



BlueCross BlueShield of North Carolina

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Medicare Advantage Companion Guide to X12 Transactions Version 4010

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Introduction to the Companion Guide for Medicare Advantage Products

Overview

Purpose

This Companion Guide provides BCBSNC Blue Medicare trading partners with guidelines for submitting electronic batch (X12) transactions for Medicare Advantage products only. For guidelines about submitting X12 transactions for other product lines, please see the [Companion Guides for HIPAA](#) implementation at www.bcbsnc.com.

The guide uses 'BCBSNC' to refer to BCBSNC Blue Medicare Products. Blue Medicare HMO and Blue Medicare PPO plans are administered by BCBSNC, an independent licensee of the Blue Cross and Blue Shield Association. All qualified Medicare beneficiaries may apply. BCBSNC does not discriminate based on color, gender, religion, national origin, age, race, disability, handicap, sexual orientation, genetic information, source of payment or health status as defined by the Centers for Medicare & Medicaid Services (CMS). Members must be entitled to Medicare Part A and enrolled in Medicare Part B and must reside in the CMS-approved service area. Members must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or another third party.

This Companion Guide documents any assumptions, conventions, or data issues that may be specific to BCBSNC business processes when implementing the HIPAA ASC X12N Implementation Guides. As such, this Companion Guide is unique to BCBSNC.

This document does NOT replace the HIPAA ASC X12N Implementation Guides for EDI transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of BCBSNC. This document provides information on BCBSNC specific code handling and situation handling that is within the parameters of the HIPAA Administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure and content. Information contained within the HIPAA Implementation Guides (IGs) has not been repeated here although the IGs have been referenced when necessary.

This Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between BCBSNC and its trading partners. Refer to the TPA for guidelines pertaining to BCBSNC legal conditions surrounding the implementation of the EDI transactions and code sets. Refer to the Companion Guide for information on BCBSNC business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. **If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.**

Content

The BCBSNC Companion Guide to HIPAA Transactions contains an Introduction chapter, and a chapter for each ASC X12N transaction used by BCBSNC. Each of the transaction chapters in

this document contains one or more tables that explain BCBSNC business rules within the context of the HIPAA ASC X12N Implementation Guides. The tables reference the Loop, Segment, and Element designations of the Implementation Guides so that users can easily access the relevant sections of the guides as needed.

Term Usage

The Companion Guide's usage of ASC X12N Transaction terms complies with the description of terms as presented in *Appendix A (ASC X12N Nomenclature)* of each ASC X12N Implementation Guide for Transaction and Code Set rules. Definitions are also given in *Section 3 (Transaction Set)* of each ASC X12N Implementation Guide. Please refer to the HIPAA Implementation Guides for definitions of terms.

Terms used in this Companion Guide that are specific to BCBSNC will be defined as presented within each transaction chapter or included in the Glossary section.

Contact Information

eSolutions

eSolutions supports applications for the electronic exchange of health care claims, remittance, enrollment, and inquiries and responses. eSolutions also provides support for health care providers and clearinghouses that conduct business electronically. If you are already submitting Medicare Advantage products electronically, and need assistance, contact the Blue Medicare Advantage HelpDesk at 1-888-310-4110.

Requests for Service

Health care providers or clearinghouses wishing to transmit electronic transactions directly with BCBSNC must sign a Trading Partner Agreement and submit the original copy to eSolutions. The Trading Partner Agreement establishes the legal relationship between BCBSNC and the trading partner. Health care providers who submit their transmissions indirectly to BCBSNC, via a clearinghouse, do not need to complete the Trading Partner Agreement, but are required to fill out an Electronic Connectivity Form.

The following procedures should be followed to obtain the Electronic Connectivity Form:

1. The health care provider calls BCBSNC Customer Services at 1-888-310-4110 and makes the request to be set up for electronic submission. The health care provider will need to supply a contact name, phone number, email address and Tax-ID.
2. An email containing an electronic form will then be emailed or faxed to the health care provider, which can be filled out electronically. The form will then need to be printed, must be signed, and the hard copy returned to BCBSNC eSolutions by mail or fax.
3. Once the form is received containing all the required information, the health care provider will be set up in the BCBSNC System to submit electronically.
4. After successful set up, the Provider will be emailed or faxed a confirmation letter.

eSolutions requires 8-10 business days to complete the set up process.

Companion Guide

This Medicare Advantage companion guide is available for all BCBSNC trading partners via the BCBSNC Web site, <http://www.bcbsnc.com/providers/blue-medicare-providers> or by calling the Medicare Advantage HelpDesk at 1-888-310-4110. For lines of business other than Medicare, please see <http://www.bcbsnc.com/content/providers/edi/hipaainfo/companionguide.htm>

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving EDI transactions with BCBSNC.

Trading Partner Requirements

Testing

Testing for transaction compliance and connectivity is required with each vendor or health care provider that directly sends/receives electronic transaction to/from BCBSNC. Testing is performed for each type of ASC X12N transaction sent.

BCBSNC eSolutions provides trading partners with support and information throughout the testing process to ensure a smooth transition to production.

Frequency of Data Exchange

Response turn-around time for transactions can vary, depending upon the sender's hardware and the transaction in question. Confirmations of transmissions should be received within one hour of batch submissions, and often sooner. See chapters on the individual transactions for time ranges for transaction exchanges.

Transmission Confirmation

Trading partners are responsible for the timely retrieval and verification of the file transmission reports and transaction responses. This includes retrieval of the Claims Status Detail and Summary Reports, as well as the 997. BCBSNC recommends that trading partners review the transmission confirmations the first business day after transactions have been submitted.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing. More detailed information is contained within each transaction chapter of the Companion Guide about batch matching transmissions with returns.

Batch File Acceptance

Batch files are accepted for processing upon verification of the sender's interchange control information. When rejected batch transactions occur due to invalid sender identifiers and/or other invalid sender interchange information, the Trading Partner will be contacted directly by BCBSNC eSolutions.

Acknowledgements

Acknowledgements are performed at the GS (Functional Group) level via a 997 transaction acknowledgement transaction. Senders should expect to receive a 997 confirmation of receipt within an hour of submitting a transaction.

TA1 acknowledgement at the IS (Interchange) level are not used. See Batch File Acceptance.

Error Reporting

Error reporting occurs through one or more of the following:

1. Transaction Reports
2. 997 acknowledgement transaction
3. Direct contact via BCBSNC eSolutions

Paired transactions, such as the 270/271 and the 276/277, contain error-reporting capabilities in the responding transactions for business errors. Claims transactions receive business edit error information via the Claims Status Detail and Summary Report. Senders should retrieve Audit reports via BCBSNC’s bulletin board.

Submitted Transaction	Transaction Structure Level of Error	Type of Error	Transaction Returned
270, 276, 278, 837-I, 837-P, 820, 834	ISA/IEA Interchange Control	<ul style="list-style-type: none"> • Invalid Identifiers • Improper Batch Structure 	Submitter will be contacted by BCBSNC eSolutions. 997 will not be returned. TA1 is not used
270, 276, 278, 837-I, 837-P, 820, 834	<ul style="list-style-type: none"> • GS/GE Segment • ST/SE Segment • Detail Segments 	HIPAA Implementation Guide Violations	997
837 Institutional 837 Professional	Detail Segments	BCBSNC Claim Adjudication Errors	Claims Detail and Summary Report

Table 1: Error Reporting for Various Transactions

Important Notice: For Implementation Guide violations, BCBSNC returns the 997 Transaction ONLY. Trading partners who are unable to accept a 997 transaction are not provided with alternative Implementation Guide error reporting mechanisms.

Stakeholder Validation Messages

Where applicable, each transaction chapter contains a table that lists these messages with suggested actions to rectify the transmission problem. Consult the relevant transaction chapter for more information about the message you have received.

Identifiers

Sender Identifier

The Sender Identifier is used at the Interchange Control, or ISA06, of a transmission. BCBSNC accepts a “Mutually Defined” (ZZ) value. BCBSNC eSolutions will assign the Trading Partner sender identifier.

Information Receiver Identifier

The Information Receiver Identifier is used for the 270/271 and 276/277 Transactions to identify the entity that is receiving the information of the inquiry. For trading partners of BCBSNC, this is the BCBSNC Provider Identifier, the Social Security Number, or the Federal Tax ID.

Provider Identifiers

Until such time as the implementation of the National Provider Identifier, BCBSNC requires the use of the BCBSNC Provider Identifier for Rendering Provider (837 Professional) and Service Facility (837 Institutional) Health Care Claim transactions.

Please see the Data Element Tables within each transaction chapter for guidance on placement and code identifiers regarding the provider identifiers.

Subscriber Identifiers

Submitters should be careful to use the full member’s identification number as it appears on the BCBSNC Member ID card.

Claim Identifiers

BCBSNC issues a claim identification number upon receipt of any accepted claim. The ASC X12N Implementation Guide refers to this number as Payer Claim Control Number, which is returned using the CLP segment on the 835 Remittance transaction.

