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Chapter 2:

837 – Professional Health Care Claim

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. The chapter contains three sections:

- a general section with material 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 Implementation Guides 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

TA1 and 997 Acknowledgements are returned at the Interchange Control Level, upon receipt of a batch transmission. Note that the TA1 and 997 Transactions may also be used to provide error messages. See the [Reporting](#) Section below for more information.

Anesthesia Billing

BCBSNC accepts nationally recognized code sets for anesthesia services and no longer requires 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/providers/contacts.cfm> or in your BCBSNC Network Management copy of *The Blue Book: Physician Office Guide*.

Batch Volume

While the HIPAA Implementation Guides allow up to 5000 claims per ST/SE Transaction Set of a transmission, BCBSNC strongly recommends limiting the number of claims per ST/SE Set to 1000.

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:

Processing for claims requiring coordination of benefits has changed. 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 Notice of Payment (NOP). **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 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.

Consistent with the specifications of the 837 Professional Implementation Guide, BCBSNC advises that no decimal point be used for diagnosis codes. The decimal point is assumed.

Corrected Claims

Corrected claims should be filed electronically, using either a value of 5, 7, or 8 in the 2300 Loop, CLM05:3. The values are from the *National Uniform Billing Data Element Specifications*, and reflect specifications made by the 837 Professional Claim - Addenda to Version 4010.

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) 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 200706262115 defines the date and time of June 26, 2007 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; a patient's "Admission Date" must not be after the "Statement Covers From Date".

Decimals

No decimals should be used in a diagnosis code.

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.

Field Length

HIPAA regulations specify field lengths for all of the data elements of the 837 Professional Health Care Claim transaction. For some of these data elements, BCBSNC processes fewer characters than the maximum allowed. The [837 Professional: Data Element Table](#), presented below, identifies any BCBSNC field length specifications.

Identifiers

Identifiers, such as the Federal Tax ID or Social Security Numbers, should be transmitted without dashes or hyphens.

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 4:30 p.m. to make the last processing cycle of the day.

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

The Centers for Medicare and Medicaid Services (CMS) have mandated the use of an NPI, to replace all proprietary identifiers, by May 23, 2008. Providers must register their NPI number with BCBSNC. For more information, contact your BCBSNC Network Management field consultant. For contact information, see <http://www.bcbsnc.com/providers/contacts.cfm>.

After May 23, 2008, 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 and AB Loop level. See the [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.

Per BCBSNC policy, 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.

Billing or Pay-to Provider

The Billing or Pay-to Provider Primary Identifier should be the group/organization ID of the billing entity. This will be a Type 2 (Group) NPI unless the Billing provider is a Sole Proprietor and only received a Type 1 (Individual) NPI.

Rendering Provider

BCBSNC does not require Rendering Provider identifiers (REF02 or NM109 of Loop 2310B or 2420A).



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. 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.

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.

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 three (3) character alpha prefix, followed by either a nine (9) or eleven (11) digit number. Some exceptions are employees of the State of North Carolina, who do not have an alpha prefix on their cards, and 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.

For detailed information about Subscriber Identification Cards and their corresponding BCBSNC plans, see Section 3 of the BCBSNC Network Management *The 2007 Provider Manual*. If you do not have a copy of *The 2007 Provider Manual*, see your BCBSNC Network Management representative or call the BCBSNC BlueLine Customer Support at 1-800-214-4844.

Claim Identifiers

BCBSNC issues a claim identification number upon receipt of any submitted claim. The ASC X12 Implementation Guides 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).

HIPAA Implementation Guide and Business Edits

Incoming claims are reviewed for HIPAA compliance and BCBSNC business rules. BCBSNC applies business edits to the incoming claims after the transmission has been reviewed for HIPAA Implementation Guide errors. 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](#) contained in this chapter. The BCBSNC business edits for the 837 Professional Health Care Claim are in Appendix B of the Companion Guide, available online at www.bcbsnc.com/providers/edi/hipaainfo.cfm. Effective December 15, 2004, all HIPAA Implementation Guide errors and BCBSNC business edit errors and explanations are returned on the *BCBSNC Claims Audit Report*. This report is available to direct senders from their electronic mailbox, or to indirect submitters from their clearinghouse or vendor.

