

# 837 Professional Health Care Claim

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# Chapter 2:

## 837 – Professional Health Care Claim

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### Overview

This chapter of the BCBSNC Companion Guide identifies processing or adjudication particular to BCBSNC in its implementation of the 837 Professional Health Care Claim Transaction for version 5010. The chapter contains three sections:

- a general section with information applicable to the processing of claims and business edits performed by BCBSNC
- a table outlining specific requests for data format or content within the transaction, or describing BCBSNC handling of specific data types
- a sample scenario that is illustrated as both a data string and mapped transaction

While all ASC X12N compliant transactions are accepted by BCBSNC, the HIPAA Technical Reports (TR3s) allow for some discretion in applying the regulations to existing business practices. Understanding BCBSNC business procedures will expedite claims processing for trading partners as they exchange EDI transactions with BCBSNC.

### Claims Processing

#### ***Acknowledgements***

Senders receive two forms of acknowledgement transactions: the TA1 Transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transmission, and 999 Transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE). At the claim level of a transaction, the only acknowledgement of receipt is the return of the NOP or the Claims Audit Report. See the [Reporting](#) Section below for more information.

#### ***Anesthesia Billing***

BCBSNC accepts nationally recognized code sets for anesthesia services and does not require the surgical CPT code on a claim for anesthesia services. BCBSNC Network Management distributes a document entitled *Billing Guidelines for Anesthesia Services* to all anesthesiologists within our network. For information about billing issues specific to anesthesiology services, contact your BCBSNC Network Management field office representative. Contact numbers are available online at <http://www.bcbsnc.com/content/providers/contacts.htm> or in your BCBSNC Network Management copy of *The Blue Book: Provider Manual*, which is also available online at <http://www.bcbsnc.com/content/providers/blue-book.htm>. For Medicare Advantage claims, see the [Blue Medicare Provider Manual](#) – also at [www.bcbsnc.com](http://www.bcbsnc.com).

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

To ensure the proper processing of claims requiring coordination of benefits, BCBSNC recommends that providers validate the patient's Membership Identification Number and supplementary or primary carrier information for every claim.



### Important Notice:

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain BCBSNC Policy Numbers for **both** primary and secondary coverage must be broken out into two claims. File the primary coverage claim first and submit the secondary coverage claim **after** the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the Explanation of Payment (EOP). **A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied, based on the need for primary insurance information.**

### Code Sets

Only standard HCPCS-CPT codes, valid at the time of the date(s) of service, should be used.

BCBSNC does not require the use of National Drug Codes (NDC) by non-retail pharmacies. J-code submissions are acceptable.

### Corrections and Reversals

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 5 = "Late Charges Only" Claim
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of Prior Claim

### Data Retention of Denied Claims

Data from claims that are denied is retained for a minimum of three years before archiving. This data is available electronically for eighteen months before archiving. After eighteen months, inquiries should be restricted to telephone inquiries only.

### Data Format/Content

BCBSNC accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

#### Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 p.m.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after a patient's service date.

**Decimals**

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

**Monetary and Unit Amount Values**

BCBSNC accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are denied.

**Phone Numbers**

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included.

***Time Frames for Processing***

Batch claims are moved through the adjudication process at cycles throughout the day. The last cycle of processing for the day occurs at 8 p.m. for Professional Health Care Claims. Batches must have passed through an initial validation process to reach the adjudication process cycle. Senders should allow time for validation and submit transmissions by 7:30 p.m. to make the last processing cycle of the day.

***Medicare Claims Processing***

For Medicare Supplemental subrogation, file directly first with Medicare, prior to filing secondary claims with BCBSNC. Primary payments should be completed before secondary claim filing.

Medicare Advantage specific X12 processing information is contained throughout this document.

**Identification Codes and Numbers*****Provider Identifiers*****National Provider Identifiers (NPI)**

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA Loop level. See the [837 Professional Data Element Table](#) for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

With the exception of Medicare Advantage providers, mid-level providers, such as physician assistants or advanced practice nurse practitioners, do not contract with BCBSNC, and BCBSNC does not collect/store their NPI. When they perform services for a BCBSNC subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) under the supervising provider's NPI. Please see the [Rendering Provider](#) section for more information.

