837 Professional Health Care Claim

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 for version 5010. The chapter contains three sections:

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

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

Claims Processing

Acknowledgements

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

Ancillary Billing

The Blue Cross and Blue Shield Association (BSBCA) defines ancillary claims as those claims from independent laboratories specialty pharmacies, or for durable medical equipment (DME). The Blue Cross and Blue Shield Association has changed the filing instructions for Ancillary claims.. Starting in November of 2012, determination of where the claim should be filed is based on where the services were requested or where the equipment was delivered, instead of being based on where the Billing Provider is contracted or where the Membership resides. Therefore if you are an Independent Lab, Specialty Pharmacy or DME Provider, please be aware you may have claims reject if you do not follow the new filing rules:

- Independent Lab & Specialty Pharmacy – If the Referring Provider is from the state of North Carolina, then file the claim to BCBSNC

- DME Providers – If the equipment was delivered to a location within the State of North Carolina, then file the claim to BCBSNC

BCBSNC will now require Referring Provider information for Independent Lab and Specialty Pharmacy ancillary claims. A Service Facility Location is required to process a DME claim when the equipment was delivered to somewhere other than a location considered the Member's Home. Out-of-state (non North Carolina) Independent Lab, Specialty Pharmacy or DME providers may enroll and submit electronic claims to Blue Cross Blue Shield of North Carolina. To do so they must submit the Electronic Connectivity Request (ECR) form. Search for "ECR form" and instructions at ***www.bcbsnc.com***.

Anesthesia Billing

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

Coordination of Benefits (COB) Processing

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

Important Notice:

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

Code Sets

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

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

Corrections and Reversals

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing.

For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

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

Data Retention of Denied Claims

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

Data Format/Content

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

Dates

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

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

Decimals

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

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

Monetary and Unit Amount Values

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

Phone Numbers

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

Time Frames for Processing

Batch claims are moved through the adjudication process at cycles throughout the day. The last cycle of processing for the day occurs at 8 p.m. for Professional Health Care Claims. Batches must have passed through an initial validation process to reach the adjudication process cycle. Senders should allow time for validation and submit transmissions by 8:00 p.m. to make the last processing cycle of the day.

We adjudicate claims Monday through Friday. Claims accepted after 8:00 p.m. on Friday and through the weekend have a receipt date of the next active business day. For example, claims received on a Saturday, will have a receipt date of the following Monday.

Medicare Claims Processing

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

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

Notice of Consent/Surprise Billing

In support of the Consolidated Appropriations Act of 2021, the Notice of Consent should be identified by the use of the **CK** value in element PWK01 of Loop 2300. This is applicable for 837 both professional and institutional claims.

Please refer to the following link for additional information regarding the Surprise Billing

https://www.cms.gov/nosurprises

In support of the Surprise Billing rule from CMS, Blue Cross NC requires all providers to submit the actual service facility address. It is the **responsibility** of the provider to supply the physical address when Place of Service is 19, 21, 22, 24 or 25. PO Boxes will NOT be accepted. They will be rejected up front.

Medicaid Claims Processing

In support of Medicaid claim filing, be aware there are two edits are being added specific to Blue Cross NC Medicaid members and timely filing

Identification Codes and Numbers

Provider Identifiers

National Provider Identifiers (NPI)