Reporting

The following table indicates which transaction or report 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
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide Violations	997 BCBSNC Claims Audit Report (effective 12/15/04)
Detail Segments	BCBSNC Business Edits (see 837-Professional Claim: Data Element Table for details) Security Validation Messages	BCBSNC Claims Audit Report (a proprietary confirmation and error report) ¹

Error Reporting for 837 Health Care Claims

¹ The *837 Denial Listing*, available on **Blue e**, also provides information about denied claims.

**Important Notice:**

BCBSNC does not return an unsolicited 277 Response for any 837 Claim.

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 or Pay-to Provider 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 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 or AB, NM109) not authorized.	The NPI at the ST/SE level of the transaction (2010AA or AB, NM109) cannot be validated
S002	Provider ID (2010AA or AB, NM109) not authorized for production.	Business partners receive a letter from eSolutions that authorizes them for either test or production transmission of the transaction in question. Verify the batch ID numbers as presented on this letter and the authorization to send a production transmission, or resubmit as a test.
S003	Sender ID (ISA06) not authorized for this Provider ID.	No relationship between this NPI and the sender of the transmission 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 or AB, 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.
S005	Provider ID (2010AA or AB, NM109) not authorized for this connectivity mode.	The Electronic Connectivity Request form completed by the provider has identified a different mode of connectivity than was set up in security. Verify the correct connectivity mode to be used.
S006	Transaction not authorized for this date.	The authorization date on the notification letter is inconsistent with that on the transmission. Verify the transaction effective date on the approval letter.

Security Validation Table

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.

837 Professional: Data Element Table

The 837 Professional Data Element Table identifies only those elements within the X12N Implementation Guide that require comment within the context of BCBSNC business processes. The 837 Professional Data Element Table references the Implementation Guide by loop name, segment name and identifier, element name and identifier, and page number. 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 **Appendix B: 837 Professional Business Edits** of the *BCBSNC Companion Guide to EDI Transactions*. **Appendix B** can be downloaded from www.bcbsnc.com/providers/edi/hipainfo.cfm.

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 Code Number	BCBSNC Business Rules	
	BHT	Beginning of Hierarchical Transaction (p. 63)					
			BHT04	Date	P009	The creation date must be a valid date and not greater than the current date.	
1000A	NM1	Submitter Name (p. 67)					
			NM109	Identification Code		Use the Submitter's Federal Tax Identifier.	
1000B	NM1	Receiver Name (p. 74)					
			NM109	Identification Code		BCBSNC's Federal Tax Identification Number.	
2000A	CUR	Foreign Currency Information (p. 82)					
			CUR02	Currency Code	P008	Currency code value should be USD.	
2010AA	NM1	Billing Provider Name (p. 84)					
			NM108	Identification Code Qualifier		XX	
			NM109	Identification Code		The Federal Tax ID or Social Security Number <u>must</u> be sent in the <u>first</u> occurrence of the REF02, according to IG regulations. See REF segment below. NOTE: IF you are both the sender (ISA06) of the transmission <u>and</u> the Billing Provider, AND your ISA06 value has been modified by BCBSNC to include an alpha suffix, do <u>not</u> send the alpha suffix in this NM109. For BCBSNC processing, this NM109 should not exceed 9 characters in length.	
	REF	Billing Provider Secondary Identification (p. 91)					
			REF01	Reference Identification Qualifier	S001	Use either "EI" or "SY".	