Mid-Level Practitioners serving Medicare Advantage members can file claims and be paid under their individual NPI as dictated by their provider agreement with Blue Medicare.

### **Billing Provider**

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

### **Rendering Provider**

BCBSNC requires Rendering Provider identifiers (NM109 of Loop 2310B or 2420A) to complete processing.



**Important Notice:** If your office staff includes physician assistants or advanced practice nurse practitioners, you may have applied for and received National Provider Identifiers NPI for them. However, do not use physician assistant or advanced practice nurse practitioners' NPI when reporting services in claim submissions to BCBSNC, unless these practitioners are serving Medicare Advantage members. Continue to report services provided by physician assistants and advanced practice nurse practitioners employed in your office under the NPI assigned provider number of the supervising physician providing the oversight. Practitioners serving Medicare Advantage members can file claims and be paid under their individual NPI as dictated by their provider agreement with Blue Medicare.

BCBSNC does not directly reimburse physician assistants or advanced practice nurse practitioners for services provided in a physician's office. Filing claims using physician assistant or registered nurse NPI can delay claims processing which can also delay payment to your practice.

### **Referring Provider**

BCBSNC has no requirement for Referring Provider information beyond that prescribed by the X12 implementation guide (TR3).

### **Subscriber Identifiers**

Submitters must use the entire alphanumeric or numeric identification code, as it appears on the subscriber's card in the 2010BA element. Nearly all BCBSNC members have a four(4) character alpha prefix, followed by either a eight (8) or ten (10) digit number. Some exceptions are Federal employees, who have only one (1) alpha prefix and eight (8) numeric characters to their member number. The alpha prefix must be included when providing the subscriber identifier in the transaction, using upper case for the letters.

The most common reason for claims failure to process is an erroneous Subscriber Identifier. To ensure accuracy, trading partners are advised to use the Health Eligibility Inquiry (270) and use the membership ID returned in the 271 Response.

For detailed information about Subscriber Identification Cards and their corresponding BCBSNC plans, see Section 3 of the BCBSNC Network Management *The Blue Book Provider Manual* at <http://www.bcbsnc.com/content/providers/blue-book.htm> . If you do not have a copy of the manual, see your BCBSNC Network Management representative or call the BCBSNC BlueLine Customer Support at 1-800-214-4844. For Blue Medicare Advantage products, use the Blue Provider Manual for Medicare Advantage, available at [www.bcbsnc.com](http://www.bcbsnc.com)

**Claim Identifiers**

BCBSNC issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or Claim Control Number (CCN). It is provided to senders in the Claims Audit Report and in the CLP segment of an 835 transaction. When submitting for a claim adjustment, this number should be submitted in the Original Reference Number (ICN/DCN) segment, 2300 Loop, REF02.

BCBSNC returns the submitter’s Patient Account Number (2300,CLM01) on the proprietary Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

**Claim Filing Indicator Code**

The Claim Filing Indicator Code identifies the type of claim being filed. BCBSNC requires that the first instance of this code (2000B, SBR09) within the 2000B looping structure be either a value of BL (Blue Cross/Blue Shield) or ZZ (Mutually Defined – for subscribers covered under the State Employee Health Plan).

**Edits and Reports**

Incoming claims are reviewed first for HIPAA compliance and then for BCBSNC business rules requirements. The BCBSNC business edits include security validation at the ST/SE level and the verification of proprietary business requirements. The business rules that define these requirements are identified in the [837 Professional Data Element Table](#) below, and are also available as a comprehensive list in the [837 Professional Claims – BCBSNC Business Edits Table](#) contained in this chapter. Both HIPAA TR3 implementation guide errors and BCBSNC business edit errors are returned on the *BCBSNC Claims Audit Report*. This report is available to direct senders from your electronic mailbox, or to indirect submitters from your clearinghouse or vendor, or online via **Blue e**, in the *837 Claims Error Listing*<sup>1</sup> transaction.