Data Formats

Character Set Restrictions

Within a data string, BCBSNC accepts any characters within the Basic Character Sets outlined in Appendix A.1.2 of each transaction ASC X12N Implementation Guide. BCBSNC returns only the tilde (~) from the Extended Character Set. Other characters that are acceptable within proper names are dashes, apostrophes, spaces, and periods.

Delimiters

Delimiters are characters used to separate data elements within a data string. Examples of standard delimiters used in ASC X12N transactions include the asterisk (*), colon (:), and the tilde (~). Delimiters used by BCBSNC are specified in the Interchange Header segment (the ISA level) of a transaction.

Transmission Senders must identify the delimiters they are using in the ISA16 element of any transaction. BCBSNC will accept all delimiters within the Basic and Extended Character Sets, listed in Section A.1.2.3 of each Implementation Guide. In responding transactions, BCBSNC

uses most characters from the Basic Character Set, but only the tilde (~) from the Extended Character Set.

Dates (Format and Content)

The following statements apply to dates contained in any of the transactions:

- 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 00 to 23, to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200906262115 defines the date and time of June 26, 2009 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.

Percentages

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

File Format (Record Lengths)

BCBSNC accepts the Implementation Guide standards for variable record lengths and file formats. BCBSNC returns a streamed format record – a record that is not broken by spaces or delimiters.

Control Segments

The Control Segments section applies to all transactions as it includes the ISA and GS Segments, which are part of every transaction structure.

ISA Segment

The Interchange Control Segment (ISA/IEA) provides essential information to the receiver of the transaction. The ISA Segment identifies both the sender and receiver’s identifiers, the time of the file transfer, and the segment terminators/delimiters used by the sender.

Senders should note that if Implementation Guide errors are found at the ISA Segment, the entire ISA/IEA segment is rejected.

Interchange Control: Data Elements Table*

*Note that this table reflects the BCBSNC business rules for both incoming and outgoing ISA/IE Segments.

Segment ID	Segment Name	Element ID	Element Name	Comments
ISA	Interchange Control Header			
		ISA01	Authorization Information Qualifier	BCBSNC expects a value of "00"
		ISA02	Authorization Information	Use 10 blank spaces
		ISA03	Security Information Qualifier	BCBSNC expects a value of "00"
		ISA04	Security Information	Use 10 blank spaces
		ISA05	Interchange ID Qualifier	<ul style="list-style-type: none"> For inbound ISA, BCBSNC expects to see a value of "ZZ" For outbound, BCBSNC returns a value of "ZZ"
		ISA06	Interchange Sender ID	<ul style="list-style-type: none"> For inbound, use the identifier established with BCBSNC eSolutions For outbound, BCBSNC uses 'BCBSNC'
		ISA07	Interchange ID Qualifier	<ul style="list-style-type: none"> For inbound ISA, BCBSNC expects to see a value of "ZZ" For outbound, BCBSNC returns a value of "ZZ"
		ISA08	Interchange Receiver ID	<ul style="list-style-type: none"> For inbound ISA use 'BCBSNC' For outbound ISA, BCBSNC returns the trading partner's identifier, established with BCBSNC eSolutions
		ISA14	Acknowledgement Requested	BCBSNC strongly recommends a value of "1" (acknowledgement requested)
		ISA15	Usage Indicator	Stakeholders should indicate whether the batch transmission is a test ("T") or production ("P") file.
IEA	Interchange Control Trailer			
		IEA01	Number of Included Functional Groups	BCBSNC prefers only one functional group per transmission
		IEA02	Interchange Control Number	This value must match ISA13

Functional Group Segment

The Functional Group Segment identifies the type of transaction being sent, identifiers for the sender and receiver of the transactions, as well as the sender's Group Control Number. BCBSNC recommends that only one Functional Group be sent per transmission.

Any Implementation Guide errors found within the Functional Group Segment are reported via a 997 Transaction. Senders should note that if Implementation Guide errors are found in the Functional Group Segment Header or Footer, the entire GS/GE Functional Group is rejected.

Functional Group: Data Elements Table

Segment ID	Segment Name	Element ID	Element Name	Comments
GS	Functional Group Header			
		GS02	Application Sender's Code	<ul style="list-style-type: none"> For inbound GS segments, BCBSNC recommends that this number is consistent with the ISA06 For outbound GS segments, BCBSNC returns the same value as ISA06, the trading partner's identifier as established with BCBSNC eSolutions
		GS03	Application Receiver's Code	<ul style="list-style-type: none"> For inbound GS segments, use a value consistent with ISA08 For outbound GS segments, BCBSNC returns the same value as ISA08, the trading partner's identifier as established with BCBSNC eSolutions
		GS06	Group Control Number	Group control number should match GE02
GE	Functional Group Trailer			
		GE02	Group Control Number	Group control number should match GE06

Connectivity Media for Batch Transactions

Synchronous File Communication

Environment

BCBSNC uses Internet FTP to control and manage all trading partner file exchanges.

Transmission Security

Transmission security is based upon utilizing PGP encryption technology where all OpenPGP key formats are supported and used for all electronic file exchanges.

Batch Retrieval

Batch files, such as 997 acknowledgements and/or reports including claims status reports, will be removed from the trading partner FTP account folder after successful download.

Communication Protocols

BCBSNC supports synchronous file communication via FTP Internet protocol.

File transmissions are sent and received within secure envelopes protected by PGP technology using public/private key encryption.

User Responsibility

It is the trading partner or sender's responsibility to obtain the required pgp encryption software. BCBSNC accepts all OpenPGP public key formats.

File Format (Record Length)

For HIPAA-compliant transactions, file formats are presented in contiguous strings. Delimiters, identified in the ISA segment of the transaction, differentiate the various data elements within the string. BCBSNC returns a streamed format record – a record that is not broken by spaces or delimiters.

Availability

BCBSNC FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Chapter 1

837 – Institutional Health Care Claim

Overview

This chapter of the BCBSNC Companion Guide identifies processing or adjudication particular to BCBSNC in its implementation of the 837 Institutional Health Care Claim Transaction. The chapter contains two 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

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 may expedite claims processing for trading partners as they exchange EDI transactions with BCBSNC.

Claims Processing

Submitting Claims

Important Notice:

BCBSNC does not accept electronic secondary coverage claims. Clearinghouses submitting claims on behalf of service providers must reject secondary claims and prevent electronic submission to BCBSNC.

Time Frames for Processing

Batch

BCBSNC FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Claim files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' claims adjudication processes.

Electronically submitted claims files received on weekends and holidays will be processed on the next business day.

Batch Volume

While the HIPAA Implementation Guides allow up to 5000 claims per ST/SE Segment of a transmission, BCBSNC strongly recommends limiting the number of claims per batch to 1000 ST/SE Segments. The HIPAA Implementation Guides mandate that if any claim contains an IG error, the entire ST/SE segment containing that claim shall be rejected.

Code Sets

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

BCBSNC prefers that no decimal point be used when sending Diagnosis codes within the HI levels of the transaction. This is consistent with the specifications of the 837 Professional Implementation Guide.

Identification Codes and Numbers

Provider Identifiers

Until such time as the National Provider Identification Numbers are assigned, BCBSNC uses the BCBSNC assigned Provider Number in the 2010AA REF segment (Billing Provider Secondary Identification). All Billing Providers who have been assigned a BCBSNC Provider ID must enter this secondary information for proper claims processing.

Subscriber Identifiers

Submitters must use the member’s complete alphanumeric or numeric identification code as it appears on the subscriber’s card for X12 subscriber and patient identifiers.

Claim Identifiers

BCBSNC issues a claim identification number upon receipt of any submitted claim. It is provided to senders in the Claims Detail and Summary Audit Report.

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.

Business Edits

Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 837 Institutional Claim Transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"> • Invalid Identifiers • Improper Batch Structure 	Submitter will be contacted by BCBSNC eSolutions 997 will not be returned TA1 is not used
<ul style="list-style-type: none"> • GS/GE Segment • ST/SE Segment • Detail Segments 	HIPAA Implementation Guide violations	997
Detail Segments		Claims Detail and Summary Audit Report

Stakeholder Validation Messages

Claims failing adjudication edits are grouped into two processing categories: Pre-adjudication and Adjudication. Errors for both of these categories are reported on the Claims Detail and Summary Audit Report.

Claims reported as ‘DENIED’ are entered into the BCBSNC adjudication system.

Claims reported as ‘POST’ are *not* entered into the BCBSNC adjudication system. Note: The BCBSNC claim number listed for a ‘POST’ error line is for information only. Due to the severity of a ‘POST’ error, further claims processing is halted, which prevents the claim number from entering the adjudication system.

The table below provides a list of the messages stakeholders may receive if a ‘POST’ edit error is encountered during claims pre-adjudication edit processing.