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

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

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

Billing Provider

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

Rendering Provider

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

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

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

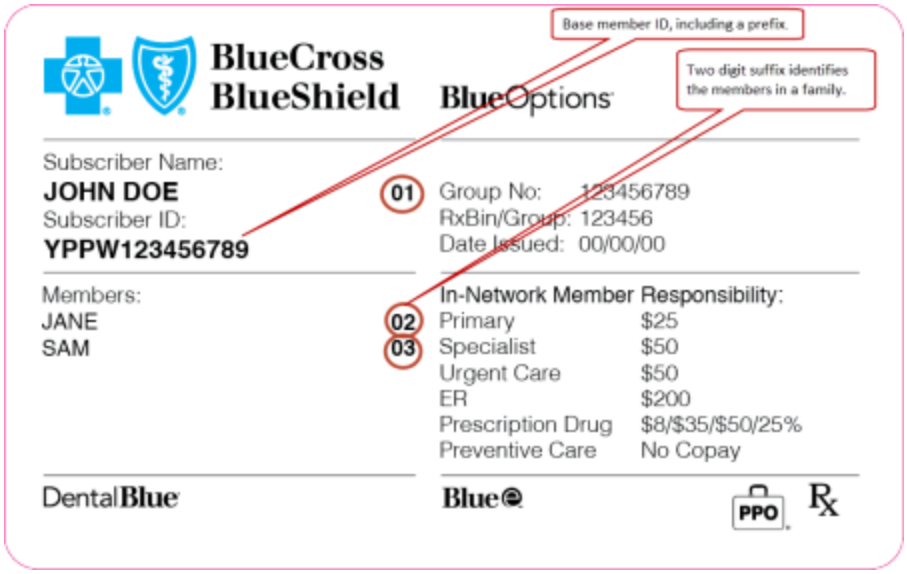
Referring Provider

BCBSNC requires Referring Provider information for independent laboratory and specialty pharmacy ancillary claims.

Subscriber Identifiers

Submitters must use the entire alphanumeric or numeric identification code in the 2010BA element, as it appears on the subscriber's card. . Nearly all BCBSNC members have a three (3) character alpha prefix, followed by eleven (11) alphanumeric characters. Some exceptions are Federal employees, who have only one (1) alpha prefix and eight (8) numeric characters to their member ID. The alpha or alpha-numeric prefix and numeric suffix must be included when providing the subscriber identifier in the transaction.

Below is a sample of a member's ID card, identifying the components: Prefix, base, suffix. All 14 positions are required when submitting a claim. BNC member claims submitted without 14 positions for the member ID are rejected.



The most common reason for claims failure to process is an erroneous Subscriber Identifier. To ensure accuracy, trading partners are advised to verify member benefits with the Health Eligibility Inquiry (270) and use the membership ID returned in the 271 Response[1]. BCBSNC members have unique member identifiers. For BCBSNC member claims, send all patient information, including complete member ID, including alpha prefixes and number suffixes, with demographics, in the 2010BA Loop.

For FEP and BlueCard (IPP) members who may not have unique identifiers, please send the

[1] Look for details on Subscriber/Dependent Member Identification REF01 and REF02 data responses in the HIPAA 270/271 Health Eligibility Inquiry and Response of the corresponding BCBSNC Companion Guide.

subscriber ID and other Subscriber information in 2010BA plus Patient Name and demographics in 2010CA to ensure timely processing.

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

Claim Identifiers

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

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

Claim Filing Indicator Code

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

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for BCBSNC business rules requirements. The BCBSNC business edits include security validation at the ST/SE level and the verification of proprietary business requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – BCBSNC Business Edits Table contained in this chapter. Both HIPAA TR3 implementation guide errors and BCBSNC business edit errors are returned on the *BCBSNC Claims Audit Report*. This report is available to direct senders from your electronic mailbox, or to indirect submitters from your clearinghouse or vendor, or online via ***Blue e***, in the *837 Claims Error Listing*[2] transaction.

Substance Use Disorder Regulations Edits

TThe Substance Abuse and Mental Health Services Administration (SAMHSA) has again updated the regulations to address confidentiality of health records for people seeking treatment for substance use disorders from federally assisted programs - Part 2 Programs. The regulations - 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records) - govern how certain patient identifiable information may be used, disclosed, and redisclosed.

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[2] The *837 Claims Denial Listing*, available on ***Blue e***, is an additional report that provides information about denied claims. Note that this report does not include errors about Medicare product claims.

These regulations are in addition to and separate from the Health Insurance and Portability Act of 1996 (HIPAA) and any State privacy laws and require Part 2 Programs to include a specific statement when disclosing applicable records (such as claims) with a patient's consent. Please note that Part 2 Programs must obtain consent from the member prior to submitting claims to Blue Cross NC and/or its delegates. The consent should reference that the disclosure is for the purpose of treatment, payment and health care operations (TPO) and that Blue Cross NC can use and redisclose the Part 2 records for treatment, payment and health care operations (TPO).