**Reporting**

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control	Invalid Message or Information Invalid Identifier/s Inactive Message Improper Batch Structure	TA1 (Negative)
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide Violations Unauthorized submission	999 * (Negative) <i>BCBSNC Claims Audit Report</i> (a proprietary confirmation and error report)

<sup>1</sup> The *837 Claims Denial Listing*, available on **Blue e**, is an additional report that provides information about denied claims. Note that this report does not include errors about Medicare product claims.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
Detail Segments	BCBSNC Business Edits (see <a href="#">837 Professional Claim BCBSNC Business Edits</a> for details)  Security Validation Messages	<i>BCBSNC Claims Audit Report</i> (a proprietary confirmation and error report)  <i>837Claims Error Listing</i> , available in <b>Blue e</b> only  <i>Claims Status Detail Error Explanation</i> (a proprietary report for Medicare Advantage and Medicare Supplemental Claims only.)

**Error Reporting for 837 Health Care Claims**



**Important Notice:**

1. BCBSNC does not return an unsolicited 277 Response for any 837 Claim.
2. If you are submitting version 5010 claims, but are still receiving version 4010 835 Remittances, a disparity may occur between the data submitted and what can be returned. Examples:
  - Name fields may be truncated on 4010A1 835 for sections where name information is used. (i.e. Insured, Patient, Corrected Name segments.)
  - No Technical Contact PER segments will be on 4010A1 835s
  - The 835 (v.4010) may include the Service Provider Segment even when it is the same as Payee.
  - The 835 (v.4010) does not report original CAS segments on a reversed Corrected claim; they would be bundled into a 'CR' CAS segment.

**Security Validation Messages**

BCBSNC has a variety of edits to ensure the security of data transmission within the Transaction Set or ST/SE portion of a transmission. These security checks or edits are in addition to the verification of identifiers within the Interchange Control envelope and Functional Group. The edits involve validating information that has been exchanged between BCBSNC and its business partners via the Electronic Connectivity Request form and the approval letter returned by BCBSNC to verify security information. These edits stop the processing of a Billing Loop within a transaction set (ST/SE batch), prior to any business edits performed on the detailed segments. Subsequent loops within the transaction set will not be affected if they pass security validation.

The table below provides a list of the messages health care providers may receive in their *BCBSNC Claims Audit Reports* if there are problems with security clearance within a loop of a transaction set. Adjacent to the messages are possible explanations for the edit and suggestions for rectifying it.

Error Code	Security Validation Message	Modification Required
S001	Provider ID (2010AA, NM109) not authorized.	The NPI at the ST/SE level of the transaction (2010AA, NM109) cannot be validated

Error Code	Security Validation Message	Modification Required
S003	Sender ID (ISA06) not authorized for this Provider ID.	No relationship between this NPI (2010AA) and the sender of the transmission (ISA06) has been communicated to BCBSNC. Verify all identifiers as they appear on the Electronic Connectivity Request form to ensure that they are correct.
S004	Provider ID (2010AA, NM109) not authorized for this transaction.	BCBSNC has not authorized this NPI. Verify that you have received a notification letter for the transmission of this specific transaction.

**Security Validation Table for 837 Health Care Claims**

If you believe you have received one of these messages erroneously after verifying the information in question, contact the eSolutions HelpDesk at (919) 765-3514 or (888) 333-8594 or email them at [EDICUSSUP@bcbsnc.com](mailto:EDICUSSUP@bcbsnc.com) .

**Modifying Erred Claims**



**Important Notice**

Submitters must make corrections to erred 837 claims on their own systems and resubmit claims via batch 837 transmission. **Blue e** is available to review erred claims (see the *HIPAA 837 Claims Error Listing*), but not for correction or resubmission of X12 format claims. Only CMS1500 or UB04 claims can be entered or corrected in **Blue e**.

## 837 Professional: Data Element Table

The 837 Professional Data Element Table identifies only those elements within the X12 5010 Technical Report implementation guide that require comment within the context of BCBSNC business processes. The 837 Professional Data Element Table references the guide by loop name, segment name and identifier, element name and identifier. The Data Element Table also references the BCBSNC Business Edit Code Number if there is an edit applicable to the data element in question. The BCBSNC Business Edit Code Numbers appear on the Claims Audit Report, along with a narrative explanation of the edit. For a list of the error messages and their respective code numbers, see [837 Professional Claim Business Edits](#).

The BCBSNC business rule comments provided in this table do not identify if elements are required or situational according to the 837 Professional Implementation Guide. It is assumed that the user knows the designated usage for the element in question. Not all elements listed in the table below are required, but if they are used, the table reflects the values BCBSNC expects to see.

