Blue Cross and Blue Shield of Kansas, Inc.

ANSI X12N 837I V4010A1
Health Care Claim Companion Guide - Institutional

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The Health Insurance Portability and Accountability Act (HIPAA) requires all health insurance payers in the United States to comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). The ANSI X12N 837 implementation guide has been established as the standards of compliance for health care claims transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N 837 Implementation Guide for the submission of institutional claims. It should be used only as a supplement to the ANSI Implementation Guides for clarification purposes – not as a replacement.

This Companion Guide is subject to change as new information is available. Please check the BCBSKS Web Site at www.bcbsks.com for updated documents.

Documentation of ASK common payer and Payer Specific edits will provide additional help in submitting your transactions. These are located on the BCBSKS Web Site at www.bcbsks.com.

General Statements

1. All transmissions submitted without a valid Trading Partner number will be rejected. A Trading Partner number can be obtained by completing the EDI Enrollment Form found on the website.
2. Only loops, segments, and data elements valid for the HIPAA Implementation Guide will be translated. Submitting data, not valid based on the Implementation Guide, will cause files to be rejected.
3. The incoming 837 transactions utilize delimiters from the following list: '>', '*', '~', '^', '|', and ':'. Submitting other delimiters may cause an interchange (transmission) to be rejected. These characters should not be used within the data if used as a delimiter.
4. Claim data submitted in the incoming 837 must use the basic character set as defined in Appendix A of the Implementation Guide. In addition to the basic character set, you may submit lower case characters and the '@' symbol from the extended character set. Any other characters from the extended character set may cause the interchange (transmission) to be rejected at the translator or in some Health Plans payment systems. Please see edit lists for further documentation. **Exception**: The apostrophe (') should not be used in any name or city field and any character used as a delimiter should not be used within the data.
5. All lower case characters submitted on an inbound 837 file will be converted to upper case when sending data to the payers processing system including Coordination of Benefits data subsequently sent to Medicare.
6. All calendar dates on an incoming 837 claim transaction must be in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the entire file.
7. Information submitted in a 'Not Used' element will not be forwarded to any payer.
8. Taxonomy codes are not required by all payers in order to process claims, but will be accepted if submitted. Taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes. Claims submitted with invalid taxonomy codes will be rejected. BCBSKS does not use taxonomy codes for claims adjudication.

9. Data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) will be edited beyond the requirements defined in the Implementation Guide. Please see edit lists for further documentation.
10. Employer Identification Numbers (EIN) may be submitted with or without a dash ("-"). When using a dash ("-") it must be in the 3rd position.
11. Social Security Numbers (SSN) may be submitted with or without dashes ("-"). When using dashes ("-") they must be in the 4th and 7th positions.
12. Compression of files is supported between the submitter and receiver.
13. File names should not contain any of the following characters: Dollar ("$"), Ampersand ("&"), Plus ("+"), Comma (","), Forward slash/Virgule ("/"), Colon (":"), Semi-colon (";"), Equals ("="), Question mark ("?"), or 'At' symbol ("@").
14. For Internet File Transmissions Only: File names must contain only alphabetical ("A-Z, a-z"), Numeric (0-9), hyphen ("-"), or underscore ("_") as characters, with hyphen and underscore not acceptable as starting and ending characters.
15. The max length for any input file name should not exceed 28 characters.
16. All revenue codes must be submitted with 4 digits. (Ex. Revenue code 250 should be submitted as 0250.)
17. Claims with external code set data that does not conform to the format requirements of the external codes set maintainer will be rejected. Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer.
18. Data submitted in Property & Casualty loops will be ignored.
19. All trading partners are required to submit NPI unless specifically identified by the payer as atypical.

Companion Information

The following information is intended to serve as a guide to the HIPAA ANSI X12N 837 Implementation Guide for the submission for institutional claims. Information contained within this document applies to all payers unless otherwise stated.