In order to facilitate this required process Blue Cross NC is implementing the following edit:

Beginning October 2021, Blue Cross NC began validating the 837 Note segment [NTE] when present. The note has changed and beginning Feb. 1st 2026, Blue Cross NC will require the CFR Part 2 Note to say: ***42 CFR Part 2 prohibits unauthorized use/disclosure of these records-TPO on file****. Blue Cross NC will be expecting providers who are Part 2 Programs to populate the exact disclosure statement when submitting substance use claims. The 837-error message is P-040 Please use the exact language required for Substance use related claims -* ***42 CFR Part 2 prohibits unauthorized use/disclosure of these records-TPO on file.***

Reporting

The following table indicates which transaction or report to review for problem data found within

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control	Invalid Message or Information Invalid Identifier/s Inactive Message Improper Batch Structure	TA1 (Negative)
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide Violations Unauthorized submission	999 * (Negative) *BCBSNC Claims Audit Report* (a proprietary confirmation and error report)
Detail Segments	BCBSNC Business Edits (see 837 Professional Claim BCBSNC Business Edits for details) Security Validation Messages	*BCBSNC Claims Audit Report* (a proprietary confirmation and error report) *837Claims Error Listing*, available in ***Blue e*** only *Claims Status Detail Error Explanation* (a proprietary report for Medicare Advantage and Medicare Supplemental Claims only.)

Error Reporting for 837 Health Care Claims

Important Notice:

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

Modifying Errored Claims

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

837 Professional: Data Element Table

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

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

837 Professional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
2010AA	NM1	Billing Provider Name				
			NM109	Identification Code	P022	• Use the valid NPI that has been registered with BCBSNC.
					P351	• Service Facility/Billing Provider Information must be a physical address when Place of Service is 19, 21, 22, 24 or 25. PO Boxes are not accepted.
					P051	• There is no record on file for the combination of NPI's received for the dates of service on the claim

[3] BCBSNC Edit Codes are not returned for Medicare Supplemental or Medicare Advantage products.

837 Professional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
2010AC	NM1	Pay-To Plan Name				
			NM109	Identification Code	P043	• Pay-To-Plan name (Loop 2010AC) must be completed when BHT06= 31
2000B	SBR	Subscriber Information				
			SBR09	Claim Filing indicator Code	P015	• For the first instance of SBR09 within this Hierarchical Level (HL), use a value of BL (Blue Cross/Blue Shield) , except for subscribers covered by State Health Employee Plan, use a value of "ZZ" (Mutually Defined) ..
2010BA	LOOP	Subscriber Name				
		Applicable to all of 2010BA				BCBSNC members have unique member IDs. For our members, send all patient information, including full ID (prefix, plus base 9, and 2 digit suffix) and demographics, in the 2010BA Loop. For FEP and BlueCard (IPP) members, please send the subscriber ID and other Subscriber information in 2010BA plus Patient Name and demographics in 2010CA.to ensure timely processing.
2010BA	NM1	Subscriber Name				
			NM103 – NM105	Name (Last, First, Middle)	P301	• BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.
			NM109	ID Code	P006	• BCBSNC uses 14 positions in Member ID. FEP uses 9 positions; BlueCard members may have up to 19 characters in the Member ID.
					P018	• Member ID must contain a valid prefix for the date of service.
					P036	• All 14 positions of the BCBSNC member ID are required.
					P042	• Claims for this Member must be submitted to alternate North Carolina Payer ID – 00602
					P044	• Claims for this Member must be submitted elsewhere
					P045	• Medicaid Claim Submission Not Valid for this Non BCBSNC Member
					P052	• Verify Member ID in Effect for date of service/resubmit or send new claim for New ID. Correction of ID not allowed
2010BA	DMG		02		P038	• First Name must be valid for the Member ID submitted.

837 Professional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
2010BA	NM1		04		P037	• Date of birth must be valid for the member ID.
2010BA	N3 & N4	Patient Address (City, State, Zip)				
			N402	State	P346	• This edit reflects filing requirements listed in the Ancillary Billing section. The edit reads: If state address is not NC, file claim with the local plan for ancillary claims.
2010CA	NM1	Patient Name				
		Applicable to all of 2010CA				For FEP and BlueCard (IPP) members, please send the subscriber ID and other Subscriber information in 2010BA plus Patient Name and demographics in 2010CA.to ensure timely processing.
2010CA	NM1	Patient Name				
			NM103	Last Name or Organization	P337	• BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.
2010CA	N3 & N4	Patient Address (City, State, Zip)				
			N402	State	P346	• This edit reflects filing requirements listed in the Ancillary Billing section. The edit reads: If state address is not NC, file claim with the local plan for ancillary claims.
2300	CLM	Claim Information				
			CLM05:1	Facility Code Value	P335	• A value of “99” (Other Unlisted Facility) is denied, unless the claim is for a Medicare Supplemental or Medicare Advantage product.
2300	DTP	Date (Onset of Current Illness/Symptom to Date – LMP)				
			DTP03	Date Time Period	P305	• If present, Date of current Illness, Accident, or LMP: ➢ must be valid ➢ cannot exceed the current date ➢ cannot be less than the patient’s date of birth.
2300	REF	Payer Claim Control Number				
			02	Reference Identifier	P034	• When submitting a corrected claim (i.e. CLM05-3 = 7), use the same claim number and format of the original claim control number.
2300	NTE	Claim Note				
			02	Claim Note Text	P040	• Please use the exact language required for Substance Abuse related claims - 42 CFR part 2

