May 27, 2010

Subject: Changes for the Institutional 837 and 835 transactions

Dear software developer,

A revised, updated copy of the ANSI ASC X12N 837 & 835 Institutional Health Care Claim & Health Care Claim Payment/Advice (BCBSM EDI Institutional 837/835 Companion Document) is now online at: http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf

The table below summarizes the changes to 837 and 835 transactions.

Section	Description of Change	Page
Table of Contents	Replaced Table of Contents	TOC
ANSI ASC X12N Institutional 837 (004010X096A1) – Reporting Instruction Clarifications		
Maximums/Limitations	Deleted “Report a maximum of 50 services per claim for MDCH”	5
Coordination of Benefits (COB)	Revised 2nd paragraph	9
Coordination of Benefits (COB) BCN	Revised 2nd bullet	9
Data Clarifications for the Institutional 835 (004010X098A1) Transaction Set		
TRN02	Added MOS	12
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Loop 1000A, N301	Added “BlueCaid – 20500 Civic Center Drive will be returned”	13
Loop 1000A, N401	Added “BlueCaid – Southfield will be returned”	13
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Loop 2100, CLP06	Added MOS	13
Loop 2100, CAS Segment	Added MOS	14
Loop 2100, NM108/NM109	Added MOS	14
Loop 2100 NM1 Segment (all three occurrences)	Added MOS	14

Section	Description of Change	Page
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Loop 2100, MOA	Added	14
Loop 2100, REF01/REF02	Added MOS	14
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BCBSM and NASCO – Pertinent information regarding Loop 2100 REF01*CE/Type of Payment Indicator		
Provider Contract Indicator	Added “Q - Blue Preferred Plus”	17
Data Clarifications for the Institutional 837 (004010X096) Transaction Set		
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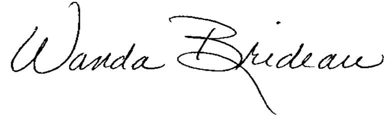
If you have any questions regarding this information, please call our Electronic Data Interchange department at 800-542-0945.

Sincerely,



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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

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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.1.

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. 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.

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.

[1]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 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

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 remainder 10
0000124 11/11 = 1 remainder 0
0000125 12/11 = 1 remainder 1
0000126 13/11 = 1 remainder 2
0000127 14/11 = 1 remainder 3
0000128 15/11 = 1 remainder 4
0000129 16/11 = 1 remainder 5

d) Create 8th 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 8th digit is greater than 4, subtract 5, or, if 8th 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. For Medicare Supplemental claims report all deductible and co-insurance amounts using a CAS segment with group code PR and applicable reason codes. Supplemental claims submitted without the amounts can be denied in process.

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
- 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.
- 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 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.

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. 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.

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. **MOS, 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

Loop	Segment/Element	Instruction	Industry/Element Name
	TRN03	**MOS, BCBSM, and NASCO** – 1382069753 will be returned **BCN FACETS** – 1382359234 will be returned	Payer Identifier
	REF02	**BCN** – 382069753	Receiver Identification
1000A	N102	**MOS, BCBSM and NASCO** – BCBSM will be returned. **Medicare Advantage** – Blue Cross Blue Shield Michigan will be returned. **BCN** – Blue Care Network of Michigan, BCN Service Company or BlueCaid will be returned.	Payer Name
1000A	N301	**MOS, BCBSM and NASCO** – 600 E. Lafayette will be returned **Medicare Advantage** – 600 Lafayette Blvd will be returned **BCN** – 25925 Telegraph Road will be returned. **BlueCaid** – 20500 Civic Center Drive will be returned.	Payer Address
1000A	N401	**MOS, BCBSM, NASCO and Medicare Advantage** – Detroit will be returned. **BCN** – Southfield will be returned. **BlueCaid** – Southfield will be returned.	Payer City
1000A	N402	**MOS, BCBSM, NASCO and BCN** – MI will be returned.	Payer State
1000A	N404	**MOS, BCBSM, and NASCO** – 48226 will be returned **Medicare Advantage** – 482262998 will be returned. **BCN** – 48034 will be returned. **BlueCaid** – 48076 will be returned.	Payer Zip Code
1000A	REF01/REF02	**BCBSM** – REF01 will contain 2U and REF02 will contain 00210. **MOS and NASCO** – REF01 will contain 2U and REF02 will contain 710. **BCN** – Not used. **Medicare Advantage** – REF01 will contain 2U and REF02 will contain 210	Additional Payer ID
1000A	PER03/PER04	**BCN** – 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	**All Payers** – Qualifier PE followed by payee name and NPI.	Payee Identification
1000B	N301/N302	**BCBSM** – May contain payee address information in N301. **MOS, NASCO, and Medicare Advantage** – Not used. **BCN** – N301 and N302 will contain payee address information.	Payee Address
1000B	N401-N403	**BCBSM and BCN** – will be returned **MOS, NASCO and Medicare Advantage** – Not used.	Payee City, State and Zip Code
1000B	REF01/REF02	**All Payers** – REF01 will contain XX and REF02 will contain the BCBSM NPI of the payee.	Additional Payee Identifier
2100	CLP01	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – 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	**MOS, BCBSM, NASCO and BCN** – Code values of 1, 2, 3, 4 or 22 will be returned.	Claim Status Code
2100	CLP06	**BCBSM** – Code values of 12 (par) or 15 (non-par) will be returned. **MOS and NASCO** – Code values of 12 (PPO), 13 (POS) or 15 (Indemnity) will be returned. **BCN**– HM will be returned.	Claim Filing Indicator Code

