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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 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 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

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 Reporting for more information on returned transactions and reports.

Anesthesia Billing

BCBSNC accepts nationally recognized code sets for anesthesia services and no longer requires the surgical CPT code on a claim for anesthesia services. BCBSNC Network Management distributes a document entitled *Billing Guidelines for Anesthesia Services* to all Anesthesiologists within our network. For information about billing issues specific to anesthesiology services, contact your BCBSNC Network Management field office representative. Contact numbers are available online at http://www.bcbsnc.com/providers/contacts.cfm or in your BCBSNC Network Management copy of *The Blue Book: 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.

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Coordination of Benefits (COB) Processing

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

Important Notice:

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

Code Sets

BCBSNC will follow CMS guidelines and be prepared to accept ICD-10 codes on the CMS compliance date. We will continue to accept ICD-9 codes until such time.

BCBSNC processes only those NUBC codes identified for Blue Cross.

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 denied claims is retained for a minimum of three years before archiving. This data is available electronically, via 276 Health Care Claim Status Inquiries, for up to eighteen months before archiving. After eighteen months, inquiries should be restricted to telephone inquiries only.

Data Format/Content

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

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Code Set Versions

For institutional claims, ICD-10 codes may be used only for diagnosis codes and inpatient procedure codes.

BCBSNC will be ready to process the ICD-10 codes on October 1, 2014 and will not accept ICD-10 codes before the October 1, 2014 implementation date. There will be no grace period or dual use period for ICD-9 codes after October 1, 2014. The following rules will be used:

- If the discharge date is greater than September 30, 2014 use ICD-10,
- If the discharge date is less than October 1, 2014, use ICD-9.

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: 00 to 23 to indicate hours and 00 to 59 to indicate minutes. 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; a patient’s “Admission Date” must not be after the “Statement Covers From 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 Institutional 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 Institutional Health Care Claims. Batches must have passed through an initial validation process to reach the adjudication process cycle. Senders should allow time for validation and submit transmissions by 7:30 p.m. to make the last processing cycle of the day.

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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.

Important Note for Medicare Crossover Claims

If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

Identification Codes and Numbers

Provider Identifiers

National Provider Identifiers (NPI)

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 Institutional Claims: Data Element Table for specific instructions about where to place the NPI within the 837 Institutional x12 record. The table also clarifies what other elements must be submitted when the NPI is used.

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.

Subscriber Identifiers

Submitters must use the entire alphanumeric or numeric identification code, as it appears on the subscriber's card in the 2010BA element. Nearly all BCBSNC members have a three (3) character alpha prefix, followed by 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 prefix must be included when providing the subscriber identifier in the transaction.

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 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

[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.

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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. 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 Institutional Data Element Table contained in this chapter, and are also available as a comprehensive list in the BCBSNC 837 Institutional Health Care Claim Business Edits table in the Appendix. Both the 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 their electronic mailbox, or to indirect submitters from their clearinghouse or vendor, or online via ***Blue e***, in the *837 Claims Error Listing*[2] transaction.

Reporting

The following table indicates which transaction or report is used for problems found within the 837 Institutional Claim Transaction. Please see Acknowledgements for more information on automatically received responses. SDGR

Transaction Structure Level of Error	Type of Error	Transaction or Report Returned
ISA/IEA Interchange Control	Invalid Message Invalid Identifier/s Inactive Message Improper Batch Structure	TA1 (Negative)
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA TR3 Violations	999* (Negative) *BCBSNC Claims Audit Report*

[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.

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Transaction Structure Level of Error	Type of Error	Transaction or Report Returned
Detail Segments	BCBSNC Business Edits (see 837 Institutional Claim - Data Element Table for details) Security Validation Messages	*BCBSNC Claims Audit 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 Claims

Important Notice:

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

Modifying Erred Claims

Important Notice

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

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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 for easy cross-reference. The Data Element Table also references the BCBSNC Business Edit Code Number if there is an edit applicable to the data element in question. The BCBSNC Business Edit Code Numbers appear on the Claims Audit Report, along with a narrative explanation of the edit. For a list of the error messages and their respective code numbers, see **Appendix C: 837 Institutional Business Edits** of the *BCBSNC Companion Guide to EDI Transactions*. Appendix C can be downloaded from www.bcbsnc.com/providers/edi/hipaainfo.cfm.

The BCBSNC business rule 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.

837 Institutional Health Care Claim

Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rule
	BHT	Beginning of Hierarchical Transaction				
			04		I-009	Creation date must be a valid date and not greater than current date.
			06		I-027	Use a value of 31 only for Medicaid subrogation claims.
2010AA	NM1	Billing Provider Name				
			09	Identification Code	I-022	NPI must be registered with BCBSNC.
2000B	SBR	Subscriber Information				
			09	Claim Filing indicator Code	I-015	For the first instance of SBR09 within this Hierarchical Level, use a value of BL (Blue Cross/Blue Shield) or a value of "ZZ" (Mutually Defined) if the subscriber is covered by State Health Employee Plan.
2010BA	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				
			09	Identification Code	I-006 I-018	BCBSNC uses up to 19 characters. If the first two positions of the Member ID Number are alpha, then the third position must be alpha also. Member ID must contain a valid prefix for the date of service.