Message	Action
Practice has not been approved for EDI billing	Correct. Resubmit affected claims
Provider number submitted is invalid for your practice	Correct. Resubmit affected claims
Member not on file	Correct. Resubmit affected claims

Field Length

HIPAA regulations specify field lengths for many of the data elements of the 837 Institutional Health Care Claim transaction. BCBSNC accepts all compliant data elements on the 837 Institutional Claim; however, monetary values that are in negative numbers will invoke special handling. Special handling can sometimes extend the normal processing time for transactions. The listing presented below identifies BCBSNC field length specifications for dates.

Dates (Format and Content)

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: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- 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”

837 Institutional: Data Element Table

The 837 Institutional Data Element table identifies only those elements within the X12N Implementation Guide that require comment within the context of BCBSNC business processes. The table references the 837 Institutional Implementation Guide by loop name, segment name and identifier, element name and identifier, and page number for easy cross-reference.

The comments provided in this table do not identify if elements are required or situational, according to the 837 Institutional 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.

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
			06	Use 'CH' Chargeable	
1000A	Submitter Information				Loop Required
		NM1:Submitter Name			
			09	Submitter's Federal Tax ID	
1000B	Receiver Information				Loop Required
		NM1:Receiver Name			
			09	561520001 – BCBSNC's Federal Tax ID	
2000A	Billing/Pay-To Provider Information				Loop Required
2010AA	Billing Provider Information				Loop Required
		NM1:Billing Provider Name			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
		REF: Secondary ID			
			01	Use 'EI' Tax ID. Identifier	Required
			02	Tax ID information	Required
2010AB	Pay-To Provider Information				Loop Required if PRV01=PT
		Not Used			
2000B	Subscriber Hierarchal				Loop Required

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Level				
		SBR: Subscriber Info.			
			01	'P' - Primary Claims	Required. Only Primary Claims Accepted via EDI. ***** Send Secondary claims via paper
			02	'18' - Self	Required for Subscriber claims
			09	'16' - Medicare Risk	Required
2010BA	Subscriber Information				Loop Required.
		NM1:Subscriber Name			
			02	'1' Person entity	'2' Not Allowed
			08	'M'	Required.
			09	BCBSNC's Member ID	Required.
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required if SBR02=18
			03	Subscriber/Patient Gender	Required if SBR02=18
2010BC	Payer Information				Loop Required
		NM1:Payer Name	08	'PI' - Payer Identification	
2000C	Patient Hierarchal Level				HL Situational. Dependent Claims Only
		PAT: Patient Info.			
			01	Patient's relationship to insured	Required for dependent claims
2010CA	Patient Information				Loop Situational. Dependent Claims Only
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required.
			03	Subscriber/Patient Gender	Required.
2300	Claim Information				Loop Required. Maximum 100 Claims.
		CLM: Claim Info.			Required.
			01	Claim submitters identifier	This is used as Patient control number for return on 835 claim payment advice.

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			02		File paper claim if amount exceeds maximum 9,999,999.00.
		DTP: Statement Dates			Required.
			01	'434'	
			02	Statement From/Thru Dates	- From date must not exceed Thru date. - From/Thru date cannot be greater than today's date. - Admission date cannot be greater than From date.
		DTP: Admission Date/Hour			Situational
			01	'435'	
			02	Admission Date/Hour	- Admission date cannot be greater than statement From date.
		CL1: Institutional Claim Code			Situational
			01	Admission Code	
			02	Admission Source Code	
			03	Patient Status Code	
		REF: Clearinghouse Claim ID			Recommended
			01	'D9'	
			02	Clearinghouse Claim ID	
		REF: Document ID Code			
			01	'DD'	
			02	Document ID Code	Optional
		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
					Do not send decimals in any Diagnosis code.
					BCBSNC uses first 5 Diag. codes.
		HI: Principal Diag. Code			
			01-1	'BK'	
			01-2	Principal Diag. Code	
		HI: Admitting Diag. Code			
			02:1	'BJ'	
			02:2	Admitting Diag. Code	

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		HI: Other Diag. Code			
			01-06:1	'BF'	BCBSNC uses first 3 Other Diag. codes.
			01-06:2	Other Diag. Code	
		HI:DRG			
			01:1	'DR'	
			02:1	DRG	
					BCBSNC uses first 5 proc. codes.
		HI: Principal procedure code			
			01:1	'BP' - HCPCS or 'BR' - ICD-9-CM	
			01:2	HCPCS or ICD-9-CM	
		HI: Other procedure code			BCBSNC uses up to 4 Other proc. codes
			01-12:1	'BO' - HCFA or BQ' - ICD-9-CM	
			01-12:2	HCFA or BQ- ICD-9-CM	
		QTY: Covered days			
			01	'CA'	
			02	Covered days	
		QTY: Non-covered days			
			01	'NA'	
			02	Non-covered days	
		QTY: Lifetime reserve days			
			01	'LA'	
			02	Lifetime reserve days	
2310A	Attending Physician Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310B	Operating Physician Info. Claim level				Loop Situational
		NM1: Physician Info.			

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310C	Other Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310D	Referring Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310E	Service Facility Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2400	Service Line Info				Loop Required
		LX: Service Line	01	Service line control number	This is used by provider as control number used for claim tracking purposes and returned on 835 claim payment advice.
		SV2:Institutional Service			
			01	Revenue code	- An inpatient claim must contain one accommodation code
			02:1	Identifiers 'HC' - HCPCS 'IV' - Home Infusion codes 'ZZ' – HIPPS Codes	CPT codes are also Level 1 HCPCS codes, use 'HC'.
			02:2	HCPCS, Home Infusion code, HIPPS information.	

Transaction: 837 Institutional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		DTP: Service Line Date			Date must be contained within the 'Statement dates'
			02	Use 'D8' format (CCYYMMDD)	
			03	Service Line Date	
2420A	Attending Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2420B	Operating Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2420C	Other Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required

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 two sections:

- A general section with the 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

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 may expedite claims processing for trading partners as they exchange EDI transactions with BCBSNC.

Claims Processing

Submitting Claims

Important Notice:

BCBSNC does not accept electronic secondary coverage claims. Clearinghouses submitting claims on behalf of service providers must reject secondary claims and prevent electronic submission to BCBSNC.

Time Frames for Processing

Batch

BCBSNC FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Claim files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' claims adjudication processes.

Electronically submitted claims files received on weekends and holidays will be processed on the next business day.

Batch Volume

While the HIPAA Implementation Guides allow up to 5000 claims per ST/SE Segment of a transmission, BCBSNC strongly recommends limiting the number of claims per batch to 1000 ST/SE Segments. The HIPAA Implementation Guides mandate that if any claim contains an IG error, the entire ST/SE segment containing that claim shall be rejected.

Code Sets

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

BCBSNC prefers that no decimal point be used when sending Diagnosis codes within the HI levels of the transaction. This is consistent with the specifications of the 837 Professional Implementation Guide.

Identification Codes and Numbers

Provider Identifiers

Until such time as the National Provider Identification Numbers are assigned, BCBSNC uses the BCBSNC assigned Provider number in the 2010AA REF segment (Billing Provider Secondary Identification). All Billing Providers who have been assigned a BCBSNC Provider ID must enter this secondary information for proper claims processing.

Subscriber and Patient Identifiers

Submitters must use the member’s complete alphanumeric or numeric identification code as it appears on the subscriber’s card for X12 subscriber and patient identifiers.

Claim Identifiers

BCBSNC issues a claim identification number upon receipt of any submitted claim. It is provided to senders in the Claim Detail and Summary Audit Report.

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.

Business Edits

Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 837 Professional Claim Transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"> Invalid Identifiers Improper Batch Structure 	Submitter will be contacted by BCBSNC eSolutions. 997 will not be returned TA1 not used
<ul style="list-style-type: none"> GS/GE Segment ST/SE Segment Detail Segments 	HIPAA Implementation Guide Violations	997
Detail Segments		Claims Detail and Summary Audit Report

Stakeholder Validation Messages

Claims failing adjudication edits are grouped into two processing categories: Pre-adjudication and Adjudication. Errors for both of these categories are reported on the Claims Detail and Summary Audit Report.

Claims reported as ‘DENIED’ are entered into the BCBSNC adjudication systems.

Claims reported as ‘POST’ are *not* entered into the BCBSNC adjudication system. Note: The BCBSNC claim number listed for a ‘POST’ error line is for information only. Due to the severity of a ‘POST’ error, further claims processing is halted which prevents the claim number from entering the adjudication system.

Message	Action
Practice has not been approved for EDI billing	Correct. Resubmit affected claims
Provider number submitter is invalid for your practice	Correct. Resubmit affected claims
Member not on file	Correct. Resubmit affected claims

Field Length

HIPAA regulations specify field lengths for many of the data elements of the 837Institutional Health Care Claim transaction. BCBSNC accepts all compliant data elements on the 837Institutional Claim; however, monetary values that are in negative numbers will invoke special handling. Special handling can sometimes extend the normal processing time for transactions. The listing presented below identifies BCBSNC field length specifications for dates.

Dates (Format and Content)

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 ours should use the following format: CCYYMMDDHHMM
- Use military format: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- 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.”