Loop	Segment/Element	Instruction	Industry/Element Name
2100	CAS Segment	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – Adjustments that are applicable to the claim level will be returned.	Claim Adjustment (Claim Level)
2100	NM103	**BCBSM** – Some names may be truncated to five positions.	Patient First Name
2100	NM108/NM109	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – NM108 will contain MI and the member ID number will be returned.	Patient Contract Number
2100	NM1 Segment	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – This information will be returned when available if applicable.	Corrected Patient/Insured Name
2100	NM1 Segment	**BCBSM** – Not used **MOS, NASCO and Medicare Advantage** – When present, NM108 will contain FI and NM109 will contain the Rendering Provider's Federal Tax ID Number. **BCN** – When present, NM108 will contain FI, BS or SL and NM109 will contain the assigned number.	Service Provider Name/ID
2100	NM1 Segment	**MOS, BCBSM, NASCO and BCN** – Returned if applicable.	Corrected Priority Payer Name
2100	MIA	**MOS, BCBSM, NASCO and BCN** – Returned if applicable.	Inpatient Adjudication Information
2100	MIO	**MOS, BCBSM, NASCO and BCN** – Returned if applicable.	Outpatient Adjudication Information
2100	REF01/REF02	**MOS, BCBSM and NASCO** – 1L or CE will be returned. • IF CE IS RETURNED PLEASE SEE THE END OF THIS DOCUMENT FOR DETAILED INFORMATION **BCN** – 1L, SY, A6, BB, or EA will be returned. **Medicare Advantage** –REF02 MA will be returned.	Other Claim Related ID
2100	DTM01	**MOS, BCBSM, NASCO and BCN** – DTM will contain 050, 232 and/or 233 **Medicare Advantage-** DTM will contain 050	Claim Date Qualifier
2100	AMT01	**MOS, BCBSM, NASCO and BCN** – AMT01 will contain AU when applicable to report contract charges.	Claim Supplemental Amount Qualifier Code
2110	SVC01-1	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – HC or NU will be returned. **MOS and NASCO** – ID may be returned in some cases, otherwise HC will be returned. **Medicare Advantage** – 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	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – HC will be returned when applicable.	HCPCS Code (qualifier)
2110	SVC07	**BCBSM** – A quantity will be returned on pay-subscriber remittances.	Original Units of Service Count
2110	CAS Segment	**MOS, BCBSM, NASCO and BCN** – Adjustments that are applicable to the service level will be returned.	Service Adjustment (Service Level)
2110	REF01	**MOS, BCBSM, NASCO and BCN** – REF01 will contain 6R and REF02 will contain the provider control number when applicable. **Medicare Advantage** – A sequential number will be returned at this time.	Service Provider ID
2110	AMT01	**MOS, NASCO, BCN and Medicare Advantage** – AMT01 will contain B6 when applicable.	Service Supplemental Amount