Page	Loop	Seg.	Data Element	Comments
INTERCHANGE CONTROL HEADER/ISA				
B.4	N/A	ISA05	Interchange ID Qualifier	'ZZ'
B.4	N/A	ISA06	Interchange Sender ID	Trading Partner Number Assigned by BCBSKS.
B.4	N/A	ISA07	Interchange ID Qualifier	'ZZ'
B.5	N/A	ISA08	Interchange Receiver ID	ASK INC (A space should be entered between ASK and INC)
FUNCTIONAL GROUP HEADER/GS				
B.8	N/A	GS02	Application Sender's Code	Trading Partner Number Assigned by BCBSKS.
B.8	N/A	GS03	Application Receiver's Code	ASK INC (A space should be entered between ASK and INC)
TRANSACTION SET/ST				
56	N/A	ST02	Transaction Set Control Number	Transmissions may be rejected that are not submitted with unique values in the ST02.
60	N/A	REF02	Transmission Type Code	The 837I transaction will not be piloted. Claims files submitted with a Transmission Type Code value of 004010X096DA1 in the REF02 will cause the file to be rejected.
LOOP 1000A - SUBMITTER NAME				
63	1000A	NM109	Submitter Identifier	Trading Partner Number Assigned by BCBSKS.

Page	Loop	Seg.	Data Element	Comments
LOOP 1000B - RECEIVER NAME				
68	1000B	NM103	Receiver Name	ASK INC (A space should be entered between ASK and INC)
68	1000B	NM109	Receiver Primary Identifier	ASK INC (A space should be entered between ASK and INC)
LOOP 2000A – BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL				
70	2000A	HL	N/A	A separate batch is created for each 2000A HL submitted within a file. To keep the Claims Confirmation Report to a minimum, it is strongly recommended that only one 2000A HL segment be submitted for each Billing Provider and Payer.
74	2000A	CUR02	Currency Code	If submitted, must equal 'USA'.
LOOP 2010AA - BILLING PROVIDER NAME				
76	2010AA	N/A	N/A	BCBSKS does not accept claims from non-provider billing entities.
77	2010AA	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI.
78	2010AA	NM109	Billing Provider Identifier	Must be a valid 10-digit NPI number if submitting 'XX' in the 2010AA NM108.
83	2010AA	REF01	Reference Identification Qualifier	One occurrence of 'SY' (Social Security Number) or 'EI' (Employer's Identification Number) is required, if submitting 'XX' in the 2010AA NM108.
84	2010AA	REF02	Billing Provider Additional Identifier	One (1) occurrence of 'SY' or 'EI' is required if the NPI is submitted in the 2010AA NM109.
86	2010AA	REF02	Billing Provider Credit Card Identifier	Credit/Debit card billing information will not be used in processing.
88	2010AA	PER	Billing Provider Contact Information	Submission of the PER segment is highly recommended. This information will be used to contact the provider in the event claims cannot be submitted to the payer.
LOOP 2000B – SUBSCRIBER HIERARCHICAL LEVEL				
99	2000B	N/A	N/A	Must be in order from one, by one (+1) and must be numeric.
104	2000B	SBR09	Claim Filing Indicator Code	Must be 'BL'.
LOOP 2010BA – SUBSCRIBER NAME				
109	2010BA	NM103	Name Last or Organization Name	Last names should be submitted without special characters or spaces providing one continuous last name. (Example: OBrien, or SmithJones)
109	2010BA	NM104	Name First	First names should be submitted without special characters or spaces providing one continuous first name. (Example: LouAnn or TMika)
110	2010BA	NM108	Identification Code Qualifier	Must be 'MI'.
110	2010BA	NM109	Subscriber Primary Identifier	Enter the BCBSKS Subscriber ID number. Alpha prefixes should be entered in capital letters.
LOOP 2010BB – CREDIT/DEBIT CARD ACCOUNT HOLDER NAME				
125	2010BB	REF02	Credit or Debit Card Authorization Number	Will not be used in processing.