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit or Security Validation Edit Code Number <sup>2</sup>	BCBSNC Business Rules
	BHT	Beginning of Hierarchical Transaction				
			BHT06	Transaction Type Code	P027	BCBSNC processes a value of 31 <u>only</u> for Medicaid submitted claims.
2010AA	NM1	Billing Provider Name				
			NM109	Identification Code	P022 S001	Use the valid NPI that has been registered with BCBSNC.
2000B	SBR	Subscriber Information				
			SBR09	Claim Filing indicator Code	P015	For the first instance of SBR09 within this Hierarchical Level (HL), use a value of BL (Blue Cross/Blue Shield) , except for subscribers covered by State Health Employee Plan, use a value of "ZZ" (Mutually Defined) ..
2010BA	NM1	Subscriber Name				
			NM103 – NM105	Name (Last, First, Middle)	P301	BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.
			NM109	ID Code	P006 P018	BCBSNC uses up to 19 characters. The Member ID Number should appear as it does on the Membership Card. If the first two positions of the Member ID Number are alpha, then the third position must be alpha also.  Member id prefix not valid for DOS.
	DMG	Demographic Information				
			DMG03	Gender Code		BCBSNC uses only the M and F values.
2010BB	NM1	Payer Name				
			NM103	Last Name or Organization Name		Use BCBSNC.

<sup>2</sup> BCBSNC Edit Codes are not returned for Medicare Supplemental or Medicare Advantage products.

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit or Security Validation Edit Code Number <sup>2</sup>	BCBSNC Business Rules
	REF	Billing Provider Secondary Identifier				
			REF02	Reference Identification	P026	For Medicaid subrogated claims only, the Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid.
2010CA	NM1	Patient Name				
			NM103	Last Name or Organization	P337	BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.
2300	CLM	Claim Information				
			CLM05:1	Facility Code Value	P335	A value of "99" (Other Unlisted Facility) is denied, unless the claim is for a Medicare Supplemental or Medicare Advantage product.
			CLM05:3	Claim Frequency Type Code	P340	To indicate a <b>corrected</b> claim, select one of the following values from the National Uniform Billing Data Element Specification Types:  <ul style="list-style-type: none"> <li>• 5 = Late charges only claim</li> <li>• 7 = Replacement of Prior Claim</li> <li>• 8 = Void/Cancel of? Prior Claim</li> </ul> Claims requiring correction should be sent in with a value of "8" to void the claim; the subsequent revised claim should be sent in with a value of "7". A value of "6" is not accepted.
	DTP	Date (Onset of Current Illness/Symptom to Date – LMP)				
			DTP03	Date Time Period	P305 P306	If present, Date of current Illness, Accident, or LMP:  <ul style="list-style-type: none"> <li>• must be valid</li> <li>• cannot exceed the current date</li> <li>• cannot be less than the patient's date of birth.</li> </ul>
	DTP	Date (Disability Begin and Disability End)				
			DTP03	Date Time Period	P336	Disability End Date cannot be prior to Disability Begin Date.
	DTP	Date - Admission				
			DTP03	Date Time Period	P308 P310	<ul style="list-style-type: none"> <li>• Date must be a valid date</li> <li>• When a Facility Code value of 21, 31, 51, or 61 is used on a charge line (CLM05-1 of 2300), Hospitalization Dates cannot be greater than current date or less than the patient's birth date.</li> </ul>