Loop	Segment/Element	Instruction	Industry/Element Name
2110	LQ01, LQ02	**BCBSM, BCN and Medicare Advantage** – LQ01 will contain HE and LQ02 will contain the Claim Payment Remark Code.	Claim Payment Remark Code
2110	PLB Segment	**MOS, BCBSM, NASCO, BCN and Medicare Advantage** – 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 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
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
Q Blue Preferred Plus
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:

Transaction Set	Element	Instruction	Pg#
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
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: Institutional NASCO and FEP: BCBSM NASCO Institutional BCBSM: BCBSM LOCAL INS Institutional BCN: FACETSTHG Medicare Advantage: MED ADVANTAGE MOS: BCBSM MOS 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 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	Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider. The Billing/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. **BCBSM and FEP** – 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. **BCBSM, BCN and FEP** – 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. **Medicare Advantage**-If reported then secondary identifiers will be validated.	Billing/Pay-to Provider Hierarchical Level Loop
2000A	PRV01	**All Payers** – 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	**All Payers** – 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	**All Payers:** • Report NM108 qualifier=XX and NM109 must contain the 10 digit NPI.	Billing Provider ID, Billing Provider Secondary ID.
2010AA	REF01/REF02	**All Payers** – Credit/Debit card information may not be used to bill any insurance payer. The EIN or SSN of the Billing provider must be reported in the REF01/REF02 of this loop.	Credit/Debit Card Billing Information
2010AA	REF01/REF02	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.	Billing Provider Secondary ID Segment

Loop	Segment/Element	Instruction	Industry/Element Name
2010AB	NM108/NM109	**All Payers:** • NM108 – Report applicable qualifier (XX=NPI). • NM109 – Report the 10 digit NPI. • If NPI is reported then either the EIN or SSN of the Billing Provider must be reported in the REF01/REF02 of this loop. **BCBSM, BCN and FEP** – If reported, the Pay-to Provider will not be used.	Pay-to Provider Segment
2010AB	REF01/REF02	**All Payers**: • REF01 – Report applicable qualifier (EI=EIN, SY=SSN). • REF02 – Report either the Billing Provider's EIN or SSN.	Pay-to-Provider Secondary Identifier
2000B	SBR01	**BCBSM**, **Medicare Advantage and MDCH** – Can be P, S or T. **BCN, FEP** – Can be P or S. **MDCH**– 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.	Payer Responsibility Sequence Number Code
2000B	SBR02	**Medicare, Medicare Advantage and MDCH**– For Medicare and MDCH, the subscriber is always the same as the patient. SBR02 must equal 18. **BCN** – To ensure proper processing only report when the insured is the patient.	Relationship Code
2000B	SBR03	**BCN** – Report the group number as shown on the subscriber's ID card.	Subscriber Group Number
2000B	SBR09 (Qualifier MI)	Claim Filing Indicators determine the destination payer by the EDI Clearinghouse. For proper claim routing and adjudication use only the following codes: BL – Blue Cross OF – Federal Employee Program (FEP HM – Blue Care Network /BCN Advantage MA – Medicare A and Medicare Advantage MC – MDCH TV – Title V 11 – State Medical Plan (Other Non-Federal) **MDCH** – 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.	Claim Filing Indicator
2010BA	NM1	**Medicare, Medicare Advantage and MDCH**– The subscriber is always the patient.	Subscriber loops
2010BA	NM103	**BCBSM, BCN, BCN Advantage, FEP, Medicare Advantage/ Medicare Plus Blue, MDCH** – Do not report numbers, special characters or embedded spaces. Must be alphabetic. Medicare-Do not report special characters	Subscriber Last Name
2010BA	NM104	**All Payers –** Do not report numbers or special characters. Must be alphabetic. Do not report numbers, embedded spaces or special characters	Subscriber First Name