837 Professional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
						prohibits unauthorized use/ disclosure of these records- TPO on file
2310A	NM1	Referring Provider Name				
			NM103, NM104, NM109	Referring Provider Address and Name	P346 P347 P349	• Please file claim with the Local Plan as defined for ancillary claims. • Referring Provider information required to process Ancillary claim. • Referring Provider is not a Valid NC Provider. Please file claim with the Local Plan per BCBS Ancillary rule.
2310B	NM1	Rendering Provider Name				
			NM109	Rendering Provider Name	P051 P342	• There is no record on file for the combination of NPI's received for the dates of service on the claim • Rendering NPI Submitted Is Not Registered with BNC
2310C	NM1	Service Facility Location Name				
			NM101		P351	• Service Facility/Billing Provider Information must be a physical address when Place of Service is 19, 21, 22, 24 or 25. PO Boxes are not accepted.
2310C	N3 & N4	Service Facility Address (City, State, and Zip)				
			N3 N402	Service Facility Address	P346	• If state address is not NC, file claim with the local plan for ancillary claims.
2320	AMT	COB Payer Paid Amount				
			AMT02	Monetary Amount	P331	• Negative Payer Amounts are denied. • **If filing a secondary or Medicare claim,** fill the actual amount paid by the other carrier. Do NOT include deductive, coinsurance, co-payments, or other adjustments in the Payer Paid Amount field.
2400	SV1	Professional Service				
			SV101:2	Product/Service ID	P005	• Newborn charges should <u>not</u> be filed on the mother's claim, but on a separate claim, under the baby's name.

837 Professional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
			SV101:3, 4, 5, and 6	Procedure Modifier	P317	• The Procedure Modifier must be consistent with the Procedure Code presented in SV101:2. (For example, modifier values of 80, 81, or 82 [Assistant at Surgery] would be consistent with surgical codes 10000 to 69999 and anesthesia codes 00100-01999.)
			SV104	Quantity	P322 P323	• Units should be greater than one (1) when a modifier of "50" is entered. • Days or units should be greater than zero (0).
2400	DTP	Date – Service Date				
			DTP03	Date Time Period	P305 P041 P046	• Claim cannot be corrected more than 1 year from Claim's Earliest Date of Service. • Future Date is not allowed • Medicaid Claim Must be Received within 3 Years from Earliest Date of Service
2420A	NM1	Rendering Provider Identification				
			NM109	Rendering Provider ID	P342 P342	• There is no record on file for the combination of NPI's received for the dates of service on the claim • Rendering NPI Submitted Is Not Registered with BNC
2430	SVD	Line Adjudication Information				
			SVD02	Monetary Amount	P028	• Negative Service Line Paid Amount must be a valid value.

837 Professional Transaction Sample

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

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

Business Scenario

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

Data Element	Value
Subscriber/Patient:	Dash Incredible
Subscriber Address:	852 ELM STREET, RALEIGH, NC 27601-3111
Sex:	M
DOB:	20140909
Employer:	Acme, Co.
Group #:	008574
Payer ID Number:	560894904
Member Identification Number	24670389600
Destination Payer:	Blue Cross Blue Shield of North Carolina (BCBSNC)
Payer Address	5901 Chapel Hill Road, Durham, NC 27707-4919
AHLIC #:	560894904
Submitter:	Clearinghouse
Billing Provider:	Billing Provider
Address:	888 Main Street, Durham, NC, 27715
TIN:	220202020
Billing Provider ID	3344556601
Contact Person	CONTACT PERSON
Patient Account Number:	PAT CONTROL NUMBER
DOS	20201204
POS	Office
Services Rendered	Office visit
Charges	1st office visit - $150.
Total charges	$150.