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules
			REF02	Reference Identification	S001 P026	Use the Employer ID No. or the Social Security Number. Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid for Medicaid submitted claims.
2010AB	NM1	Pay-to-Provider Name				
			NM108-9	Identification Qualifier and Code		See NM108 and NM109 for Billing Provider Name, above.
2010AB	REF	Pay-To Provider Secondary Identification (p. 106)				
			REF01 -2	Reference Identification Qualifier and ID	S001 P020 P021 P022 P026	See REF01 and REF02 for Billing Provider Secondary Identification, above.
2000B	SBR	Subscriber Information (p.110)				
			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) or a value of "ZZ" (Mutually Defined) if the subscriber is covered by State Health Employee Plan.
2010BA	NM1	Subscriber Name (p. 117)				
			NM102	Entity Type Qualifier	P003	When Subscriber's Name Qualifier (NM101) equals "IL", the Entity Type Qualifier must equal "1".
			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 P023 P024 P025	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. Member ID prefixes of YPF, YPW, or YPJ (Medicare PPO or HMO members) should file claims with Partners National Health Plan. See Appendix B for full edit.
	DMG	Demographic Information (p. 124)				
			DMG02	Subscriber's Birth Date	P002 P303	The Subscriber's Birth Date must contain a valid date that is not greater than the current date.
			DMG03	Gender Code		BCBSNC uses only the M and F values.
2010BB	NM1	Payer Name (p.130)				
			NM103	Last Name or Organization Name		Use BCBSNC.
2010BC	NM1	Patient Name (p.135)				
			NM109	Patient Identifier		Member's ID must be valid for Date of Service.

837 Professional Health Care Claim							
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules	
2010CA	NM1	Patient Name (p. 158)					
			NM102	Entity Qualifier		When NM1 01 equals "IL" (for 2010BA, Subscriber Name) or "QC" (Patient Name), NM1 02 (Entity Qualifier) must equal "1" (Person).	
			NM103	Last Name or Organization	P337	BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.	
			NM109	Membership ID	P017 P018 P023 P024 P025	Patient's member id must be valid. Member id prefix not valid for DOS. Member ID prefixes of YPF, YPW, or YPJ (Medicare PPO or HMO members) should file claims with Partners National Health Plan. See Appendix B for full edit.	
	DMG	Demographic Information (p. 164)					
			DMG02	Patient's Birth Date	P016	The Patient's Birth Date must contain a valid date that is not greater than the current date.	
			DMG03	Gender Code		BCBSNC uses only the M and F values.	
2300	CLM	Claim Information (p. 170)					
			CLM01	Claim Submitter's Identifier		This should be the patient's account number and is used as the Control Number for return on the 835 Claim Payment/Advice.	
			CLM02	Monetary Amount	P011	Negative amounts are denied.	
			CLM05:1	Facility Code Value	P335	<ul style="list-style-type: none"> • A value of "99" (Other Unlisted Facility) is denied. 	
			CLM05:3	Claim Frequency Type Code	P340	<p>To indicate a corrected claim, select one of the following values from the National Uniform Billing Data Element Specification Types:</p> <ul style="list-style-type: none"> • 5 = Late charges only claim • 7 = Replacement of Prior Claim • 8 = Void/Cancel or Prior Claim <p>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.</p>	

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules
	DTP	Date (Onset of Current Illness/Symptom to Date – LMP) (p. 189 - 196)				
			DTP03	Date Time Period	P304 P305 P306 P307	If present, Date of current Illness, Similar Illness, Accident, or LMP: <ul style="list-style-type: none"> • must be valid • cannot exceed the current date • cannot be less than the patient's date of birth.
	DTP	Date (Disability Begin and Disability End) (p. 201, 203)				
			DTP03	Date Time Period	P336	Disability End Date cannot be prior to Disability Begin Date.
	DTP	Date - Admission (p. 209)				
			DTP03	Date Time Period	P308 P310	<ul style="list-style-type: none"> • Date must be a valid date • 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. <p>NOTE: Use the earliest date of service on the claim as the "Date-Admission" for any service that is rendered in an inpatient setting (CLM05-1, Facility Code = 21, 31, 51, or 61) and requires a "Date-Admission" per HIPAA Implementation Guide regulations.</p>