Loop	Segment/Element	Instruction	Industry/Element Name
2010BA	NM109	**All Payers –** NM109 is required for reporting the subscriber's identification number. Use qualifier MI in NM108. **BCBSM** (including Blue Card claims), Medicare Advantage – 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. **BCN/BCN Advantage –** Submit the contract number as reported on the members ID card. Must contain at least 9 digits. **FEP** – Must be an R followed by eight digits. **Medicare –** Enter the patient's Medicare Health Insurance Claim Number (HICN).	Subscriber Identification
2010BA	N301/N302/N401/ N402/N403	**FEP** – For proper adjudication, report these elements if the patient is not the same as the subscriber. **Medicare and MDCH**– Required on all claims.	Subscriber Address.
2010BA	DMG segment	**All Payers** – Required when the patient is the same as the subscriber.	Subscriber Demographic Information
2010BA	DMG02	**BCN** – When present must be a valid date. Cannot be greater than the system date. **Medicare and MDCH**– Must be a valid date. Cannot be greater than the system date.	Subscriber Birth Date
2010BA	DMG03	**BCN** – When present must be M or F. **Medicare and MDCH**– Must be a valid code.	Subscriber Gender Code
2010BB	NM101 through NM109	**All Payers** – Credit/Debit card information may not be used to bill any insurance payer.	Credit/Debit Card Holder Name
2010BC	NM103	**BCBSM and Medicare Advantage** – Enter BCBSM. **BCN** – Enter BCN **FEP** – Enter BCBSM-FEP **Medicare** – Enter MEDICARE. **MDCH** – Enter MEDICAID	Payer Name
2010BC	NM108	**All Payers** – Enter PI.	Qualifier
2010BC	NM109 (Qualifier PI)	**BCBSM, FEP, Medicare Advantage, BCN and BCN Advantage** – 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. **Medicare** – This element must equal 00452 when the Claim Filing Indicator Code (2000B-SBR09) is MA (Medicare) and will be transferred to NGS. **MDCH** – 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
2000C	All	**Medicare, Medicare Advantage and MDCH** – The subscriber is always the same as the patient; therefore, the Patient Hierarchical Level (2000C) is not used. **BCBSM, BCN and FEP** – Required if the patient is not the subscriber.	Patient Hierarchical Level
2010CA	NM103	**BCBSM, BCN** – Must contain at least two alpha characters. Do not include special characters or embedded spaces.	Patient Last Name
2010CA	NM104	**BCBSM, BCN, MDCH and Medicare** – Patient first name must be at least one character. Do not include special characters or embedded spaces.	Patient First Name
2010CA	NM109 Qualifier MI	**Required only if the patient identifier is different than the subscriber ID reported in loop 2010BA.**	Patient Primary Identifier

Loop	Segment/Element	Instruction	Industry/Element Name
2010CA	DMG02	**BCBSM, BCN and FEP** – Must be less than or equal to admission date (2300, DTP03, Qualifier 435).	Patient Birth Date
2010CA	DMG03	**BCN** – When present, must equal M or F.	Patient Gender Code
2300	CLM02	**All Payers** – 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	**BCBSM** – Must equal 11-14, 16, 18, 21-23, 33, 71, 76, 81-83, 85-86. **BCN** – Must equal 11-13, 21-23, 33, 72-75, 81-83, 85, 86. **Medicare** – Must equal 11-14, 18, 21-23, 26, 71-77, 83, 85-86 or 89. **Medicare Advantage** – Must equal 11,-14, 18, 21-23, 26, 32- 34, 71-77, 83, 85-86 or 89. **MDCH** – Must equal 11-14, 18, 21- 23, 26, 33, 71-75, 81-83, 85, 86 or 89. **FEP** – Must equal 11-13, 14, 18, 21-23, 33-34, 71-76, 79, 81-86, 89 **BCBSM –** If the type of bill equals 81X or 82X, the claims will process as inpatient **BCN –** If the type of bill equals 81X, the claim will process as outpatient. **FEP** – 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 only valid for Medicare Advantage Home Health claims. When reporting bill types XX7 and XX8, the original document must be reported (Loop 2300/REF01 qualifier F8). **BCN** – When submitting a replacement claim for BCN, report CLM05-3 as a 7 (XX7) when billing Primary Payer.	Claim Frequency Type Code
2300	CLM06	**Medicare Advantage** – Report the provider signature indicator with a ' Y'	Provider Signature Indicator
2300	DTP03 Qualifier 096	**All Payers** – Must be in HHMM format. Required when the Type of Bill is 11X, 18X or 21X. Required on inpatient claims. **HOSPICE SUBMITTERS: BCBSM** – When billing Blue Cross (BL) claims, if the type of bill equals 811 or 814, a **discharge hour is required**.	Discharge Hour
2300	DTP03 Qualifier 434	**All Payers** – From and Thru Dates reported cannot be greater than the date the file was created. **BCN, Medicare and MDCH**– 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 Qualifier 435	**All Payers** – 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. **BCBSM** – 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	**All Payers** – Required on inpatient claims.	Admission Type Code
2300	CL102	**BCN and MDCH** – Must equal 1-9 if inpatient. **Medicare** – Must equal 1-9 or A-D if inpatient.	Admission Source Code
2300	CL103	**BCBSM, BCN, FEP and Medicare** – Required on Inpatient claims **MDCH** – Required for inpatient and outpatient. **All Payers** – Must be 30 when billing interim claims bill type nn2 or nn3.	Patient Status Code
2300	PWK01/PWK02,	**BCBSM –** BCBSM prefers that claim attachments are available on request at provider site (PWK02 qualifier AA). **Medicare** – Any data submitted in the PWK segment may not be considered for processing.	Paperwork