Page	Loop	Seg.	Data Element	Comments
LOOP 2010BC – PAYER NAME				
127	2010BC	NM108	Identification Code Qualifier	Must be 'PI'.
128	2010BC	NM109	Payer Identifier	Must be '47163'.
LOOP 2010CA – PATIENT NAME				
146	2010CA	NM103	Name Last or Organization Name	Last names should be submitted without special characters or spaces providing one continuous last name. (Example: OBrien, or SmithJones)
146	2010CA	NM104	Name First	First names should be submitted without special characters or spaces providing one continuous first name. (Example: LouAnn or TMika)
LOOP 2300 – CLAIM INFORMATION				
159	2300	CLM02	Total Claim Charge Amount	A negative value will result in the claim being rejected. Total submitted charges must equal the sum of the line item charge amounts.
160	2300	CLM07	Medicare Assignment Code	Must be populated accurately on secondary and tertiary claims to insure accurate payment.
183	2300	AMT02	Patient Amount Paid	A negative value will result in the claim being rejected.
205	2300	NTE02	Claim Note Text	Characters that can be used as delimiters cannot be used in narrative.
228	2300	HI	Health Care Diagnosis Code	Must be submitted without decimal points.
LOOP 2310A – ATTENDING PHYSICIAN NAME				
323	2310A	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI.
323	2310A	NM109	Attending Physician Primary Identifier	Must be a valid 10-digit NPI number if submitting 'XX' in the 2310A NM108.
LOOP 2310E – SERVICE FACILITY NAME				
359	2310E	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI.
359	2310E	NM109	Laboratory or Facility Primary Identifier	Must be a valid 10-digit NPI number if submitting 'XX' in the 2310E NM108.
LOOP 2320 – OTHER SUBSCRIBER INFORMATION				
332	2320	AMT02	Other Payer Paid Amount	A negative value will result in claim rejection.
334	2320	AMT02	Allowed Amount	A negative value will result in claim rejection.
LOOP 2400 – SERVICE LINE NUMBER				
446	2400	SV201	Service Line Revenue Code	Revenue code '0001' should not be used. (This is for paper use only.)
448	2400	SV203	Line Item Charge Amount	Must contain total charges of claim.
LOOP 2410 – DRUG IDENTIFICATION				
Add. 37	2410	LIN03	National Drug Code	The format for the National Drug Code is 5-4-2 (11 positions). Claims that contain NDC codes in any other format will be rejected.
LOOP 2430 – SERVICE LINE ADJUDICATION INFORMATION				

997 – Functional Acknowledgement

1. We suggest retrieval of the TA1 & ANSI 997 functional acknowledgement files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.
2. The version of the 837 inbound transactions will be returned in the GS08 (Version/Release/Industry/Identifier Code) of the 997.
3. Separate response files and/or reports are created for each ISA-IEA Interchange within a physical file.

Claims Confirmation Report

1. The Claims Confirmation Report can only return the value in the first occurrence of the 2010AA-REF02. If a TP wants the billing provider number to be returned on the Claims Confirmation Report it must be submitted in the first occurrence of the 2010AA-REF02.
2. Separate response files and/or reports are created for each ISA-IEA Interchange within a physical file.
3. A separate batch is created for each 2000A HL submitted within a file. To keep the Claims Confirmation Report to a minimum, it is strongly recommended that only one 2000A HL segment be submitted for each Billing Provider and Payer.

Suggestions for Generating Data Interchanges

1. From the aspect of the ASC X12 and the Implementation Guides, more than one ST/SE segment set *may* be used with one functional group (GS/GE segment set).
2. We recommend, though, that a single ST/SE segment set be generated per GS/GE segment set and that a single GS/GE segment set be generated per ISA/IEA segment set. This will eliminate the chances of multiple billing providers' transactions being rejected on a 997 if there is a problem within only one ST/SE segment set.
3. If claims are being submitted for a single Billing Provider number, we recommend a single 2000A-HL Loop be generated within the single ST/SE segment set for that Billing Provider Number.
4. If claims are being submitted for multiple Billing Provider Numbers, we recommend that a separate data interchange (ISA/IEA segment set with a single GS/GE segment set with a single ST/SE segment set and a single 2000A-HL loop) be generated for each Billing Provider Number.