837 Professional Health Care Claim							
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules	
2300	DTP	Date - Discharge (p. 211)					
			DTP03	Date Time Period	P309 P310	<ul style="list-style-type: none"> Date must be a valid date 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. Hospitalization Discharge Date must be equal to or greater than the Admission Date. <p>NOTE: Use the latest date of service on the claim as the "Date- Discharge" for any service that is rendered in an inpatient setting (CLM05-1, Facility Code = 21, 31, 51, or 61) and requires a "Date-Admission" per HIPAA Implementation Guide regulations.</p>	
2300	HI	Health Care Diagnosis Code (p. 265)					
			HI XX	Entire Segment	P333	<ul style="list-style-type: none"> Do not transmit decimal points in the diagnosis codes. The decimal point is assumed. A diagnosis code (HI0X:2) is required for processing 	
			HI01:2	Industry Code	P319	<ul style="list-style-type: none"> BCBSNC processes only the first 4 diagnosis codes submitted. Diagnosis Codes from 800 to 995 must be accompanied by a Date of Current Injury (DTP01 equals 439). 	
2310A	NM1	Referring Provider Name (p. 283)					
			NM101	Entity Identifier Code		Entity Identifier Code should equal "DN" – the Referring Provider.	
2310B	NM1	Rendering Provider Identification (p. 290)					
			NM109	Rendering Provider ID		See the Rendering Provider section of this document for details on using this segment.	
2310B	REF	Rendering Provider Secondary Identification (p. 296)					
			REF01	Reference Identification Qualifier		If you use this loop, use the "1B" value.	
2320	SBR	Other Subscriber Information (p.321)					
			SBR09	Claim Filing Indicator Code		Use a value of ZZ (Mutually Defined) only to indicate State Health Employee Plan coverage.	
	AMT	COB Payer Paid Amount (p. 332)					
			AMT01	Amount Qualifier Code		AMT01= D (Payer Amount Paid)	
			AMT02	Monetary Amount	P331 P345	<ul style="list-style-type: none"> Negative Payer Amounts are denied. If filing a secondary or Medicare claim, fill the actual amount paid by 	

837 Professional Health Care Claim							
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules	
						the other carrier. Do NOT include deductive, coinsurance, co-payments, or other adjustments in the Payer Paid Amount field. <ul style="list-style-type: none"> The Paid Amount at the claim level (2320 AMT02) must match the sum of the Paid Amount(s) at the line level (SVD02). 	
	AMT	COB Approved Amount (p. 333)					
			AMT01	Amount Qualifier Code		AMT01= AAE (COB Approved Amount)	
			AMT02	Monetary Amount	P344	<ul style="list-style-type: none"> Either the approved amount or allowed amount at the claim level must match the total of all line level approved amounts. 	
	AMT	Coordination of Benefits (COB) Allowed Amount (p. 334)					
			AMT01	Amount Qualifier Code		When filing secondary or Medicare crossover claims, use B6 = Allowed - Actual	
	AMT	Coordination of Benefits (COB) Patient Paid Amount (p339)					
			AMT02	Monetary Amount	P332	Negative Patient Paid Amounts are denied.	
	DMG	Subscriber Demographic Information (p.343)					
			DMG02	Date Time Period	P302	Birth date must contain a valid date and cannot exceed the current date.	
			DMG03	Gender Code		BCBSNC uses only the M and F values.	
2330A	NM1	Other Subscriber Name (p. 351)					
			NM102	Entity Type Qualifier	P004	Use a value of 1 (Person)	
2400	LX	Service Line (p. 398)					
			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 (p. 400)					
			SV101:1	Product/Service ID Qualifier	P010	Use only HC (HCPCS) as the qualifier code.	
			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, and 5	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.)	