837 Professional Health Care Claim							
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit or Security Validation Edit Code Number <sup>2</sup>	BCBSNC Business Rules	
2300	DTP	Date - Discharge					
			DTP03	Date Time Period	P309 P310	<ul style="list-style-type: none"> <li>Date must be a valid date</li> <li>When a Facility Code value of 21, 31, 51, or 61 is used on a charge line (CLM05-1 of 2300), Hospitalization Dates cannot be greater than current date or less than the patient's birth date.</li> <li>Hospitalization Discharge Date must be equal to or greater than the Admission Date.</li> </ul>	
2300	HI	Health Care Diagnosis Code					
			HI01:2	Industry Code	P319	Diagnosis Codes from 800 to 995 must be accompanied by a Date of Current Injury (DTP01 equals 439).	
2310B	NM1	Rendering Provider Name					
			NM109	Rendering Provider Name	P346	Rendering Provider ID should ONLY be sent when it is a different number from the Billing Provider NM109 in 2010AA.  See the <a href="#">Rendering Provider</a> section of this document for additional details on using this segment.	
2320	CAS	Claim Level Adjustment					
			CAS02	Monetary Amount	P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.	
	AMT	COB Payer Paid Amount					
			AMT02	Monetary Amount	P331 P345	<ul style="list-style-type: none"> <li>Negative Payer Amounts are denied.</li> <li><b>If filing a secondary or Medicare claim</b>, fill the actual amount paid by the other carrier. Do NOT include deductive, coinsurance, co-payments, or other adjustments in the Payer Paid Amount field.</li> <li>The Paid Amount at the claim level (2320 AMT02) must match the sum of the Paid Amount(s) at the line level (SVD02).</li> </ul>	
	AMT	Remaining Patient Liability					
			AMT02	Monetary Amount	P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.	
2330A	NM1	Other Subscriber Name					
			NM102	Entity Type Qualifier	P004	Use a value of 1 (Person)	

837 Professional Health Care Claim							
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit or Security Validation Edit Code Number <sup>2</sup>	BCBSNC Business Rules	
2400	LX	Service Line					
			LX01	Assigned Number		BCBSNC uses LX01 as a line item control number. Use actual values instead of placeholders for this element in order to receive matching line numbers in the 835 Transaction: 2110 SVC06 and the 2110 REF Service Identification segments responses.	
	SV1	Professional Service					
			SV101:2	Product/Service ID	P005	Newborn charges should <u>not</u> be filed on the mother's claim, but on a separate claim, under the baby's name.	
			SV101:3, 4, 5, and 6	Procedure Modifier	P317	The Procedure Modifier must be consistent with the Procedure Code presented in SV101:2. (For example, modifier values of 80, 81, or 82 [Assistant at Surgery] would be consistent with surgical codes 10000 to 69999 and anesthesia codes 00100-01999.)	
			SV104	Quantity	P322 P323	<ul style="list-style-type: none"> <li>Units should be greater than one (1) when a modifier of "50" is entered.</li> <li>Days or units should be greater than zero (0).</li> </ul>	
	DTP	Date – Service Date					
			DTP03	Date Time Period	P313 P314 P315 P330 P316	<ul style="list-style-type: none"> <li>'From Date' and 'To Date' must be consistent with Hospitalization Dates.</li> <li>The "From Date" must be prior to the "To Date".</li> <li>Service date must not be greater than current date.</li> <li>Earliest Date of Service for all charge lines must not be prior to Patient's Birth date.</li> </ul>	
2420A	NM1	Rendering Provider Identification					
			NM109	Rendering Provider ID	P346	Rendering Provider ID should be sent in this loop <u>ONLY</u> if the number is different from the Rendering Provider NM109 in the 2300 loop, <u>OR</u> no rendering provider NM109 was sent in the 2300 loop and the Rendering Provider ID is different than the Billing Provider ID sent in 2010AA.  See the <a href="#">Rendering Provider</a> section of this document for additional details on using this segment.	
2430	SVD	Line Adjudication Information					
			SVD02	Monetary Amount	P344	The sum of all line level payments and patient responsibility line level	

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit or Security Validation Edit Code Number <sup>2</sup>	BCBSNC Business Rules
						adjustments, must match the claim level payment and patient responsibility adjustments.

## 837 Professional Transaction Sample

The following sample presents three formats for the data contained within an 837 Professional claim:

- a high-level business scenario typical within BCBSNC claims processing
- a data string, illustrating the actual record transmission
- a file map that allows users to see all submitted data elements and their relationship to the entire transaction

### Business Scenario

The Patient is the same person as the Subscriber. The Payer is Blue Cross and Blue Shield of North Carolina. The encounter has been transmitted through a clearinghouse. The Submitter is the clearinghouse.