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837 Institutional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit Code Number**	**BCBSNC Business Rule**
					I-029 I-030	An alpha prefix is required on the Member ID. The Member ID must be valid for the DOS.
2010BB	REF	Billing Provider Secondary Identifier				
			02	Reference Identification	I-026	For Medicaid subrogated claims, Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid .
2010CA	LOOP	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.
2300	CLM	Claim Information				
			05	Claim Frequency Code	I-033	Claim Frequency Type Code of '0' is not accepted.
	DTP	Statement Dates				
			03	Date Time Period	I-361 I-304 I-305 I-307	If date ranges are presented: • Claim must contain only one version of Inpatient Procedure Codes; create two separate claims using appropriate code version and dates for each. • The 'Statement Covers From' Year must not be greater than the 'Statement Covers Through' year • The 'Statement Covers From and Through' dates must not be greater than today's date. • Admission Date must not be greater than the 'Statement Covers From' date

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837 Institutional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit Code Number**	**BCBSNC Business Rule**
	DTP	Admission Date/Hour				
			03	Date Time Period	I-307 I-308	• Admission Date must not be greater than the "Statement Covers From" Date. • Admission Date must not be greater than today's date.
	CL1	Institutional Claim Code				
			03	Patient Status Code	I-309 I-310 I-363	• If the patient is still in the hospital, he/she cannot have a status of 'discharged patient'. (If Type of Bill (CLM05:1) is equal to "11X" or "12X" with a Frequency of 2 or 3, the Patient Status cannot be any value from 1 to 8, or 20.) • If Type of Bill (CLM05:1) is equal to 111, 114, 121, or 124, the Patient Status cannot be 30. • If the Occurrence Code equals '55', Patient Status must equal '21', '40', '41', or '42'.
	REF	Payer Claim Control Number				
			02	Reference Identifier	I-034	When submitting a corrected claim (i.e. CLM05-3 = 7), use the same claim number and format of the original claim control number.
	HI	**Apply to all HI Segments with Diagnosis Code Qualifier**				
					I-031 I-362	• Claim must contain only one version of the Diagnosis Code ; Create two separate claims using appropriate code version and dates for each • The ICD version for Diagnosis and Inpatient Procedure Code(s) must be equal. Please resubmit the claim with the same code versions
	HI	Other Diagnosis Information				
			01:4	Date Time Period	I-335	• Principal Procedure Date must not contain a future date.
2300	HI	Principle Procedure Information				
			01:4	Date Time Period	I-334 I-357	• Principal procedure codes and dates must be entered for Revenue Code 036X. • For Inpatient claims, Principal Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period.
	HI	Other Procedure Information				

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837 Institutional Health Care Claim

Loop ID	Segment Type	Segment Designator	Element ID	Data Element	BCBSNC Business Edit Code Number	BCBSNC Business Rule
			01:4	Date Time Period	I-338	• Other Procedure Date must not contain a future date.
	HI	Occurrence Span Information				
			01-12: 4	Occurrence Span Date	I-343 I-316	• 'Occurrence Span Thru' date must be greater than or equal to the 'Occurrence Span From' Date. • Occurrence Span Date must be less than or equal to the 'Statement Covers From' date if the Occurrence Code is 01 thru 06, 10, or 11.
2300	HI	Occurrence Information				
			01-12: 4	Occurrence Date	I-313 I-314 I-364	• Occurrence date must be less than or equal to 'Statement Covers From' date if the Occurrence Code is 01-06, 10, or 11. • Occurrence Date must not be greater than today's date. • If Patient Status equals '21', '40', '41', or '42', Occurrence Code '55' must be present.
2330A	NM1	Other Subscriber Name				
			02	Entity Qualifier	I-004	When NM101 equals "IL" (Other Subscriber's Name), NM102 Entity Qualifier must equal "1" (Person).
2400	SV2	Institutional Service Line				
			01	Product/Service ID	I-319 I-005 I-353	• An Inpatient Claim must contain at least one Accommodation Revenue code. • Newborn charges should be filed separately under the baby's name, NOT on the mother's claim. • Any revenue code used must be one contractually agreed upon between BCBSNC and the health service provider.
			02:2	Product/Service ID	I-321	HCPCS code must be present when Bill Type equals 83X and a Revenue Code of 49X is present. Appropriate HCPCS and/or CPTcodes should be included when billing outpatient or ambulatory surgical claims for Medicare Advantage or Medicare Supplemental products.
			05	Quantity (service unit count)	I-325 I-326	• Units of Service must be greater than zero for accommodation rate revenue codes [010X-021X]. • The sum of accommodation days (units) must equal the number of

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837 Institutional Health Care Claim						
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit Code Number**	**BCBSNC Business Rule**
						days in the "State Covers Period"
2400	DTP	Service Line Date				
			03	Date Time Period	I-323 I-358 I-035	• Service Date must be contained within the 'Statement Covers From and Thru' Dates. • For Inpatient claims, Other Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period. • Claim cannot be corrected more than 1 year from Claim's Earliest Date of Service.