837 Professional Health Care Claim						
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rules
			SV102	Monetary Amount	P320 P013	<ul style="list-style-type: none"> Line Charge must not be greater than \$9,999,999.99. Negative line charges are denied.
			SV104	Quantity	P322 P014 P323 P321	<ul style="list-style-type: none"> Units should be greater than one (1) when a modifier of "50" is entered. Negative units are denied. Days or units should be greater than zero (0). Days, units, minutes must not be greater than 9,999,999
	DTP	Date – Service Date (p. 436)				
			DTP03	Date Time Period	P313 P314 P315 P330 P316	<ul style="list-style-type: none"> 'From Date' and 'To Date' must be consistent with Hospitalization Dates. The "From Date" must be prior to the "To Date". Service date must not be greater than current date. Earliest Date of Service for all charge lines must not be prior to Patient's Birth date.
2410	LIN	Drug Identification (See 837-Professional Addenda – X098A1 – p. 72)				
			LIN03	Product/Service ID		Please use the NDC code in 5-4-2 format.
	CTP	Drug Pricing (See 837- 837 Professional Addenda – X098A1 – p. 74)				
			CTP03	Unit Price		Please follow the Addenda IG directions.
			CTP04	Quantity		Please follow the Addenda IG directions.
			CTP05	Composite Unit of Measure		Please follow the Addenda IG directions.
2420A	NM1	Rendering Provider Identification (p. 503)				
			NM109	Rendering Provider ID		See the Rendering Provider section of this document for details on using this segment.
2420A	REF	Rendering Provider Secondary Identification (p. 507)				
			REF01	Reference Identification Qualifier		If you use this loop, use the "1B" value.
			REF02	Reference ID		See the Rendering Provider section of this document for details on using this segment.

837 Professional Transaction Sample

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

- a high-level 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 Billing Provider.

Data Element	Value
Subscriber/Patient:	Mary Dough
Subscriber Address:	PO Box 12312, Durham, NC 27715
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
Billing Provider/Sender:	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	6/1/2007
POS	Office
Services Rendered	Office visit
Charges	1 st 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 A: ASSC X12 Nomenclature” in the ASC X12N 837.

ISA*00* *00* *01*9012345720000 *01*9088877320000
 *020822*1134*U*00200*000000007*0*T*~
 GS*HC*901234572000*908887732000*20070822*1615*7*X*004010X098A1~
 ST*837*0007~
 BHT*0019*00*123BATCH*20070822*1615*CH~
 REF*87*004010X098A1~
 NM1*41*1*SMITH*ELIZABETH*A***XX*0123456789~
 PER*IC*WILMA FLINTSTONE*TE*9195551111~
 NM1*40*2*BLUE CROSS AND BLUE SHIELD NC*****46*987654321~
 HL*1**20*1~
 NM1*85*1*SMITH*ELIZABETH*A**M.D.*24*0123456789~
 N3*123 MUDD LANE~
 N4*DURHAM*NC*27701~
 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*20070601~
 SE*24*0007~
 GE*1*7~
 IEA*1*000000007~

837 Professional File Map

Loop ID		Segments	Elements																	
1		TRANSACTION SET HEADER	ST	ST01	ST02															
				837	0007~															
1		BEGINNING OF HIERARCHICAL TRANSACTION	BHT	BHT01	BHT02	BHT03	BHT04	BHT05	BHT06											
				0019	00	123batch	20070822	1615	CH~											
1		TRANSACTION TYPE IDENTIFICATION	REF	REF01	REF02															
				87	004010X098A 1~															
1	1000A	Submitter Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				41	1	Smith	Elizabeth	A			46	123456789 ~								
1	1000A	Submitter EDI Contact Information	PER	PER01	PER02	PER03	PER04	PER05	PER06	PER07	PER08	PER09								
				IC	Wilma Flintstone	TE	919555111 1~													
1	1000B	Receiver Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				40	2	BCBSNC					46	987645432 1~								
1	2000A	Billing/Pay-To Provider Hierarchical Level	HL	HL01	HL02	HL03	HL04													
				1		20	1~													
1	2010AA	Billing Provider Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109								
				85	1	Smith	Elizabeth	A			XX	989898989 ~								
1	2010AA	Billing Provider Address	N3	N301																
				123 Mudd Lane~																
1	2010AA	Billing/Provider City/State/Zip Code	N4	N401	N402	N403														
				Durham	NC	27701														
1	2000B	Subscriber Hierarchical Level	HL	HL01	HL02	HL03	HL04													
				2	1	22	0~													