Data String Example

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

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

```
ISA*00*          *00*          *30*220202020     *30*560894904     *201214*1629*^*00501*268054101*0*P
*:~
GS*HC*220202020*560894904*20201214*1629*268054101*X*005010X222A1~
ST*837*268054101*005010X222A1~
BHT*0019*00*VX2G8NMKY1PSN*20201214*1629*CH~
NM1*41*2*CLEARINGHOUSE*****46*220202020~
PER*IC*CONTACT PERSON*TE*1234567890~
NM1*40*2*BLUE SHIELD OF NORTH*****46*560894904~
HL*1**20*1~
PRV*BI*PXC*101YM0800X~
NM1*85*1*PROVIDER*BILLING****XX*3344556601~
N3*888 MAIN STREET~
N4*DURHAM*NC*270074919~
REF*EI*464961128~
PER*IC*CONTACT PERSON*TE*1234567890~
HL*2*1*22*1~
SBR*P**008574******BL~
NM1*IL*1*INCREDIBLE*MR****MI*ZZZ5201452101~
NM1*PR*2*BLUE SHIELD OF NORTH*****PI*560894904~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*INCREDIBLE*DASH~
N3*852 ELM STREET~
N4*RALEIGH*NC*280003111~
DMG*D8*20140909*M~
CLM*PAT CONTROL NUMBER*150***11:B:1*Y*A*Y*Y~
REF*D9*VX2G8NMKY1PSN~
HI*ABK:F902~
LX*1~
SV1*HC:90837*150*UN*1***1~
DTP*472*D8*20201204~
REF*6R*1~
SE*30*268054101~
GE*1*268054101~
IEA*1*268054101~
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837 Professional File Map

Loop ID	Segment Name	Segment ID	Elements								
	TRANSACTION SET HEADER	**ST**	**ST01**	**ST02**	**ST03**						
			837	0007	005010X222A1~						
	BEGINNING OF HIERARCHICAL TRANSACTION	**BHT**	**BHT01**	**BHT02**	**BHT03**	**BHT04**	**BHT05**	**BHT06**			
			0019	00	VX2G8NMKY1PSN	20201214	1629	CH~			
1000A	**Submitter Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			41	2	CLEARINGHOUSE					46	220202020~
1000A	**Submitter EDI Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**	**PER09**
			IC	CONTACT PERSON	TE	9195551111~					
1000B	**Receiver Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			40	2	BCBSNC					46	560894904~
2000A	**Billing/Pay-To Provider Hierarchical Level**	**HL**	**HL01**	**HL02**	**HL03**	**HL04**					
			1		20	1~					
2010AA	**Billing Provider Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			85	1	Provider	Billing				XX	3344556601~
2010AA	**Billing Provider Address**	**N3**	**N301**								
			888 MAIN STREET~								
2010AA	**Billing/Provider City/State/Zip Code**	**N4**	**N401**	**N402**	**N403**						
			Durham	NC	27701						
2010AA	**Billing Provider Tax Identification**	**REF**	**REF01**	**REF02**							
			EI	123456789							
2000B	**Subscriber Hierarchical Level**	**HL**	**HL01**	**HL02**	**HL03**	**HL04**					
			2	1	22	0~					

Loop ID	Segment Name	Segment ID	Elements								
2000B	**Subscriber Information**	**SBR**	**SBR01**	**SBR02**	**SBR03**	**SBR04**	**SBR05**	**SBR06**	**SBR07**	**SBR08**	**SBR09**
			P	18	ABC123101						BL~
2010BA	**Subscriber Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			IL	1	Dough	Mary	B			MI	24670389600
2010BA	**Subscriber Address**	**N3**	**N301**								
			POBox 12312~								
2010BA	**Subscriber City/State/Zip Code**	**N4**	**N401**	**N402**	**N403**	**N404**					
			Durham	NC	27715						
2010BA	**Subscriber Demographic Information**	**DMG**	**DMG01**	**DMG02**	**DMG03**						
			D8	19670807	F~						
2010BB	**Payer Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			PR	2	BCBSNC					PI	987654321~
2300	**Claim Information**	**CLM**	**CLM01**	**CLM02**	**CLM03**	**CLM04**	**CLM05**	**CLM06**	**CLM07**	**CLM08**	**CLM09**
			Ptacct2235057	100.5			11::1	Y	A	Y	N
2300	**Claim Identification No. For Clearing Houses and Other Transmission Intermediaries**	**REF**	**REF01**	**REF02**							
			EA	Medrec11111~							
2300	**Health Care Diagnosis Code**	**HI**	**HI01**	**HI02**							
			BK:	78901~							
2400	**Service Line**	**LX**	**LX01**								
			1~								
2400	**Professional Service**	**SV1**	**SV101**	**SV102**	**SV103**	**SV104**	**SV105**	**SV106**	**SV107**	**SV108**	**SV109**
			HC:99212	100.5	UN	1	12		1		N~
2400	**Date - Service Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**						
			472	D8	20100801~						
	TRANSACTION SET TRAILER	**SE**	**SE01**	**SE02**							