837 Professional Claims: Data Element Table

The 837 Professional Claims: Data Element table identifies only those elements within the X12N Implementation Guide that require comment within the context of BCBSNC business processes. The table references the 837 Institutional Implementation Guide by loop name, segment name and identifier, element name and identifier, and page number for easy cross-reference.

The comments provided in this table do not identify if elements are required or situational, according to the 837 Professional Claims 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.

Transaction: 837 Professional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
			06	Use 'CH' Chargeable	
1000A	Submitter Information				Loop Required
		NM1:Submitter Name			
			09	Submitter's Federal Tax ID	
1000B	Receiver Information				Loop Required
		NM1:Receiver Name			
			09	561520001 – BCBSNC's Federal Tax ID	
2000A	Billing/Pay-To Provider Information				Loop Required
		PRV: Provider Specialty Info			
			01	Use 'BI' when 2010AA Billing Provider Loop is used to send Rendering Facility Provider Use 'PT' when 2010AB Pay-To Provider Loop is used to send Rendering Facility Provider	
			03		Use 'Unknown' if not available
2010AA	Billing Provider Information				Loop Required
		NM1:Billing Provider Name			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
		REF: Secondary ID			
			01	Use 'EI' Tax ID. Identifier	Required
			02	Tax ID information	Required
2010AB	Pay-To Provider Information				Loop Required if PRV01=PT

Transaction: 837 Professional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		Not Used			
2000B	Subscriber Hierarchal Level				Loop Required
		SBR: Subscriber Info.			
			01	'P' - Primary Claims	Required. Only Primary Claims Accepted via EDI. ***** **Send Secondary claims via paper
			02	'18' - Self	Required for Subscriber claims
			09	'16' - Medicare Risk	Required
2010BA	Subscriber Information				Loop Required.
		NM1:Subscriber Name			
			02	'1' Person entity	'2' Not Allowed
			08	'MI'	Required.
			09	BCBSNC Member ID	Required.
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required if SBR02=18
			03	Subscriber/Patient Gender	Required if SBR02=18
2010BC	Payer Information				Loop Required
		NM1:Payer Name	08	'PI' - Payer Identification	
2000C	Patient Hierarchal Level				HL Situational. Dependent Claims Only
		PAT: Patient Info.			
			01	Patient's relationship to insured	Required for dependent claims
2010CA	Patient Information				Loop Situational. Dependent Claims Only
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required.
			03	Subscriber/Patient Gender	Required.
2300	Claim Information				Loop Required. Maximum 100 Claims.
		CLM: Claim Info.			Required.

Transaction: 837 Professional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			01	Claim submitters identifier	This is used as Patient control number for return on 835 claim payment advice.
			02	Claim Amount	File paper claim if amount exceeds maximum 9,999,999.00.
			05	Place of service	Required.
		DTP: Date onset of current illness			Situational
			01	'431'	
			02	Date onset of current illness	- cannot exceed current date or patients date of birth
		REF: Clearinghouse Claim ID			Recommended
			01	'D9'	
			02	Clearinghouse Claim ID	
		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
					Do not send decimals in any Diagnosis code.
					BCBSNC uses first 5 Diag. codes.
		HI: Principal Diag. Code			
			01-1	'BK'	
			01-2	Principal Diag. Code	
		HI: Other Diag. Code			
			02: 07-1	'BF'	Up to 4 Other Diag.
			02: 07-2	Other Diag. Code	
2310A	Referring Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
			02	UPIN Number	
2310B	Rendering Provider Info. Claim level				Loop Situational

Transaction: 837 Professional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310D	Service Facility Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2400	Service Line Info				Loop Required
		LX: Service Line	01	Service line control number	This is used by provider as control number used for claim tracking purposes and returned on 835 claim payment advice.
		SV1:Professional Service			
			01: 1	'HC' - HCPCS or 'IV' - Home Infusion codes	CPT codes are also Level 1 HCPCS codes, use 'HC'.
			02: 2	HCPCS or Home Infusion code	
		DTP: Service Date From/To			
			01	'472'	
			02	Use 'D8' format: (CCYYMMDD) or 'RD8' format: (CCYYMMDD-CCYYMMDD)	
			03	Service Line Date	
		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
		REF:CLIA Clinical lab improvement facility amendment			
			01	'X4' - CLIA#	
			02	CLIA#	
2420A	Referring Provider Info. Service level				Loop Situational
		REF: Secondary ID			
			01	Use 'G2' Payer Provider Number	Optional. Preferred

Transaction: 837 Professional					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			02	Payer Provider Number	
		REF: Secondary ID			
			01	Use '1G' UPIN Number	Optional .Secondary Preference
			02	UPIN Number	
2420F	Rendering Provider Info. Service level				Loop Situational
		PRV: Specialty Info			
			03	Specialty code	Required if loop sent; Use 'Unknown' if not available
		REF: Secondary ID			
			01	Use 'G2' Payer Provider Number	Required if loop sent
			02	Payer Provider Number	
		REF: Secondary ID			
			01	Use '1G' UPIN Number	Optional
			02	UPIN Number	

Chapter 3

270-271 Health Care Eligibility Benefit Inquiry and Response

Overview

This chapter of the BCBSNC Companion Guide identifies processing particular to BCBSNC in its implementation of the 270-271 Health Care Eligibility Benefit Inquiry and Response Transaction. The chapter contains two sections:

- A general section with material applicable to the processing the of 270/271 transaction pair.
- A table outlining specific data format or content within the transactions, or describing BCBSNC handling of specific data types

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.

Claims Status Processing

Submitting Requests

Important Notice:

BCBSNC accepts 270 Health Care Eligibility Benefit Inquiry Transactions in batch mode only. Real-time 270 transactions are not accepted.

Response to Requests

BCBSNC returns 271 Health Care Eligibility Benefit Response Transactions in batch mode only.

BCBSNC will return 271 Health Care Eligibility Benefit Response Transactions with table level loops in a form structurally similar to the 270 Health Care Eligibility Benefit Inquiry and include all originally sent 270 segments.

Clearinghouses submitting claim status requests on behalf of service providers may need to restructure BCBSNC 271 Health Care Eligibility Benefit Response prior to return of information to service provider. BCBSNC will not create a individual response 271 X12 envelope for each batch of 270 requests submitted via clearinghouse.

Time Frames for Processing

Batch

BCBSNC FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' processes.

Electronically submitted files received on weekends and holidays will be processed on the next

business day.

270 files received on weekends and holidays will be processed on the next business day.

Batch Volume

A maximum of 1,000 Subscriber/Dependent level requests for each 270 transaction can be submitted. Use additional 270 transactions if necessary.

Code Sets/Identifiers

BCBSNC uses HIPAA codes sets and identifiers according to the 270/271 Implementation guide.

Subscriber/Dependent Identifiers

Submitters must use the member’s complete alphanumeric or numeric identification code as it appears on the subscriber’s card for X12 subscriber and patient identifiers.

Business Edits

Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 270-271 Health Care Eligibility Benefit Inquiry and Response Transactions.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"> Invalid Identifiers Improper Batch Structure 	Submitter will be contacted by BCBSNC eSolutions 997 will not be returned TA1 is not used
<ul style="list-style-type: none"> GS/GE Segment ST/SE Segment Detail Segments 	HIPAA Implementation Guide violations	997
Detail Segments		HIPAA compliant Inquiry/Response segments accepted/generated according to 270/271 Implementation guides.

Field Length

HIPAA regulations specify field lengths for many of the data elements used in the segments of X12N transactions as defined in the implementation guides.. BCBSNC accepts all compliant data elements included in X12N transactions. The listing presented below identifies BCBSNC field length specifications for dates.

Dates (Format and Content)

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: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26,

2002 at 9:15pm

- 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"

270 Data Element Table

This Element Table presents a matrix of those elements listed in the HIPAA Implementation Guide that require Companion Guide annotation. The matrix identifies the element in question according to its loop, segment, and element identifiers within the HIPAA Implementation Guide. Adjacent to the element's identifiers is the BCBSNC business rule specific to that data element or segment.

Transaction: 270 Health Care Eligibility Benefit Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				Required
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
2000A	Informational Source Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	20 – Information Source	
			04	1 – Subordinate HL's exist	
2100A	Payer Name				Loop Required
		NM1:Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	BCBSNC	
2000B	Information Receiver Hierarchal Level				Loop Required
		HL: Hierarchial Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HL's exist	

Transaction: 270 Health Care Eligibility Benefit Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
2100B	Receiver Name				Loop Required
		NM1:Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Subscriber Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	22 - Subscriber	
			04	1 – Subordinate HL's exist.	Required for Dependent Inquiry – 2110D Loop Id (HL03 = 23) must exist
				0 – Subordinate HL's do not exist	Required for Subscriber Inquiry 2100C Loop ID. Dependent Inquiry – 2110D Loop Id (HL03 = 23) must not exist.
				0 – Subordinate HL's do not exist	Required for Subscriber Inquiry 2100C Loop ID. Dependent Inquiry – 2110D Loop Id (HL03 = 23) must not exist.
		TRN: Trace Number			Required
2100C	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	Expected for Dependent Inquiry – 220E Loop Id when Subscriber Inquiry 2200D not present
				QC – Use only when Subscriber is the patient	Expected for Subscriber Inquiry 2200D regardless of presence of Dependent Inquiry
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
		REF: Subscriber Addl. Info.	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110C	Subscriber Request Parmenters				Loop Situational
		EQ: Service Type Code	01	30 - Generic Request for	
		DTP: Subscriber Date	01	307: Eligibility	
2000D	Dependent Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	23 – Dependent	
			04	0 – Subordinate HL's do not exist	Required for Dependent Inquiry – 2200E Loop Id must exist.