Loop ID		Segments		Elements								
1	2000B	Subscriber Information	SBR	SBR01	SBR02	SBR03	SBR04	SBR05	SBR06	SBR07	SBR08	SBR09
				P	18	ABC123101						BL~
1	2010BA	Subscriber Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
				IL	1	Dough	Mary	B			MI	24670389600
1	2010BA	Subscriber Address	N3	N301								
				POBox 12312~								
1	2010BA	Subscriber City/State/Zip Code	N4	N401	N402	N403	N404					
				Durham	NC	27715						
1	2010BA	Subscriber Demographic Information	DMG	DMG01	DMG02	DMG03						
				D8	19670807	F~						
1	2010BB	Payer Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109
				PR	2	BCBSNC					PI	987654321~
1	2300	Claim Information	CLM	CLM01	CLM02	CLM03	CLM04	CLM05	CLM06	CLM07	CLM08	CLM09
				Ptacct22350 57	100.5			11::1	Y	A	Y	N
1	2300	Claim Identification No. For Clearing Houses and Other Transmission Intermediaries	REF	REF01	REF02							
				EA	Medrec11111~							
1	2300	Health Care Diagnosis Code	HI	HI01	HI02							
				BK:78901~								
1	2400	Service Line	LX	LX01								
				1~								
1	2400	Professional Service	SV1	SV101	SV102	SV103	SV104	SV105	SV106	SV107	SV108	SV109
				HC:99213	100.5	UN	1	12		1		N~
1	2400	Date - Service Date	DTP	DTP01	DTP02	DTP03						
				472	D8	20070601~						
1		TRANSACTION SET TRAILER	SE	SE01	SE02							
24				24	0007~							

Document Change Log

The following change log identifies changes that have been made from version 1.0 (published to the EDI Web site April 2003) of *Chapter 2: 837 Health Care Claim - Professional*.

Chapter Section	Page Number	Change Description
Claims Processing: Anesthesia Billing	1	The following line was added to this section: "BCBSNC accepts nationally recognized code sets for anesthesia services and no longer requires the surgical CPT code on a claim for anesthesia services."
Security Validation Table	5	The Loop, Segment, and Element identifier was added to each error message description. See table for details.
Data Format: Decimals	2	Dollar amounts must contain no more than 2 positions when a decimal point is used.
Data Element Table	7	The following element was added to the table: 2010AA, NM109 (Identification Code) - Use the nine-digit Employee ID or Social Security Number. IMPORTANT NOTE: IF you are both the sender (ISA06) of the transmission <u>and</u> the Billing Provider, AND your ISA06 value has been modified by BCBSNC to include an alpha suffix, do <u>not</u> send the alpha suffix in this NM109. For BCBSNC processing, this NM109 should not exceed 9 characters in length.
Data Element Table	8, 8, 10, 8	Added the following BCBSNC Business Error Codes: P016, P017, P336, P337. Removed the BCBSNC Business Error Code P019.
Data String Example	13	Modifications were made to the following data segments: 2000B, SBR; 2300, CLM; 2400 SV1; SE02
Data Element Table	10	Removal of reference to BCBSNC Business Edit P326, referencing the use of qualifier 1B. This edit has been deleted.
Data Element Table	8	Removal of reference to Pay-to Provider Name as a redundancy of the Implementation Guide; inclusion of 2010AB label for the loop.
Provider Identifiers	3	Added references to Referring Provider; extended description of Billing/Pay-to Provider Identifier.
Data Element Table	9	Added reference to 2300, CLM05:3 – Claim Frequency Type Code
Business Scenario	12	Modified the value for Payer ID.