Loop	Segment/Element	Instruction	Industry/Element Name
2300	K301	**All Payers –** Present on Admission (POA) is required. **All Payers –** It is recommended that this data element be reported for all inpatient hospital claims: • Position 1-3 – will contain the value, POA. • Position 4 – POA indicator of the principal diagnosis code. • Position 5 – begins the reporting of POA indicators for all other diagnosis codes (including e-codes), if applicable. • A value of Z or X must be reported to indicate the end of reporting of the POA indicators for the other diagnosis. • The position following the Z or X value represents the POA indicator for a submitted e-code if applicable or can be left blank.	
2300	NTE01/NTE02	**BCBSM, BCN and FEP** – 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. **BCBSM** – 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. RMKAN = Medical emergency, acute illness. RMKAT = Documentation attached. RMKCN = Medical emergency, chronic illness. RMKEM = Medical emergency, referred. RMKDC = Individual consideration. RMKSC = Status to an original claim. RMKSP = Medical emergency, severe pain. **MDCH**– Report ADD in NTE01 and provide free-text remarks, if needed in REF02.	Billing Notes
2300	AMT01/AMT02	**All Payers** – Credit/Debit card information may not be used to bill any insurance payer.	Credit/Debit Card Maximum Amount
2300	REF02 Qualifier F8	**BCN –** 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 Qualifier G4	**MDCH** – Report the 9 digit number assigned by the Admission and Certification Review contractor.	Peer Review Organization (PRO) Approval Number
2300	REF01 Qualifier EA	**FEP** – Required on supplemental claims.	Medical Record ID Number
2300	HI Segment Diagnosis Code	**All Payers** – Diagnosis must be reported to the highest level of specificity.	Diagnosis Code
2300	HI02-2 Qualifier BJ	**All Payers** – Diagnosis must be reported to the highest level of specificity. Required on inpatient claims. **Medicare** – 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 Qualifier BK, BN and BF	**BCBSM, BCN and FEP** – One principal diagnosis, one admitting and up to eight additional diagnosis codes will be referenced per claim. Additional diagnosis codes will not be referenced. **BCN, Medicare and MDCH**– Cannot be the same as the principal diagnosis code. **Commercial** – Diagnosis must be coded to the highest level of specificity. Duplicate diagnosis codes are not allowed.	Additional Diagnosis Codes