Transaction: 270 Health Care Eligibility Benefit Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		TRN: Trace Number			Required
2100D	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
		REF: Subscriber Addl. Info	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110D	Dependent Request Parenters				Loop Situational
		EQ: Service Type Code	01	30 – Generic Request for	
		DTP: Subscriber Date	01	307: Eligibility	

271 Data Element Table

This Element Table presents a matrix of those elements listed in the HIPAA Implementation Guide that require Companion Guide annotation. The matrix identifies the element in question according to its loop, segment, and element identifiers within the HIPAA Implementation Guide. Adjacent to the element's identifiers is the BCBSNC business rule specific to that data element or segment.

Transaction: 271 Health Care Eligibility Benefit Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal				Required
		BHT: Beginning of			
			04	Transaction creation date	
2000A	Information Source Hierarchal Level				Loop Required

Transaction: 271 Health Care Eligibility Benefit Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		HL: Hierarchal Level			
			03	20 – Information Source	
			04	1 – Subordinate HL's exist	
2100A	Payer Name				Loop Required
		NM1:Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	BCBSNC	
2000B	Information Receiver Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HL's exist	
2100B	Receiver Name				Loop Required
		NM1:Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Subscriber Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	22 - Subscriber	
			04	1 – Subordinate HL's exist.	
				0 – Subordinate HL's do not exist	
		TRN: Trace Number			Required
2100C	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	
				QC – Use only when Subscriber is the patient	
			08	MI – Member ID Number	

Transaction: 271 Health Care Eligibility Benefit Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			09	BCBSNC Member ID	
		REF: Subscriber Addl.	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110C	Subscriber Request Parmenters				Loop Situational
		EB: Eligibility Info	01	1 – Active Coverage	
				6 – Inactive	
				V – Cannot Process	
		DTP: subscriber Date	01	307: Eligibility	
		MSG: Message Text	01	Message when applicable	
2000D	Dependent Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	23 – Dependent	
			04	0 – Subordinate HL's do not exist	
		TRN: Trace Number			Required
2100D	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
		REF: Subscriber Addl. Info	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110D	Dependent Request Parmenters				Loop Situational
		EB: Eligibility Info	01	1 – Active Coverage	
				6 – Inactive	
				V – Cannot Process	
		DTP: Subscriber Date	01	307: Eligibility	
		MSG: Message Text	01	Message when applicable	

Chapter 4

835 – Claim Payment/Advice

Overview

This chapter of the BCBSNC Companion Guide identifies processing or adjudication particular to BCBSNC in its implementation of the 835 Health Care Claim Transaction.

The 835 Transaction, Health Care Claim Advice, provides an electronic verification of the payment of electronic and/or paper claims submitted to BCBSNC for processing. The 835 Transaction is returned for both the Professional and Institutional 837 claim submission.

The 835 EOP Advice will be sent electronically. If requested, submitters may receive it in paper form as well.

Time Frames for Processing

BCBSNC sends 835 batch transactions weekly immediately following check creation. Response time to 837 claim submissions varies, and may be longer than one week.

BCBSNC will anticipate an acknowledgement response to the 835 from submitters in the form of a 997.

Electronic Funds Transfer (EFT)

The BCBSNC 835 transaction does not include Electronic Funds Transfer, only EOP remittance advice.

Claims Remittance Processing

1. BCBSNC generates electronic 835 Transactions only for claims that have a “paid” or “denied” record on file. Claims that are still in the adjudication process or that have been returned with error messages do not receive an 835 response (See 837 Companion Guide for information about status reports).
2. The claims submitted via batch transactions might not be returned together within the original batch or in the original order. Submitters can match checks with remittance advice by using the trace number (TRN segment) or check number. Submitters can match 837 submissions with 835 EOP advice by using the Patient Control Number (CLP01).
3. Payees will see all originally submitted procedure codes broken out on the SVC06 element, with the adjusted dollar amount in the CAS03 segment.
4. Claim adjustments will be reported at the service level.

835 Mapping from 837

Payees may need to be aware of values used from the 837 for adjudication or re-association. Any mapping issues particular to BCBSNC business rules are identified on the 835 Data Element Table.

Identification Codes and Numbers

In creating the 835 Transaction, BCBSNC uses the standard medical and non-medical codes sets prescribed in Appendix C of the 835 Implementation Guide.

Provider Identifier

Until such time as the National Provider Identifier is issued, the 835 Transaction returns the BCBSNC Provider number, BCBSNC Practice number, and UPIN. Payee IRS number is also included but may not be on an individual provider level.

Subscriber Identifier

On the 835, the Insured ID (NM109 of Claim Payment Info Insured Name Segment) represents the subscriber member number.

Claims Identifier

The Claims Identifier is the BCBSNC generated claim number for tracking the claim (CLP07).

Reason Adjustment Codes

The 835 Transaction Standard limits the content of the Service Adjustment CAS Segment CAS02 Claim Adjustment Reason Code Element to those codes listed in WPC's Health Care Claim Adjustment Reason Code Guide (see Appendix A for the complete code list).

835 Data Element Table

The following Data Element Table defines some of the specific BCBSNC business rules applicable to the 835 Remittance.

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
	Transaction Set Header		
		ST01: Transaction Set ID	'835'
		ST02: Transaction Set Control Number	Transaction set control number
		BPR Financial Information	
		BPR01: Transaction Handling Code	'I' – remittance only
		BPR02: Provider Payment Amount	Prov payment amount
		BPR03: Credit/Debit flag Code	"C"
		BPR04: Payment Method Code	'CHK'
		BPR05: Payment Format Code	NOT USED
		BPR06: ID Number Qualifier (Originating)	NOT USED
		BPR07: Identification Number (Originating)	NOT USED
		BPR08: Account Number Qualifier (Originating)	NOT USED
		BPR09: Account Number (Originating)	NOT USED

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		BPR10: Originating Company Identifier	NOT USED
		BPR11: Originating Company Supplemental Code	NOT USED
		BPR12: ID Number Qualifier (Receiving)	NOT USED
		BPR13: Identification Number (Receiving)	NOT USED
		BPR14: Account Number Qualifier (Receiving)	NOT USED
		BPR15: Account Number (Receiving)	NOT USED
		BPR16: Paid Date	Paid Date
		TRN Reassociation Trace#	
		TRN01: Trace Type Code	'1'
		TRN02: Reference Identification (check or trace#)	Check or Trace#
		TRN03: Originating Company Identifier (Payer IRS)	'1' + IRS number
		CUR Segment Foreign currency information	NOT USED
		REF Segment – EV Clearing House (if applicable)	NOT USED
		REF Segment – F2	NOT USED
		DTM Segment Adjudication Cycle Data	
		DTM01: Adjudication Cycle Date Qual	'405'
		DTM02: Paid Date	
1000A	PAYER IDENTIFICATION		
		N1 Segment Payer Identification	
		N101: Entity Identifier Code	'PR'
		N102: Payer Name	Payer Name
		N103: Identification Code Qualifier	NOT USED
		N104: Identification Code (Payer ID)	NOT USED
		N3 Segment Payer Address	
		N301: Payer Address Line	Address 1
		N302: Payer Address Line 2	Address2
		N4 Segment Payer city, street, zip	
		N401: Payer City name	City
		N402: Payer State or Province code	State
		N403: Payer Postal Code	Zip

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		REF Segment	NOT USED
		Additional Payer Information	
		REF01: Payer Id Number	
		REF02: Payer Id	
		PER Segment	NOT USED
		Payer Contact Information	
1000B	PAYEE IDENTIFICATION		
		N1 Segment	
		Payee Identification	
		N101: Entity Identifier Code (Payee ID)	'PE'
		N102: Payee Name	Payee Name
		N103: Identification Code Qualifier	'FI'
		N104: Identification Code (Payee IRS)	'1' + IRS number
		N3 Segment	NOT USED
		Payee Address	
		N4 Segment	NOT USED
		Payee city, state, zip	
		REF Segment	NOT USED
		Payee Additional Information	
2000	HEADER NUMBER		
		LX Segment	
		Header Number	
		LX01: LX Counter	Incremented for each line number
		TS3 Segment	NOT USED
		Provider Summary Information	
		TS2 Segment	NOT USED
		Provider Supplemental Summary Information	
2100	CLAIM PAYMENT INFO		
		CLP Segment	
		Claim Payment Information	
		CLP01: Patient Control Number	Patient Control Number
		CLP02: Claim Status Code	Claim Status Code
		CLP03: Total Claim Charge Amt	Total Claim Charge Amt
		CLP04: Claim Payment Amt	Claim Payment Amt
		CLP05: Patient Resp Amt	NOT USED
		CLP06: Claim Filing Ind. Code	Claim Filing Ind. Code
		CLP07: Payer Claim Control Number	BCBSNC Claim Number