			24	0007~							

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

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

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

Error Code*	Explanation Message	837 Professional Cross-references[4]
P005	Newborn charges should not be filed on the Parent's claim. They should be filed separately under the baby's name and Member ID.	2400, Professional Service, SV101:2
P006	Member ID must be valid.	2010BA, Subscriber Name, NM109
P015	The first occurrence of Claim Filing Indicator must be BL or ZZ.	2000B, Subscriber Information, SBR09
P018	Member ID not valid for Date of Service (DOS).	2010BA, Subscriber Name, NM109
P022	Provider NPI not registered with BCBSNC. Please contact Network Management at 1-800-777-1643 to resolve this matter.	2010AA, Billing Provider Name, NM109
P028	Negative Service Line Paid Amount invalid.	2430, Line Adjudication Information, SVD02
P032	When filing Medicare primary claims to BCBSNC for adjudication, please allow at least 30 days from the date of the Medicare EOB.	2430, Line Check or Remittance Date, DTP03
P034	Invalid format for Original Claim ID. Please resubmit with valid ID.	2300, Payer Claim Control Number, REF02
P035	Claim cannot be corrected more than 2 years from Claim's Earliest Date of Service.	2400, Date – Service Date, DTP03
P036	Full 14 positions of Member ID are required.	2010BA, Subscriber Name, NM109

[4] This column is cross-referenced to the 837 Professional (005010X222A1) and Companion Guide Data Element Table. The Cross Reference provides TR3 (Technical Report, Type 3) Loop ID, Segment Name, and the segment ID/element number combined (e.g. NM102).

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

Error Code*	Explanation Message	837 Professional Cross-references[4]
P037	Date of Birth not valid for Member ID.	2010BA or 2010CA, Subscriber/Patient Name, DMG02
P038	First name not valid for Member ID.	2010BA or 2010CA, Subscriber/Patient Name, NM104
P040	Please use the exact language required for Substance Abuse related claims - 42 CFR Part 2 prohibits unauthorized use/disclosure of these records- TPO on file	2300, Claim Note, NTE02
P041	Future Date is not allowed	2400, Date – Service Date, DTP03
P042	Claims for this Member must be submitted to alternate North Carolina Payer ID - 00602	2010BA, Subscriber Name, NM109
P043	Pay-To-Plan Name (Loop 2010AC) must be completed when BHT06 = 31	2010AC, Pay-To-Plan Name, NM109
P044	Claims for this Member must be submitted elsewhere	2010BA, Subscriber Name, NM109
P045	Medicaid Claim Submission Not Valid for this Non BCBSNC Member	2010BA, Subscriber Name, NM109
P046	Medicaid Claim Must be Received within 3 Years from Earliest Date of Service	2400, Date – Service Date, DTP03
P051	There is no record on file for the combination of NPI's received for the dates of service on the claim	2010AA, Billing Provider Name, NM109
P052	Verify Member ID in Effect for date of service/resubmit or send new claim for new member ID. Correction of ID not allowed	2010BA, Subscriber Name, NM109
	BREAK IN ERROR MESSAGE NUMBERING	
P301	Invalid Subscriber Name as submitted. Contains special characters other than dashes, apostrophes, spaces or periods.	2010BA, Subscriber Name, NM103
P305	If present, Date of LMP must be valid, and cannot be greater than current date or patient's date of birth.	2300, Date - Last Menstrual Period, DTP03
P317	Modifier is equal to '80', '81', '82' (assistant at surgery) and is inconsistent with a non-surgical procedure code.	2400, Professional Service, SV101:3
P322	Units must be greater than one (1) when a Modifier of '50' is entered.	2400, Professional Service, SV104
P323	Days or Units must be numeric and greater than zero.	2400, Professional Service, SV104

Error Code*	Explanation Message	837 Professional Cross-references[4]
P331	Negative Payer Amount Paid invalid.	2320, Coordination of Benefits (COB) Payer Paid Amount, AMT02
P335	Facility Type Code 99 invalid for BCBSNC business.	2300, Claim Information, CLM05:1