Loop	Segment/Element	Instruction	Industry/Element Name
2300	HI03-2 Qualifier BP, BR and BO	**BCBSM, BCN and FEP** – One principal and five additional procedure codes can be reported per claim. Additional procedure codes will not be referenced by adjudication. **BCBSM** – If secondary diagnosis code indicates cancelled surgery, then procedure code is not required. **BCN** – 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. **MDCH** – Required on inpatient claims when reporting revenue code 036n. **BCN and MDCH**– Must report a valid principal procedure date.	Principal Procedure Code, Additional Procedure Codes
2300	HI01-2 through HI12-4 Qualifier BI	**BCBSM, BCN and FEP** – 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 Qualifier BI	Dates reported must be less than or equal to file submission date. **BCBSM, BCN and FEP** – Only dates reported in HI01-4 and HI02-4 will be referenced. All other occurrence span dates will not be referenced by adjudication. **BCN** – Required if corresponding occurrence span code is reported.	Occurrence Span From and Thru Dates
2300	HI01-2 through HI12-2 Qualifier BH	**BCBSM, BCN and FEP** – 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
2300	REF01 Qualifier 9F	**BCBSM –** To report services referred by a PPO physician, report the referring providers NPI preceded by the letters PPO. This should appear as PPOxxxxxxxxxx where the NPI is equal to xxxxxxxxxx.	Referral Number
2300	HI01-4 through HI10-4 Qualifier BH	**BCBSM, BCN and FEP** – 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. **BCBSM** – Occurrence code 35 is required to be reported on physical therapy claims.	Occurrence Code Dates
2300	HI01-2 through HI12-2 Qualifier BE	Must be a valid code. **BCBSM, BCN, FEP and MDCH** – If corresponding value associated amount is present, value code is required. **BCBSM** – 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. **MDCH** – 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. **Note:** 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 Qualifier BE	**BCBSM, BCN and FEP** – Required if corresponding value code is reported in HI01-2 through HI12-2. **BCBSM** – When the type of bill is XX8, the value amount for A3, B3 or C3 must be zero. **MDCH** – Must be greater than zero if the corresponding value code reported is not 02.	Value Code Associated Amount
2300	HI01-2 through HI12-2 Qualifier BG	If present, must be a valid code. **BCBSM, BCN 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.	Condition Code

Loop	Segment/Element	Instruction	Industry/Element Name
2300	QTY01 Qualifier CA	**BCBSM**: • QTY segment is used to report quantities that apply to the entire (applicable) claim. • 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. • 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. **BCBSM, BCN and FEP** – 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. • 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. **BCBSM/BCN** – 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). **FEP** – 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. **Medicare** – 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. **MDCH** – Required on inpatient when supplemental to Medicare. **Medicare Advantage** –To avoid unnecessary edits it is recommend to report at least one occurrence of this segment and qualifier	Covered Days
2300	QTY01 Qualifier CD	**BCBSM** – Must be greater than zero when the bill type is 11X and value code 9 or 11 is present. **Medicare** – 61st through 90th day of a benefit period for inpatient, and the 21st through the 100th 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. **MDCH** – Required on inpatient when supplemental to Medicare.	Coinsurance Days
2300	QTY01 Qualifier LA	**Medicare** – **E**ach 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. **BCBSM** – Must be greater than zero when the bill type is 11X and value code 8 or 10 is present. **MDCH**– If quantity is greater than zero, value codes 8 or 10 and value amounts are required.	Lifetime Reserve Days
2305	CR701	**BCBSM** – For proper adjudication, submit Home Health and Hospice on the Institutional 837 rather than Professional 837.	Discipline Type Code
2310A	NM103	**MDCH** – Required on all claims.	Attending Physician Last Name
2310A	NM104	**Medicare, Medicare Advantage and MDCH** – Required on all claims.	Attending Physician First Name
2310A	NM108/NM109	**All Payers** – **All Payers –**. Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI.	Attending Physician ID

Loop	Segment/Element	Instruction	Industry/Element Name
2310A	REF01/REF02	**All Payers**: • REF01 – Report applicable qualifier (EI=EIN, SY=SSN). • REF02 – Report either the Attending Physician's EIN or SSN.	Attending Physician Secondary Identifier
2310B	NM103/NM104	**Medicare** – Required if Operating Physician Secondary ID is reported.	Operating Physician First and Last Name
2310B	NM108/NM109	**All Payers** – Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI.	Operating Physician ID
2310B	REF01/REF02	**All Payers**: • REF01 – Report applicable qualifier (EI=EIN, SY=SSN). • REF02 – Report either the Operating Physician's EIN or SSN. **Medicare** – 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	**All Payers –**. Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI.	Other Provider ID
2310C	REF01/REF02	**All Payers**: • REF01 – Report applicable qualifier (EI=EIN, SY=SSN). • REF02 – Report either the Other Provider's EIN or SSN.	Other Provider Secondary ID
2310E	NM108/NM109	**All Payers** – Report NM108 qualifier XX and NM109 which must contain the 10 digit NPI..	Service Facility ID
2310E	PRV	**BCBSM and FEP** – 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	**All Payers** – • REF01 – Report applicable qualifier (EI=EIN, SY=SSN). • REF02 – Report either the Other Provider's EIN or SSN.	Service Facility Secondary ID
2320	SBR Segment Other Subscriber Information	**All Payers** – Required if other payers could potentially be involved in payment of this claim. SBR01 is used to identify the payment responsibility of the other payer.	Other Subscriber Information Segment
2320	SBR03	**BCN –** Required, if applicable. **MDCH** – 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	**All Payers –** Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information. **BCBSM** – Medicare supplemental claims require reporting of deductible or coinsurance amounts with claim adjustment group code PR when applicable.	
2320	OI06	**FEP** – For proper adjudication, use code Y.	Release of Information Code
2330A	NM103/NM105	**BCBSM, BCN and FEP** – For proper adjudication, do not report numbers or special characters. **MDCH** – Enter the name of the subscriber as it appears on the files of the other payer.	Other Insured Name
2330A	NM109 Qualifier MI	**All Payers –** Use the unique number assigned to the subscriber by the other payer indicated in loop 2330B.	Other Insured Primary ID