Data Element	Value
Subscriber/Patient:	Mary B Dough
Subscriber Address:	PO Box 12312, Durham, NC 27701
Sex:	F
DOB:	August 7, 1967
Employer:	Acme, Co.
Group #:	ABC123101
Payer ID Number:	987654321
Member Identification Number	24670389600
Destination Payer:	Blue Cross Blue Shield of North Carolina (BCBSNC)
Payer Address	5901 Chapel Hill Road, Durham, NC 27707
AHLIC #:	987654321
Submitter:	ABC Clearinghouse
Billing Provider:	Elizabeth Smith, MD
Address:	123 Mudd Lane, Durham, NC, 27715
TIN:	123456789
Billing Provider ID	0123456789
Contact Person & Phone Number	Wilma Flintstone 919 555-1111
Patient Account Number:	Ptacct2235057
DOS	8/1/2010
POS	Office
Services Rendered	Office visit
Charges	1 <sup>st</sup> office visit - \$100.50
Total charges	\$100.50

### Data String Example

The following transmission sample illustrates the file format used for an EDI transaction, which includes delimiters and data segment symbols. Note that the sample contains only one ST/SE set within the Functional Group (GS) and only one claim within the ST/SE set. Normally there would be multiple claims within an ST/SE set. For more information about batch sizes, see the [Batch Volume](#) section of this chapter.

This sample contains a line break after each tilde to provide an easy illustration of where a new data segment begins. For more information about BCBSNC file format requests, see Record Format/Lengths in the **Connectivity** section of the *Introduction to the BCBSNC Companion Guide to EDI Transactions*. For more information about the file formats and application control structures, see “Appendix B: ASC X12 Nomenclature” in the ASC X12N 5010 837.

ISA\*00\* \*00\* \*01\*9012345720000 \*01\*9088877320000  
 \*100822\*2\*1134\*U\*00200\*000000007\*0\*T\*~  
 GS\*HC\*901234572000\*908887732000\*20100822\*1615\*7\*X\*005010X222~  
 ST\*837\*0007\*005010X222~  
 BHT\*0019\*00\*123BATCH\*20100822\*1615\*CH~  
 NM1\*41\*2\*ABC CLEARINGHOUSE\*\*\*\*\*46\*123456789~  
 PER\*IC\*WILMA FLINTSTONE\*TE\*9195551111~  
 NM1\*40\*2\*BCBSNC\*\*\*\*\*46\*987654321~  
 HL\*1\*\*20\*1~  
 NM1\*85\*1\*SMITH\*ELIZABETH\*A\*\*M.D.\*XX\*0123456789~  
 N3\*123 MUDD LANE~  
 N4\*DURHAM\*NC\*27701~  
 REF\*EI\*123456789~  
 HL\*2\*1\*22\*0~  
 SBR\*P\*18\*ABC123101\*\*\*\*\*BL~  
 NM1\*IL\*1\*DOUGH\*MARY\*B\*\*\*MI\*24670389600~  
 N3\*P O BOX 12312~  
 N4\*DURHAM\*NC\*27715~  
 DMG\*D8\*19670807\*F~  
 NM1\*PR\*2\*BCBSNC\*\*\*\*\*PI\*987654321~  
 CLM\*PTACCT2235057\*100.5\*\*\*11::1\*Y\*A\*Y\*N~  
 REF\*EA\*MEDREC11111~  
 HI\*BK:78901~  
 LX\*1~  
 SV1\*HC:99212\*100.5\*UN\*1\*12\*\*1\*\*N~  
 DTP\*472\*D8\*20100801~  
 SE\*24\*0007~  
 GE\*1\*7~  
 IEA\*1\*000000007~