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		CLP08: Facility Type Code	Facility Type Code
		CLP09: Claim Frequency Code	Claim Frequency Code
		CLP10: Patient Status Code	
		CLP11: DRG Code	DRG Code
		CLP12: Quantity (DRG Weight)	NOT USED
		CLP13: Percent (Discharge fraction)	NOT USED
		CAS Segment	NOT USED
		Claim Adjustment	
		NM1 Segment	
		Patient Name	
		NM101: Entity ID Code (Patient Name Qual)	'QC'
		NM102: Entity type Qualifier (Insured Name Qual)	'1'
		NM103: Patient Name Last	Patient Name Last
		NM104: Patient Name First	Patient Name First
		NM105: Patient Name Middle	Patient Name Middle
		NM106: Prefix	Prefix
		NM107: Patient Name Suffix	Patient Name Suffix
		NM108: Id Code Qual	'MI'
		NM109: Patient Identifier	Patient Identifier
		NM1Segment	
		Insured Name	
		NM101: Insured or Subscriber	'IL'
		NM102: Insured Type	'1'
		NM103: Insured Name Last	Insured Name Last
		NM104: Insured Name First	Insured Name First
		NM105: Insured Name Middle	Insured Name Middle
		NM106: Insured Name Prefix	Insured Name Prefix
		NM107: Insured Name Suffix	Insured Name Suffix
		NM108: Insured ID Type	'MI'
		NM109: Insured Id	Insured Id
		NM1 Segment	NOT USED
		Corrected Patient/Insured Name	
		NM1 Segment	
		Service Provider Name	
		NM101: Rendering Name Qual	'82'
		NM102: Rendering Name Type	Rendering Name Type
		NM103: Rendering Name Last	Rendering Name Last
		NM104: Rendering Name First	Rendering Name First
		NM105: Rendering Name Middle	NOT USED
		NM106: Rendering Name Prefix	NOT USED

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		NM107: Rendering Name Suffix	NOT USED
		NM108: Rendering ID Qual	'BD'
		NM109: Rendering ID (BCBSNC Provider#)	Rendering ID (BCBSNC Provider #)
		NM1 Segment Crossover Carrier Name	NOT USED
		NM1 Segment Corrected Priority Payer Name	NOT USED
		MIA Segment Inpatient Adjudication Information	NOT USED
		MOA Segment Outpatient Adjudication Information	NOT USED
		REF Segment Other Claim Related Identification	NOT USED
		REF Segment Rendering Provider Identification	
		REF01: Rendering Prov Id Qual	'G2'
		REF02: Rendering Prov Id (BCBSNC Practice#)	Rendering Prov Id (BCBSNC Practice#)
		REF Segment Rendering Provider Identification	
		REF01: Rendering Prov ID Qual	'1G'
		REF02: Rendering Prov Id (UPIN)	Rendering Prov Id (UPIN)
		DTM Segment Claim Date	
		DTM01: Claim Date Qual	'050'
		DTM02: Claim Date Received	
		PER Segment Claim Contact Information	NOT USED
		AMT Segment Claim Supplemental Information	NOT USED
		QTY Segment Claim Supplemental Info Quantity	NOT USED
2110	SERVICE PAYMENT INFO		
		SVC Segment Service Payment Information	
		SVC01-1: Procedure Code Qual	'HC'

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		SVC01-2: Adjudicated Procedure Code/ Rev Cd	Adjudicated Procedure Code/ Rev Cd
		SVC01-03: Modifier1	Modifier1
		SVC01-04: Modifier2	Modifier2
		SVC01-05: Modifier3	Modifier3
		SVC01-06: Modifier4	Modifier4
		SVC01-07: Proc description	NOT USED
		SVC02: Charge Amount	Charge Amount
		SVC03: Paid Amount	Paid Amount
		SVC04: Revenue Code	Revenue Code
		SVC05: Units of service PAID	Units of service PAID
		Procedure code submitted (Not Adjudicated)	
		SVC06-1: Procedure Code Qual	'HC'
		SVC06-2: Procedure Code	Procedure Code
		SVC06-3: Modifier1	Modifier1
		SVC06-4: Modifier2	Modifier2
		SVC06-5: Modifier3	Modifier3
		SVC06-6: Modifier4	Modifier4
		SVC06-7: Proc description	NOT USED
		SVC07: Orig. units of service count	Orig. units of service count
		DTM Segment	
		Service Date (From)	
		DTM01: Service Period Start Qual	'150'
		DTM02: Service DATE (effective)	Service DATE (effective)
		CAS Segment 1-6	
		Service Adjustment *See attached Adjustment Code Table	
		CAS01: Claim Adjust Code	Claim Adjust Code
		CAS02: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS03: Monetary Amt	Monetary Amt
		CAS04: Quantity	NOT USED
		CAS05: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS06: Monetary Amt	Monetary Amt
		CAS07: Quantity	NOT USED
		CAS08: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS09: Monetary Amt	Monetary Amt
		CAS10: Quantity	NOT USED
		CAS11: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS12: Monetary Amt	Monetary Amt
		CAS13: Quantity	NOT USED
		CAS14: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS15: Monetary Amt	Monetary Amt
		CAS16: Quantity	NOT USED

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
		CAS17: Claim Adjust Reason Code	Claim Adjust Reason Code
		CAS18: Monetary Amt	Monetary Amt
		CAS19: Quantity	NOT USED
		REF Segment	NOT USED
		Service Identification (Service Payment info)	
		REF Segment	
		Rendering Prov Info	
		REF01: Id Qual	'1J'
		REF02: Rendering Prov Id (BCBSNC Prov#)	Rendering Prov Id (BCBSNC Prov#)
		REF03	NOT USED
		REF04	NOT USED
		REF Segment	
		Rendering Prov Info	
		REF01: Id Qual	'HPI'
		REF02: Rendering Prov Id. (NPI)	Rendering Prov Id. (Future NPI)
		REF03	NOT USED
		REF04	NOT USED
		REF Segment	REF 2 nd occurrence
		Rendering Prov Info	
		REF01: Id Qual	'1G'
		REF02: Rendering Prov Id. (UPIN)	Rendering Prov Id (UPIN)
		Service Supplemental AMT	NOT USED
		Service Supplemental QUANTITY	NOT USED
		Health Care Remark Codes LQ	
		LQ01: Remittance Remark/EX-Codes Qual	'HE'
		LQ02: Remittance Remark/Ex-Code	Remittance Remark/ Ex-Code
		PLB Segment 1-6	
		Provider Adjustment	
		PLB01: Provider ID	Provider ID
		PLB02: End of Providers Fiscal Year	End of Providers Fiscal Year
		PLB03-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB03-02: Adjustment Identifier	Adjustment Identifier
		PLB04: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB05-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable

Transaction: 835			
Loop ID	Loop ID Description	Segment/ Element	Element Value
			code (forwarding balance)
		PLB05-02: Adjustment Identifier	Adjustment Identifier
		PLB06: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB07-01: Adjustment Reason Identifier Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB07-02: Adjustment Identifier	Adjustment Identifier
		PLB08: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB09-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB09-02: Adjustment Identifier	Adjustment Identifier
		PLB10:: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB11-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code
		PLB11-02: Adjustment Identifier	Adjustment Identifier
		PLB12: Amount	Amount (positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB13-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code
		PLB13-02: Adjustment Identifier	Adjustment Identifier
		PLB14: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)

Chapter 5

276/277 Health Care Claim Status Request and Response

Overview

This chapter of the BCBSNC Companion Guide identifies processing particular to BCBSNC in its implementation of the 276 Health Care Claim Status Request and 277 Health Care Claim Status Response Transaction. The chapter contains two sections:

- A general section with material applicable to the processing of the 276/277 transaction pair
- A table outlining specific data format or content within the transactions, or describing BCBSNC handling of specific data types

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.

Claims Status Processing

Submitting Requests

Important Notice:

BCBSNC accepts 276 Health Care Claim Status Request Transactions in batch mode only. Real time 276 transactions are not accepted.

Response to Requests

BCBSNC returns 277 Health Care Claim Status Response Transactions in batch mode only.

BCBSNC will return 277 Claim Status Response Transactions with table level loops in a form structurally similar to the 276 Claim Status Request and include all originally sent 276 segments.

Clearinghouses submitting claim status requests on behalf of service providers may need to restructure BCBSNC 277 Health Care Claims Status Response prior to return of information to service provider. BCBSNC will not create an individual response 277 X12 envelope for each batch of 276 provider level requests submitted via clearinghouse.