P337	Invalid Patient Name as submitted – contains special characters other than dashes, apostrophes, spaces or periods.	2010CA, Patient Name, NM103 and/or NM104
P342	NPI submitted is not registered with BCBSNC.	2310B or 2430A , Rendering Provider Name, NM109
P346	Please file claim with the Local Plan as defined for ancillary claims.	2010BA or 2010CA, Subscriber/Patient Address, N402, and/or 2310C, Service Facility Location Address, N402
P347	Referring Provider information required to process ancillary claims.	2310A, Referring Provider Name, NM103, NM104, NM109 (when NM101 = DN)
P349	Referring Provider is not a Valid NC Provider. Please file claim with the Local Plan per BCBS Ancillary rule.	2310A, Referring Provider Name, NM103, NM104, NM109 (when NM101 = DN)
P350	Quantity for anesthesia codes should be reported using the 'MJ' qualifier to identify minutes submitted.	2400, Professional Service, SV103
P351	Service Facility/Billing Provider Information must be a physical address when Place of Service is 19, 21, 22, 24 or 25. PO Boxes are not accepted	2310C, Service Facility (NM101 = 77) 2010AA, Billing Provider (NM101 = 85)

Appendix B: BCBSNC Business Edits for Senior Market Health Care Claim

The following error codes and messages may be returned after initial acceptance of the claim, but will prohibit the claim from processing. If a claim receives one of the below codes, the provider will receive a follow-up letter identifying the claim, error code, and explanation message.

Error Code	Explanation Message
AM91	The diagnosis is inconcisistent with the procedure.
AM9A	The procedure code is inconsistent with the modifier used or a required modifier is missing.
AMAT	The diagnosis is inconsistent with the patients age.
AMAZ	The procedure/revenue code is inconsistent with the patients age.
AMLC	The procedure code/bill type is inconsistent with the place of service.
AMLD	Invalid location code.
AMQ3	Procedure code modifier(s) needed for service rendered.
AMQU	Appropriate admin code required.
AMRC	Appropriate CPT/HCPCS code required.
AMRH	Appropriate CPT/HCPCS code required.
AMRN	Appropriate revenue code required.
AMSN	Appropriate HIPPS code required.
AMYF	Appropriate type of bill required.
AMZO	The procedure code is inconsistent with the mdofier used or a required modifier is missing.
AMQ8	The diagnosis is inconsistent with the procedure.
AMQ5	The procedure code is inconsistent with the place of service.
AMAW	The diagnosis is inconsistent with the patients age.
AMQG	The procedure code is inconsistent with the modifier used or a required modifier is missing.

Error Code	Explanation Message
AMVQ	Invalid or missing required claims data.
AMZJ	Invalid bill type.
AMZK	Invalid number of HIPPS codes.
AMZL	Invalid HIPPS codes.
AMZM	Invalid home health claim dates.
AMZN	Invalid number of HIPPS codes.
AMZP	HIPPS code indicates NRS provided, NRS not on claim.
AMZS	Invalid or missing CBSA.
AMZT	Final claim needs at least one visit-related REV code.
AMZU	No available HHRG WEIGHT/RATE.
AMZI	Invalid revenue code for pricing.
AMNP	The procedure code is inconsistent with the modifier used or a required modifier is missing.
AMY8	Invalid code combination.
AM5X	Invalid proceure code/modifier combination.
AMV0	Missing diagnosis code.
AMV2	Invalid units for revenue code.
AMV4	Medically unlikely edit.
AMV5	Service billed as panel.
AMV6	Invalid units for modifier.
AMV8	Incorrect billing of telehealth site fee.
AMVM	HCT/HGB exceeds monitoring threshold W/O appropriate modifier.
AMVY	Incorrect billing of AMCC Test.

Document Change Log

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

Chapter Section	Change Description	Date of Change	Version
Claims Processing	• Addition of Corrections and Reversals section	10/22/10	1.1
	• Addition of Medicare Advantage and Medicare Supplemental Claims processing Information	01/2011	2
Appendix	• Removal of business edits redundant with validator edits.	01/2011	2.1
Data Element Table	• Clarification of conditions for sending the Rendering Provider ID (Loops 2310B and 2420A, NM109)	04/2011	2.2