## 837 Professional File Map

Loop ID	Segment Name	Segment ID	Elements								
	TRANSACTION SET HEADER	ST	ST01	ST02	ST03						
			837	0007	005010X222~						
	BEGINNING OF HIERARCHICAL TRANSACTION	BHT	BHT01	BHT02	BHT03	BHT04	BHT05	BHT06			
			0019	00	123batch	20100822	1615	CH~			
1000A	Submitter Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
			41	2	ABC Submitter					46	123456789~
1000A	Submitter EDI Contact Information	PER	PER01	PER02	PER03	PER04	PER05	PER06	PER07	PER08	PER09
			IC	Wilma Flintstone	TE	9195551111~					
1000B	Receiver Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
			40	2	BCBSNC					46	9876454321~
2000A	Billing/Pay-To Provider Hierarchical Level	HL	HL01	HL02	HL03	HL04					
			1		20	1~					
2010AA	Billing Provider Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
			85	1	Smith	Elizabeth	A			XX	989898989~
2010AA	Billing Provider Address	N3	N301								
			123 Mudd Lane~								
2010AA	Billing/Provider City/State/Zip Code	N4	N401	N402	N403						
			Durham	NC	27701						
2010AA	Billing Provider Tax Identification	REF	REF01	REF02							
			EI	123456789							
2000B	Subscriber Hierarchical Level	HL	HL01	HL02	HL03	HL04					
			2	1	22	0~					
2000B	Subscriber Information	SBR	SBR01	SBR02	SBR03	SBR04	SBR05	SBR06	SBR07	SBR08	SBR09
			P	18	ABC123101						BL~
2010BA	Subscriber Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
			IL	1	Dough	Mary	B			MI	246703896

Loop ID	Segment Name	Segment ID	Elements																		
																					00
2010BA	Subscriber Address	N3	N301																		
			POBox 12312~																		
2010BA	Subscriber City/State/Zip Code	N4	N401	N402	N403	N404															
			Durham	NC	27715																
2010BA	Subscriber Demographic Information	DMG	DMG01	DMG02	DMG03																
			D8	19670807	F~																
2010BB	Payer Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109										
			PR	2	BCBSNC														PI	987654321	
2300	Claim Information	CLM	CLM01	CLM02	CLM03	CLM04	CLM05	CLM06	CLM07	CLM08	CLM09										
			Ptacct22350 57	100.5			11::1	Y	A	Y	N										
2300	Claim Identification No. For Clearing Houses and Other Transmission Intermediaries	REF	REF01	REF02																	
			EA	Medrec11111 ~																	
2300	Health Care Diagnosis Code	HI	HI01	HI02																	
			BK:	78901~																	
2400	Service Line	LX	LX01																		
			1~																		
2400	Professional Service	SV1	SV101	SV102	SV103	SV104	SV105	SV106	SV107	SV108	SV109										
			HC:99212	100.5	UN	1	12														
2400	Date - Service Date	DTP	DTP01	DTP02	DTP03																
			472	D8	20100801~																
	TRANSACTION SET TRAILER	SE	SE01	SE02																	
			24	0007~																	

## Appendix: BCBSNC Business Edits for the 837 Health Care Claim

The following proprietary error codes and messages are returned via the Claims Audit Report. The Claims Audit Report can be accessed from your electronic mailbox for direct submitters, or online, via **Blue e** (<https://providers.bcbsnc.com/providers/login.faces>) - see the *837 Claim Denial Listing*.

**Important Note:** These error codes are not returned for Medicare Advantage or Medicare Supplemental claims.

Error Code*	Explanation Message	837 Professional Cross-references <sup>3</sup>
P004	When Other Insured's Entity Code (NM101) = IL, Entity Qualifier must equal '1'.	2330A, Other Subscriber Name, NM102
P005	Newborn charges should not be filed on the Parent's claim. They should be filed separately under the baby's name and Member ID.	2400, Professional Service, SV101:2
P006	Member ID must be valid. (Valid ID is an exact representation of that on the Membership ID Card.)	2010BA, Subscriber Name, NM109
P015	The first occurrence of Claim Filing Indicator must be BL or ZZ.	2000B, Subscriber Information, SBR09
P018	Member ID prefix not valid for Date of Service (DOS).	2010BA, Patient Name, NM109
P022	An issue was found with the submitted NPI. An EDI representative will contact you with further information.	2010AA, Provider ID, NM109
P026	Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid for Medicaid submitted claims.	2010BB, Provider ID, REF02
P027	Medicare Advantage/Medicare Supplement Member ID is invalid. Please correct and resubmit.	2010BA, Member ID, NM109
P028	Negative Service Line Paid Amount invalid.	2430, Service Line Paid Amount, SVD02

<sup>3</sup> This column is cross-referenced to the 837 Professional (005010X222) and Companion Guide Data Element Table. The Cross Reference provides TR3 (Technical Report, Type 3) Loop ID, Segment Name, and the segment ID/element number combined (e.g. NM102).

\*A disruption in the numbering of the Error Codes indicates the removal of an error that previously existed.