Time Frames for Processing

Batch

BCBSNC FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' processes. Electronically submitted files received on weekends and holidays will be processed on the next business day.

276 files received on weekends and holidays will be processed on the next business day.

Batch Volume

A maximum of 1,000 Subscriber/Dependent level requests can be submitted for each Service Provider Level. Use additional Service Provider levels if necessary.

Code Sets/Identifiers

BCBSNC uses HIPAA code sets and identifiers according to the 276/277 Implementation guide. Standard code sets used include Claim Status Category and Claims Status codes.

Subscriber/Dependent identifiers

Submitters must use the member’s complete alphanumeric or numeric identification code as it appears on the subscriber’s card for X12 subscriber and patient identifiers.

Business Edits

Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 276/277 Transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"> Invalid Identifiers Improper Batch Structure 	Submitter will be contacted by BCBSNC eSolutions 997 will not be returned TA1 is not used
<ul style="list-style-type: none"> GS/GE Segment ST/SE Segment Detail Segments 	HIPAA Implementation Guide violations	997
Detail Segments		Format compliant inquiry data supplied within 276 will generate 277response. 277responses may or may not return the expected information depending on the validity of the 277 parameters.

Field Length

HIPAA regulations specify field lengths for many of the data elements used in the segments of X12N transactions as defined in the implementation guides. BCBSNC accepts all compliant data elements included in the X12N transactions. The listing presented below identifies BCBSNC field length specifications for dates.

Dates (Format and Content)

The following statements apply to any dates within a 276/277 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: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- 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”

Implementation of Claim Level Vs. Service Line Level 276 Inquiries

BCBSNC processes Claim Level and Service Line Level Inquiries as separate and unique requests for Claim Status Information.

For example: Both subscriber or dependent level inquiries having segment parameters other than the TRN segment within their respective Claim Submitter Trace and Service Line Information Loops will be treated as one Claim Level Request and one Service Level Request.

Additional: Claim Level parameters will not serve to filter, select or retrieve information when extracting and formatting 277 responses for Service Level Requests.

Multiple TRN 276 Claim Status Inquiries: Data Element Table

The BCBSNC Implementation tables below are not intended to be a comprehensive description of each 276/277 segment available. The table identifies all tables and loops. Elements for segments requiring additional explanation listed for certain segments are highlights certain segment table outlining specific data format or content within the transactions, or describing BCBSNC handling of specific data types.

Transaction: 276 Health Care Claim Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				Required
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
2000A	Information Source Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	20 – Information source	
			04	1 – Subordinate HLs exist	
2100A	Payer Name				Loop Required

Transaction: 276 Health Care Claim Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
		NM1: Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	BCBSNC	
2000B	Information Receiver Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HLs exist	
2100B	Receiver Name				Loop Required
		NM1: Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Service Provider Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	21 – Information Receiver	
			04	1 – Subordinate HLs exist	
2100C	Service Provider Name				Loop Required
		NM1: Subscriber Name			
			01	1P – Service Provider Name	
			08	SV – Service Provider Number	
			09	Partner's assigned provider number	
2000D	Subscriber Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	22 – Subscriber	
			04	1 – Subordinate HLs exist	Required for Dependent Inquiry – 2200E Loop ID (HL03=23) must exist
			0	Subordinate HLs do not exist	Required for Subscriber Inquiry 2200D Loop ID. Dependent Inquiry – 2200E Loop ID (HL03=23) must not

Transaction: 276 Health Care Claim Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
					exist.
		DMG: Demographic Information			Required for 2100D Subscriber Inquiry – 2200D Loop ID must exist.
2100D	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	Expected for Dependent Inquiry – 2200E Loop ID when Subscriber Inquiry 2200D not present.
				QC – Use only when Subscriber is the Patient	Expected for Subscriber Inquiry 2200D regardless of presence of Dependent Inquiry 2200E.
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
2200D	Subscriber Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or BCBSNC assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only
2210E	Subscriber Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			04	Revenue Code	Not Used
		REF: Service Line Item ID			
			01	FJ – Line Item Control Number	Allowed but not functional. Providers Line Item not saved in Payer system.

Transaction: 276 Health Care Claim Request					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
2000E	Dependent Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	23 – Dependent	
			04	0 - Subordinate HLs do not exist	Required for Dependent Inquiry – 2200E Loop ID must exist
		DMG: Demographic Information			Required for 2100D Subscriber Inquiry – 2200D Loop ID must exist
2100E	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
2200E	Dependent Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or BCBSNC assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only
2210E	Dependent Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			04	Revenue Code	Not Used
		REF: Service Line Item ID			
			01	FJ – Line Item Control Number	Allowed but not functional. Providers Line Item not saved in Payer system.

277 Data Element Table

This Element Table presents a matrix of only those HIPAA Implementation Guide elements that require annotation about BCBSNC business processes. The matrix identifies the element in question according to its loop, segment, and element identifiers within the ASC X12N Implementation Guides. Adjacent to the element's identifiers is the BCBSNC comments specific to that data element.

Transaction: 277 Health Care Claim Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				Required
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
2000A	Information Source Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	20 – Information Source	
			04	1 – Subordinate HLs exist	
2100A	Payer Name				Loop Required
		NM1: Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	BCBSNC	
2000B	Information Receiver Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HLs exist	
2100B	Receiver Name				Loop Required
		NM1: Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Service Provider Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	21 – Information Receiver	
			04	1 – Subordinate HLs exist	

Transaction: 277 Health Care Claim Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
2100C	Service Provider Name				Loop Required
		NM1: Subscriber Name			
			01	1P – Service Provider Name	
			08	SV – Service Provider Number	
			09	Partner's assigned provider number	
2000D	Subscriber Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	22 – Subscriber	
			04	1 – Subordinate HLs exist	Required for Dependent Inquiry – 2200E Loop ID (HL03 = 23) must exist
				0 – Subordinate HLs do not exist	Required for Subscriber Inquiry 2200D Loop ID. Dependent Inquiry – 2200E Loop ID (HL03 = 23) must not exist.
2100D	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL - Subscriber	
				QC – Subscriber is the Patient	
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
2200D	Subscriber Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or BCBSNC assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only.
2220D	Subscriber Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required

Transaction: 277 Health Care Claim Response					
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
			01	HC – HCPCS	
				NU – Revenue Code	
			03	Payment Amount	
			04	Revenue Code	Not Used
2000E	Dependent Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	23 – Dependent	
			04	0 – Subordinate HLs do not exist	
2100E	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Pateint	
			08	MI – Member ID Number	
			09	BCBSNC Member ID	
2200E	Dependent Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or BCBSNC assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only.
2220E	Dependent Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			03	Payment Amount	
			04	Revenue Code	Not used

Chapter 6

278 – Health Care Services Review (278-13) and Response (278-11)

Overview

This chapter of the BCBSNC Companion Guide identifies processing medical referrals and hospital admissions particular to BCBSNC in its implementation of the 278 Health Care Services Review/Response Transaction. The chapter contains two sections:

- a general section with material applicable to the processing of Referrals/Admissions 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

Time Frames for Processing

Admission and referral processing is done in batch after the end of the business day. Batches must have passed through an initial validation process to reach the enrollment process. Senders should allow time for validation and submit transmissions by 5:30 p.m.

Batch Volume

There are no standard Batch Volume limitations.

Acknowledgements

A 997 will be returned to the submitter upon the receipt of a batch transmission. This is conditional, based upon the integrity of the ISA. If the ISA is in error and/or the submitter’s ID is erroneous, no 997 will be sent.

Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 834 Benefit Enrollment and Maintenance transaction.

Transmission Structure Level of Error	Type of Error	Transaction Returned
<ul style="list-style-type: none"> • GS/GE (Functional Group) • ST/SE (Transaction Set) • Detail Segments 	HIPAA Implementation Guide Violations	997
<ul style="list-style-type: none"> • Detail Segments 	BCBSNC Business Edits (See 278 – Data Element Table for details)	AMISYS Error Report

Identification Codes and Numbers

Provider Identifiers

Until such time as the National Provider Identification Numbers are assigned, BCBSNC uses the BCBSNC’ Provider Number in the 2310 NM1 segment (Individual or Organizational Name). As outlined in the Data Element Table, this field is not required. Therefore, if the member does not have knowledge of this number, nothing needs to be entered here.

Subscriber Identifiers

Submitters should use the subscriber's SSN until HIPAA legislation requires differently.

Dates (Format and Content)

All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.