Appendix	• Addition of P027	05/2011	2.3
Appendix	• Addition of P028 – effective November 2011 • Removal of references to 997 Acknowledgements, which will not be returned	10/2011	2.4
Appendix	• Addition of P029, P030, P031, P346, P347, P348, P349 • Removal of P319 • **P341 – added a note that this edit will not be used after 10/1/2014**	Changes go into affect 10/2012, unless otherwise noted	2.5
Appendix	• Minor verbiage change to P018 and P016.	08/10/12	2.6
Appendix	• Minor verbiage change to P349	09/18/12	2.7
Code Set Versions; Appendix	• Update Code Set Versions; Addition of Edit P032	Effective 10/1/13	2.8
Appendix	• Removal of Security Validation section; these edits are no longer returned. • Revised P022; edit updated to read “Provider NPI not registered with BCBSNC. Please contact Network Management at 1-800-777-1643 to resolve this matter.”	Effective immediately	2.9
Appendix	• Addition of P033: Claim Frequency Type Code of ‘0’ is not accepted.	Effective July 2014	3.0
Subscriber Identifiers and Data Element Table	• Clarification for submission of patient and subscriber name and demographic information (2010BA and 2010CA Loops)	February 2015	3.1
Appendix and Data Element Table	• Addition of P034 business edit for inclusion of the Payer Claim Control number in a corrected claim	June 2015	3.2

Chapter Section	Change Description	Date of Change	Version
Data Element Table	• Addition of Business Rule P035 – Claim cannot be corrected more than 1 year from Claim's Earliest Date of Service.	January 2015	3.3
Subscriber Identifiers and Data Element Table	• Subscriber/Member ID: Additional instruction to use the BCBSNC Companion Guide for Health Eligibility Inquiry 270/271, to ensure accurate member ID is obtained for submission on the 837. • Modification to business edit P035 from 1 to 2 years allowed for timely filing • Addition of business edit P350 (see Appendix)	January 2017	3.4
Data Element Table; Appendix; Business Scenario; Data String Example; 837 Professional File Map	• Removal of multiple business edits which were redundant with frontend HIPAA edits. Edits removed: P004, 026-27, 029-31, 033, 310, 315-6, 329-30, 336, 340-1, 344-5, 348.	December 2017	4
Time Frames for Processing Appendix B	• Clarification of a claim's posted receipt date • Addition of Appendix B: BCBSNC Business Edits for Senior Market Health Care Claim	May 2018	5
Subscriber Identifiers ; Data Element Table Appendix A	• Advising implementation of new business edits to be effective in February 2019 requiring the user of all 14 positions of the member's ID: P036, P037, P038 • Modifications in 837 Professional: Data Element Table to reflect the addition of new edits	October 2018	5.1
NC Health Information Exchange (NCHIE) Edits	• Addition of Business Rule P039 - Provider Not Compliant under NC GS 90-414.4 (A1) NCHIE Mandate.	February 2019	5.2
Substance Use Disorder Regulations Edits	• Addition of P040 • Deletion of P039	September 2020	5.3
837 Professional: Data Element Table	• Addition of P041 • Addition of P042 • Addition of P043	August 2021	5.4
Notice of Consent/Surprise Billing	• Addition of Notice of Consent/Surprise Billing instructions	December 2021	5.5

Chapter Section	Change Description	Date of Change	Version
837 Professional: Data Element Table	• Addition of P351 business edit requiring Service Facility location for Place of Service 19, 21, 22, 24, or 25	July 2022	5.6
837 Professional: Data Element Table	• Addition of P044 business edit • Additional clarification of P351 business edit	November 2022	5.7
837 Professional: Data Element Table	• Verbiage change for P351 business edit	October 2023	5.8
837 Professional: Data Element Table	• Addition of business edit P044 • Addition of business edit P045 • Addition of business edit P046	January 2023	5.9
837 Professional: Data Element Table	• Removal of business edit P313 • Removal of business edit P314	March 2024	5.10
837 Professional: Data Element Table	• Change to P-040 • Addition of P-051 • Addition of P-052	October 2025	5.11