Loop	Segment/Element	Instruction	Industry/Element Name
2330B	NM103	**All Payers** – If other payer information is known, report Other Payer Names as follows: **BCBSM** – Enter BCBSM **BCN** – Enter BCN **FEP** – Enter BCBSM-FEP **Medicare** – Enter MEDICARE **MDCH** – Enter MEDICAID **Other Payer** – Report the Insurance Name	Other Payer Name
2330B	NM109	**MDCH** – 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	**BCBSM, BCN and FEP** – For optimal adjudication of your claims, report no more than 99 service lines per claim. **Medicare** – Report 450 or less service lines on each institutional claim.	Service Line Counter
2400	SV201	**BCBSM –** 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. **BCBSM, BCN FEP** – 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. **BCBSM and FEP** – Continue to report J procedure codes for injections and chemotherapy drugs. **BCN** – Report modifier 50 and units in SV205 for lab, radiology or surgical procedures.	Product/Service ID Qualifier
2400	SV203	**BCBSM** – Type of bill 74X. For service dates 3/1/08 and greater, when billing physical therapy, occupational therapy or speech therapy, report zero (0.00) charges for revenue codes 420, 430 or 440 as applicable. **BCBSM, BCN, FEP and Medicare** – 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). **BCN, Medicare and MDCH** – 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). **Medicare and Medicare Advantage** – A zero must be reported for revenue codes 0022 and 0024. **MDCH** – Zero charge amounts are not accepted.	Service Line Charge Amount
2400	SV205	**BCBSM:** • 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. • 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. **BCN** – 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. **BCN, Medicare and MDCH**– If SV201 equals 0100 through 0219, must be greater than zero.	Service Line Units
2400	SV206	**All Payers** – Required when associated revenue code is 0100-0219. **BCBSM and BCN** – If multiple room rates fall within the same accommodation code billed on a claim, indicate the highest rate in this element. **MDCH** – Must be present. Zero is an acceptable rate.	Service Line Rate

Loop	Segment/Element	Instruction	Industry/Element Name
2400	SV207	**BCN, Medicare and MDCH**– Must not be greater than SV203.	Service Line Non-covered Charge Amount
2400	PWK	**BCBSM** – BCBSM prefers that claim attachments are available on request at provider site (PWK02 qualifier AA). **Medicare** – Any data submitted in the PWK segment may not be considered for processing.	Paperwork
2410	LIN Segment	**MDCH**– Will only recognize the first repeat of this segment. All additional repeats will be ignored.	Drug Identification Segment
2420A	NM108/NM109	**All Payers** – **NPI requirements** – Refer to the section titled '**National Provider Identifier (NPI)**' on page 6 for NPI specifications.	Attending Physician
2420B	NM108/NM109	**All Payers** – **NPI requirements** – Refer to the section titled '**National Provider Identifier (NPI)**' on page 6 for NPI specifications.	Operating Physician
2420C	NM108/NM109	**All Payers** – **NPI requirements** – Refer to the section titled '**National Provider Identifier (NPI)**' on page 6 for NPI specifications.	Other Physician
2420D	NM108/NM109	**All Payers** – **NPI requirements** – Refer to the section titled '**National Provider Identifier (NPI)**' on page 6 for NPI specifications.	Referring Provider Name
2430	All	**MDCH** – 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	**All payers – Required when the prior payment had service line adjustments reported on a remittance.**	
2430	CAS02	**Medicare Advantage, MDCH** – 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.

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.