Glossary

Term	Definition
<	A symbol to indicate a value is “less than” another. For example, 2 < 3. This symbol is used in some BCBSNC proprietary error messages.
>	A symbol to indicate a value is “greater than” another. For example, 3 > 2. This symbol is used in some BCBSNC proprietary error messages.
ANSI	American National Standards Institute; the ANSI defines the stream file format X12N, upon which the HIPAA-compliant electronic transactions are modeled. The ANSI format allows variable record lengths. See the Washington Publishing Company Web site for more information on ANSI formats and HIPAA compliance.
ASC	Accredited Standards Committee
Billing Provider	The entity providing medical services requesting the adjudication of the claim. The Billing Provider is identified in both 837 transactions.
Billing Service	An entity that provides claims services to providers/suppliers. A billing service collects claim information from a provider or supplier electronically or on paper and will bill the insurance payer.
Category Codes	An ANSI code set that indicates claim level status information, particularly in a 277 Transaction. The limited set of ANSI category codes used by BCBSNC is contained in the Companion Guide Chapter on the 276 and 277 Transactions: Claim Status and Response.
CCN	Claim Control Number. See Claim Identifier
Claim Identifier	The BCBSNC assigned number for individual claims. In the HIPAA ASC X12 Transaction Implementation Guides, this Identification Number is sometimes described as the Internal Control Number (ICN), the Document Control Number (DCN), or the Claim Control Number (CCN).
Clearinghouse	An entity that transfers or moves EDI transactions for a health care provider or supplier.
COB	Coordination of Benefits
Code Set	A group of codes with pre-defined meanings, either medical or non-medical. A code set may be controlled by X12 or by an independent industry group. Only values from a named code set may be used in specific data elements. Appendix C of every implementation guide contains listings of external code sources used in the IG.

Term	Definition
Delimiters	A delimiter is a character used to separate two data elements (or sub-elements) or to terminate a segment within a data string. Delimiters are specified in the interchange header segment, ISA. Examples of standard delimiters used in ANSI X12 transactions include the asterisk (*), colon (:), and the tilde (~). See Data String Example sections of any of the transaction chapters of this document for further examples.
Dependent	The individual for whom a health insurance claim is being submitted if different from the subscriber.
DOB	Date of Birth
DOS	Date of Service
DX	Diagnosis Code
EDI	Electronic Data Interchange; the eSolutions division of BCBSNC establishes connectivity arrangements with trading partners for electronic transmission.
EFT	Electronic Funds Transfer is the automatic transfer of payment to a provider or supplier's bank account.
Element	A data component identified in the HIPAA Implementation Guides that collectively comprise the content of a transaction segment. Data elements have identifiers that indicate the segment to which they belong, such as NM1-01, which indicates the NM1 Segment, and the 01 element within that segment.
Element Table	The Companion Guide includes a Transaction Element Table for each transaction to provide BCBSNC business rule annotations at the segment and element level for that specific transaction.
Envelope	A section of an EDI Transaction that defines some portion of the electronic exchange, such as the Communications Envelope or the Interchange Envelope.
EOP	Explanation of Payment
ERA	Electronic Remittance Advice
File Map	File maps are included in this document to illustrate the sample data strings as they correspond to the HIPAA Implementation Guides (IG) and BCBSNC processing. IG Loops, Segments, and Elements are identified. The File Maps allow the user to see an entire transaction condensed so that it can be viewed within a couple of pages.

Term	Definition
Functional Acknowledgement (997)	A functional acknowledgement is sent via a 997 Transaction, in response to the receipt of an electronic transaction at the Functional Group (GS/GE) level. A 997 Transaction can also be used to indicate Implementation Guide errors. See the Introduction to the Companion Guide, Reporting, for more information.
HCPCS	HCFA Common Procedural Coding System is a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.
Information Receiver	The information receiver is a new label used in the 270/271 and 276/277 Transactions to identify the entity making the inquiry and therefore receiving the information from the inquiry.
GS/GE	The header and trailer identifiers for the Functional Group portion of an ISA/IEA envelope within an EDI transmission. The Functional Group identifies the type of transaction sent, such as an 837 or a 270.
ID	Identifier
ICN	Internal Control Number. See Claim Identifier.
Interchange Acknowledgement (TA1)	A TA1 transaction provides acknowledgement of receipt of a transmission at the Interchange Control (ISA/IEA) level. A TA1 can also be used to indicate Implementation Guide errors at the ISA/IEA level. See the Introduction to the Companion Guide for more information.
ISA/IEA	The header and trailer identifiers for the Interchange Control envelope. The ISA/IEA header and trailer define the parameters of an Interchange Group envelope within an EDI transmission.
Loop	The largest named unit of information in a transaction set. A loop contains logically related segments in order to group related information. Loops are labeled by a combination of nominative and numeric identifiers, such as <i>2000 Billing/Pay to Provider</i> . The numeric portion of the label indicates its placement within the transaction (<i>2000</i>), while the descriptive name identifies its focus (<i>Billing/Pay to Provider</i>).
Member ID	Sometimes called the certificate number, this is the BCBSNC identification number for a subscriber or member of a health care plan. Note that not all members are subscribers. Dependents of subscribers may have their own member identification number.

Term	Definition
National Provider ID (NPI)	A national system for uniquely identifying all providers of health care services, supplies, and equipment. These identifiers have not yet been assigned. BCBSNC is requesting the use of the BCBSNC Provider Number until the NPI has been assigned. In some cases where the provider does not have a BCBSNC Provider Number, the provider's Federal Tax Identifier (or Social Security Number) may be used instead. Use of the Federal Tax Identifier instead of the BCBSNC Provider Number should be verified with BCBSNC eSolutions prior to usage.
NOP	Notification of Payment is contained in an 835 Transaction. It contains detailed information, at the line item level, about what claims were paid or denied.
NSF	National Standard Format. The NSF defines standard code sets used universally in business or government. Within the context of HIPAA, the NSF generally refers to a flat text file format used for the HCFA 1500 claim prior to the implementation of the ASC X12N format.
NUBC	The National Uniform Billing Codes define the billing codes used by institutional providers for processing claims.
Patient	The individual for whom a health insurance claim is being submitted.
Pay-to Provider	The Pay-to Provider identifies a loop in both the 837 Institutional and Professional transactions. The Pay-to Provider loop is required if the provider receiving payment is different from the Billing Provider.
Qualifier	A code from an approved code list used to define the data contained in the element following the qualifier.
Receiver Identifier	The Receiver Identifier is used in an 835 Transaction if the recipient of the payment is other than the payee identified in the transaction. It is distinct from the Information Receiver ID used in the 270 and 276 transactions.
Segment	A group of data elements that defines a portion or "level" of a loop. Each segment focuses on a particular subject within a loop, such as <i>Provider Information</i> , and is comprised of any number of elements. Segments are labeled by an alpha or alphanumeric indicator and a descriptive name, such as <i>NM1 Individual or Organizational Name</i> .
Sender	The sender of an electronic transaction may be a clearinghouse, service bureau, health institution, or health provider. The sender must have a unique identifier, entered in the ISA level of the transaction for successful electronic transmission. See the Introduction to the Companion Guide for definitions for all identifiers.

Term	Definition
Special Characters	Generally only those characters contained on a lower-case keyboard are accepted for electronic transmission. Data elements such as names may contain dashes, apostrophes, spaces, or periods. See Character Set Restrictions in the Introduction to the Companion Guide for more information about special characters.
Stakeholder	A stakeholder is any entity with which BCBSNC has a Trading Partner Agreement and/or a request for electronic connectivity. It can be either a health care provider, that provider's clearinghouse or service bureau, or an employer group.
ST/SE Set	The ST/SE set is a portion of an interchange envelope that contains numerous detail segments of a transaction. Multiple ST/SE segments may be contained within a Functional Group. In an 837 Functional Group, for example, an ST/SE segment contains multiple claims. Each ST/SE segment contains transactions grouped by healthcare provider.
Submitter	The submitter is identified in the ST/SE level of a transaction and is a health care provider or health care institution. BCBSNC distinguishes between a <i>submitter</i> and the <i>sender</i> of an EDI transaction, which is often a clearinghouse or service bureau.
TOB	An abbreviation for Type of Bill or Bill Type used in some BCBSNC proprietary error messages.
Trading Partner (TP)	A business entity with which an agreement exists to exchange information, either electronically or on paper.
TPA	Trading Partner Agreement; A Trading Partner Agreement must be completed by an entity wishing to send electronic transactions to BCBSNC. See the <i>Contact Information: Requests for Service</i> section of the <i>Introduction to the Companion Guide</i> for more information about the TPA.
Transaction	Within the context of HIPAA, BCBSNC refers to a transaction as that collection of data elements necessary to perform a business function, whether that is the adjudication of a claim or the response to an inquiry.
Transmission	Two possible definitions are used within context of the Companion Guide: the actual electronic send action, or the entire Communications Envelope that includes the ISA or Interchange Envelope/s.
Vendor	An entity that provides hardware, software, and/or ongoing technical support to health care providers or suppliers for their electronic transmissions of transactions.
WPC	Washington Publishing Company (WPC) publishes the ANSI developed HIPAA Transaction Implementation Guides and their accompanying Status, Category, and Adjustment Reason Code lists.

Document Change Log

The following log identifies changes that have been made to this document.

Chapter Section	Change Date	Change Description
	03/2010	<ul style="list-style-type: none"> Removal of transactions that are not supported by BCBSNC
Overview	05/2010	<ul style="list-style-type: none"> Advice on using this document only for Medicare lines of business Links added to the www.bcbscnc.com site for Companion Guides to other lines of business.