Error Code *	Explanation Message	837 Professional Cross-references <sup>3</sup>
	BREAK IN ERROR MESSAGE NUMBERING for 837P	
P301	Invalid Subscriber Name as submitted. Contains special characters other than dashes, apostrophes, spaces or periods.	2010 BA, Subscriber Name, NM103
P310	If a Facility Code Value of 21, 31, 51 or 61 (CLM05-1) is used on a charge line, Hosp. Dates cannot be greater than current date or less than patient's DOB.	2300, Date- Admission or Date Discharge, DTP03
P313	From Date inconsistent with Hospitalization dates.	2400, Date – Service Date, DTP03
P314	To Date inconsistent with Hospitalization dates.	2400, Date – Service Date, DTP03
P315	To Date prior to From Date.	2400, Date – Service Date, DTP03
P316	Earliest Date of Service for all charge lines must not be prior to Patient's Birth Date.	2400, Date – Service Date, DTP03
P317	Modifier is equal to '80', '81', '82' (assistant at surgery) and is inconsistent with a non-surgical procedure code.	2400, Professional Service, SV101:3
P319	Accident Diagnosis Codes [800-995] require Date of Onset (DTP01 =431) or Date of Current Injury (DTP01 = 439).	2300, HC Diagnosis Code, HI01:2 in reference to 2300, Date of Onset, <u>or</u> Accident Date, <u>or</u> 2300 LMP, DTP01
P322	Units must be greater than one (1) when a Modifier of '50' is entered.	2400, Professional Service, SV104
P323	Days or Units must be numeric and greater than zero.	2400, Professional Service, SV104
P329	Hospitalization Discharge Date must be equal to or greater than the Admission Date.	2300, Date – Discharge, DTP03
P330	Service Date cannot be greater than current date.	2400, Date – Service, DTP03
P331	Negative Payer Amount Paid invalid.	2320, Payer Amount Paid, AMT02
P335	Facility Type Code 99 invalid for BCBSNC business.	2300, Facility Type Code, CLM05-1

Error Code *	Explanation Message	837 Professional Cross-references <sup>3</sup>
P336	Disability End Date cannot be prior to Disability Begin Date.	2300, Date – Disability Begin, DTP03 and p. 203, 2300, Date- Disability End, DTP03.
P337	Invalid Patient Name as submitted – contains special characters other than dashes, apostrophes, spaces or periods.	2010CA, Patient Name, NM103 and/or NM104.
P340	Claim Frequency Type Code of "6" is not accepted.	Claim Information, 2300 CLM05-3, p. 173
P341	E-code cannot be the primary diagnosis code.	Health Care Diagnosis Code, 2300 HI01-2 (when HI01-1 = BK
P342	NPI submitted is not registered with BCBSNC.	Rendering Provider Name, 2310B or 2430A, NM109; Rendering Provider Identification Code
P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.	COB Payer Paid Amount, 2320, AMT02 (when AMT01=D); Line Adjudication Information, 2430, SVD02 , 2320 and 2430: CAS01=PR and AMT01=EAF,
P345	The Paid Amount at the claim level must match the sum of the Paid Amount(s) at the line level.	COB Payer Paid Amount 2320, AMT02 (when AMT01=D); Line Adjudication Information 2430, SVD02

## Document Change Log

The following change log identifies changes that have been made to the Companion Guide for 5010 837 Professional Health Care Claim transactions (originally published to the EDI Web site October 2010).

Chapter Section	Change Description	Date of Change	Version
<a href="#">Claims Processing</a>	Addition of Corrections and Reversals section	10/22/10	1.1
	Addition of Medicare Advantage and Medicare Supplemental Claims processing Information	01/2011	2
<a href="#">Appendix</a>	Removal of business edits redundant with validator edits.	01/2011	2.1
<a href="#">Data Element Table</a>	Clarification of conditions for sending the Rendering Provider ID (Loops 2310B and 2420A, NM109)	04/2011	2.2
<a href="#">Appendix</a>	Addition of P027	05/2011	2.3
<a href="#">Appendix</a>	<ul style="list-style-type: none"> <li>Addition of P028 – effective November 2011</li> <li>Removal of references to 997 Acknowledgements, which will not be returned</li> </ul>	10/2011	2.4