Chapter Section	Page Number	Change Description
Data Element Table	10	Added the Business Edit Reference Number (P338) for REF02 of 2310B loop.
Data Element Table	9	Revised P329 edit language for DTP03 – Hospitalization Discharge Date must be greater than or equal to Admission Date.
Data Element Table	11	Removed P318 edit reference for SV101:3 - Use a modifier value of “26” only for Labs, X-rays, and some diagnostic tests. This edit is removed as of 3/13/04.
Data Element Table	11	Modified annotation for elements SV101:3, 4, and 5.
Data Element Table and Provider Identifiers: Rendering Provider	4 and 10	Modified annotation for 2310B, REF02 – the first occurrence of the Rendering Provider Secondary Identification must be the BCBSNC Provider Number, for proper processing.
Data Element Table	9	Revised P329 edit language for DTP03 – Hospitalization Discharge Date must be <u>equal to or greater than</u> Admission Date.
Data Element Table	9	From CLM05:03, removed the code type “6” which is no longer in use.
Data Element Table	11	Amount of “days, units, or minutes” modified from “10,000” to 1,000.
Data Element Table	9	Edit P007 removed (relevant to 2300 Loop , CLM02)
Data Element Table	11	Edit P320 removed (relevant to 2400 Loop, SV102)
Data Element Table	11	Edit P321 modified to “not greater than 9,999,999” (relevant to 2400 Loop, SV104)
Data Element Table	10	Edit P324 removed (relevant to 2300 Loop, AMT02)
Data Element Table	10	Edit P328 removed (relevant to 2320 Loop, AMT02)
Security Validation	6	A modification to clarify that only claims within the same Billing or Pay-to Provider loop containing a security validation edit error are rejected. Other claims within the same transaction set that do not contain security validation errors continue to pass through additional business edits, and if successful, pass through to adjudication.
Billing/Pay-to Provider	4	Added clarification that either the Billing or Pay-to Provider segments (2010AA or 2010AB) can be used for the BCBSNC Provider ID, until the NPI is instituted.
Data Element Table	10	Reference to 2300 REF02 (Prior Authorization or Referral Number) removed.
Data Element Table	11	Reference to Business Edit P320 entered for value SV102 in the 2400 loop (line charges).
Data Element Table	9, 10	Addition of Business Edit P339 for value DTP03 (both Admission and Discharge Date Segments) of the 2300 Loop. Clarification of the edit is contained in the note.
Data Element Table	9	Addition of Business Edit P340 (for CLM05-3 of the 2300 Loop), effective as of December 11, 2004.

Chapter Section	Page Number	Change Description
Batch Volume	1	Removed reference to batch rejection of claims containing Implementation Guide errors.
Data Element Table	13	Additional comments added to 2420A Rendering Provider REF01.
Provider Identifiers	3	Addition of the 2420A Rendering Provider qualifier information
Reporting	4-5	Changes to reflect the change to claim level rejection, rather than batch level rejection, when claims contain HIPAA Implementation Guide Errors.
Data Element Table	11	Removal of requirement for LMP DTP for pregnancy-related diagnosis codes in the reference to BCBSNC business edit P319.
Data Element Table	multiple	Removal of references to P339 and P334 for 2010 AA/AB NM 109 & REF02, and 2300 DTP segments; Addition of references to NPI acceptance.
Provider Identifiers	3	Addition of NPI (National Provider Identifier) information
Data Element Table		Added P018 Edit for 2010BA and 2010CA
Data Element Table		Added business edit numbers P018-P022 and P342-3; Deleted P327
Data Element Table		Added business edit numbers P344 and P345 – effective for July 2007
Billing or Pay-to Provider	4	Added advice about types 1 and 2 NPI use.
Rendering Provider		Revised requirements for using the REF02 and NM109 elements for Rendering Providers
Data Element Table		V6.3 Addition of the LIN and CTP segments for Drug information - Loop 2410.
Data Element Table		Added edits P023, P024, P025 – Filing Medicare HMO and PPO claims with Partners National Health Plan
Data Element Table		Removed P343 and P342
Data Element Table	8	Changed description of code P018.
Data Element Table	9	Changed description of code P018.
Data Element Table	9	Changed description of code P017.
Data Element Table	11	Removed P338.
Global		Removed all references to BCBSNC Proprietary Identifier and removed requirements of the REF segments for proprietary identifiers.
Global		Changed “customer support” to “eSolutions HelpDesk”.