professional and Institutional**)** – BCBSM **Medicare Advantage / Medicare Plus Blue**– Blue Cross Blue Shield Michigan **BCN** – Blue Care Network of Michigan	Payer Name	77
1000A	N401	Professional and Institutional 835 files only will return the following: **BCBSM, Medicare Advantage / Medicare Plus Blue, MOS and NASCO (**includes FEP Professional and Institutional**)** – Detroit **BCN –** Detroit	Payer City	90
1000A	N402	Professional and Institutional 835 files only will return the following: **All BCBSM Payers, Medicare Advantage / Medicare Plus Blue and BCN** – MI	Payer State	91
1000A	N403	Professional and Institutional 835 files only will return the following: **BCBSM and NASCO (**includes FEP Professional and Institutional**) –** 48226 **Medicare Advantage / Medicare Plus Blue** – 482262998 **BCN** – 48226	Payer Zip	91
1000A	REF01, REF02	**BCBSM LOCAL Professional** – o REF01 – 2U o REF02 – 00710 **BCBSM LOCAL Institutional** – o REF01 – 2U o REF02 – 00210 **Medicare Advantage / Medicare Plus Blue** – o REF01 – 2U o REF02 – BCBSM **MOS** and **NASCO (**includes FEP Professional and Institutional**)**– o REF01 – 2U o REF02 – 710 **BCN** – Not used.	Additional Payer ID	92-93
2100	CLP06	Professional and Institutional 835 files only will return the following: **BCBSM and Medicare Advantage / Medicare Plus Blue** – Code values of 12 (Preferred Provider Organization (PPO) par arrangements) or 15 (Indemnity non-par arrangements). **MOS and NASCO (**includes FEP Professional and Institutional**)** – Code values of 12 (PPO), or 15 (Indemnity). **BCN** – HM, MB, MA, ZZ or 15	Claim Filing Indicator Code	126

BCBSM and NASCO Institutional 835s only.
Pertinent information regarding Loop 2100 REF01*CE/Type of Payment Indicator:

Voucher Codes – First Position		
Field (not mapped or discontinued)	Field	Description
	1	Inpatient Regular
	2	Out-of-State and Michigan Non-Par
	3	Outpatient Regular
4		
	5	BC Complementary Inpatient
	6	BC Complementary Outpatient
	7	Home Health Complementary
	8	Skilled Nursing Facility (SNF)
9		Pay Subscriber (Modes) not mapped for NASCO/MOS
A		Bank Host Regular Inpatient (not mapped)
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
Accommodation Codes – Second Position		
Field (not mapped or discontinued)	Field	Description
	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
	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
	P	Skilled Nursing Facility, Full Days (Patient over 65) non-Medicare Admission
	T	Outpatient Psychiatric Facility
	W	Regular Home Health Care Program

DRG_PPA Process Indicator (Method of Reimbursement) – Third Position		
Field (not mapped or discontinued)	Field	Description
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 Charge
	K	Trust/PPO Outpatient Peer group 5, Ratio Cost to Charge
	L	PHA Lower of Cost to Charge
	M	Psych Managed Care
N		PHA new DRG
	P	PPO/Trust
S		Ford flat rate/price
	T	Case Management/CCM extra contractual
U		BCN Inpatient Total contract charge
	V	Traditional Inpatient total
W		Trust/PPO Inpatient Total contract charge
X		POS or CCP extra contractual
Provider Contract Indicator – Fourth Position		
Field (not mapped or discontinued)	Field	Description
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
	Q	Blue Preferred Plus
S		Psych Managed Care (network 556)
	T	Trust/PPO
“Blank”		PHA
R		Regional Community Blue
Special Use Indicator – Fifth Position		
Field (not mapped or discontinued)	Field	Description
	%	Percent of PHA
A		Mid Michigan

NOTE: The MOS Type of Payment Indicator is five characters. The first character is the Voucher Code, the second character is the Accommodation Code, the third character is the DRG-PPA Indicator, the fourth character is the Provider Contract Indicator and the fifth character is the Special Use Indicator.

APPENDICES

A. Implementation Checklist

- Register With Availity
- Setup FTP Connection
- Review Availity's Documentation
  - Availity Health Information Network EDI Connection Guide
  - Availity Health Information Network Batch Electronic Data Interchange (EDI) Standard Companion Guide
- Contact Availity
  - Visit Availity.com or contact Availity Client Services at 1-800-AVAILITY (282-4548)

B. Frequently Asked Questions

- How can I obtain EDI acknowledgement reports through Availity?
  - Log in to availity.com** and navigate to EDI Reporting Preferences. Select the format of File Acknowledgements (payer response reports).

- Will Availity EDI or Blue Cross EDI resolve EOB/voucher rejections?
  - No. Providers will need to contact the provider inquiry department for the claim processed. The provider inquiry department will advise providers of the reason their claims rejected in processing. Based on the reason, a provider should know if it was due to how they billed the claim so they can correct and resubmit the claim if needed.

- Will Availity EDI or Blue Cross EDI help register providers with Blue Cross and BCN health plans?
  - No. To register, call Blue Cross Provider Enrollment and Data Management at 1-800-822-2761.

- Who do I contact if I have issues with Availity EDI?
  - For questions, assistance and support during and after the transition, contact Availity Client Services.
  - Note: For all issues, ensure you note the agent's name and ticket number for any follow-up.
  - Submit an online support ticket. Log in to availity.com** and navigate to Help & Training > Availity Support.
  - Call 1-800-AVAILITY (282-4548)
  - Availity Client Services can assist with questions regarding trading partner setup, EDI edits, acknowledgement/edit reports, whether your claims file got sent to Blue Cross or BCN, and help you locate your 835 ERA. If Availity cannot resolve your issue, they will open a ticket with Blue Cross EDI.

- I HAVE QUESTIONS ABOUT REGISTERING WITH AVAILITY.
  - Contact 1-800-AVAILITY (282-4548).

- To learn more on getting ready with Availity, go to www.availity.com/bcbsm-edi.

C. Change Summary

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

The table below summarizes the changes to this companion document.

Section	Description of Change	Page	Date
Loop 2010BA and 2010CA	Updated NM103 and NM104 requirements for Professional and Institutional 837.	16,17, 23,24	Jan 2025
835 1000A BCN Address updates	Updated 1000A, N102, N401, N403	29	Feb 2024
Control Segments ISA-IEA	Updated table with note for 837 dental transactions to reflect that BCBSM only accepts FEP dental claims.	13	Nov 2023
837 Professional Claims	Removed Medicare Part B from Loop 2000B SBR09 claim filing indicator code description for 'MB'	16	August 2023
835 Remittance Advice	Added 835 distribution schedule table	26	August 2023
Entire document	Published new Batch Transaction companion guide		July 2023