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837 Institutional Transaction Sample

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

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

Business Scenario

The following test sample presents a high-level scenario likely to occur and the subsequent handling typically used by BCBSNC.

The patient is also the subscriber, Mary Dough. She has had three procedures performed as an outpatient at the Howdee Hospital.

Data Element	Value
Subscriber:	Mary Dough
Subscriber Address:	Box 12312 Durham, NC 27701
Sex:	F
DOB:	August 7, 1967
Insurance ID#:	24672148306
Payer ID #:	987654321
Patient:	Same as subscriber
Primary Payer:	BCBSNC
Submitter:	Howdee Hospital
EDI #:	123456789
Receiver:	BCBSNC
EDI #:	987654321
Billing Provider:	Howdee Hospital
Provider #	0123456789
Address:	123 Howdee Blvd. Durham, NC 27701
Contact Person and Number	Betty Rubble, 919-555-1111
Attending Physician:	Elizabeth Smith
Attending Physician NPI:	1005554102
UPIN #	P97777
Patient Account Number:	2235057
Date of Admission:	7/30/2010
Place of Service:	Hospital
Occurrence Codes and Dates:	41 on 5/1/2010 27 on 7/15/2010 33 on 4/15/2010 C2 on 4/10/2010
Value Code	30
Value Amount	$20.
Condition Codes:	01
ICD-9 Procedure Code and Date:	449.1, 7/30/2010
Principal Diagnosis Code:	250.00
Secondary Diagnosis Codes:	789.01
Revenue Codes	0300 0320 0270
Services:	HC

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Data Element	Value
Institutional Services Rendered:	81000 76092 J1120
Line Item Charge Amounts	$120. $50. $30.
Total Charges:	$200.

Data String Example

The following transmission sample illustrates the file format used for an EDI transaction, which includes delimiters and data segment symbols. The sample includes the ISA (Interchange Control) and GS (Functional Group) portions of a transmission, and only one ST/SE segment.

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 837.

```
ISA*00*          *00*          *01*9012345720000  *01*9088877320000
*100816*1144*U*00200*000000031*0*T*:~
GS*HC*901234572000*908887732000*20100816*1615*31*X*005010X223A1~
ST*837*0034*005010X223A1~
BHT*0019*00*3920394930203*20100816*1615*CH~
NM1*41*2*HOWDEE HOSPITAL*****46*0123456789~
PER*IC*BETTY RUBBLE*TE*9195551111~
NM1*40*2*BCBSNC*****46*987654321~
HL*1**20*1~
NM1*85*2*HOWDEE HOSPITAL*****XX*1245011012~
N3*123 HOWDEE BLVD~
N4*DURHAM*NC*27701~
REF*EI*123456789~
PER*IC*WILMA RUBBLE*TE*9195551111*FX*6145551212~
HL*2*1*22*0~
SBR*P*18*XYZ1234567******BL~
NM1*IL*1*DOUGH*MARY****MI*24672148306~
N3*BOX 12312~
N4*DURHAM*NC*27715~
DMG*D8*19670807*F~
NM1*PR*2*BCBSNC*****PI*987654321~
CLM*2235057*200***13:A:1***A**Y*Y~
DTP*434*RD8*20100730-20100730~
CL1*1*9*01~
REF*F8*ASD0000123~
HI*BK:25000~
HI*BF:78901~
HI*BR:4491:D8:20100730~
HI*BH:41:D8:20100501*BH:27:D8:20100715*BH:33:D8:20100415*BH:C2:D8:20100410~
HI*BE:30:::20~
HI*BG:01~
NM1*71*1*SMITH*ELIZABETH*AL***34*243898989~
REF*1G*P97777~
LX*1~
SV2*0300*HC:81000*120*UN*1~
```


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DTP*472*D8*20100730~
LX*2~
SV2*0320*HC:76092*50*UN*1~
DTP*472*D8*20100730~
LX*3~
SV2*0270*HC:J1120*30*UN*1~
DTP*472*D8*20100730~
SE*38*0034~
GE*1*30~
IEA*1*000000031~

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837 Institutional File Map

The file map illustrates the relationship of the sample claim data to the relevant Loops, Segments, and Elements of the 837 Institutional Transaction Implementation Guide. Note that this file map starts at the ST segment of the transmission, and only one claim is contained here. Normally, multiple claims for multiple subscribers are included in one ST/SE segment.

Loop ID		Segment	Elements									
	TRANSACTION SET HEADER	**ST**	**ST01**	**ST02**	ST03							
			837	0034	005010X223A1							
	BEGINNING OF HIERARCHICAL TRANSACTION	**BHT**	**BHT01**	**BHT02**	**BHT03**	**BHT04**	**BHT05**	**BHT06**				
			0019	00	3920394930203	20100816	1615	CH				
1000A	**Submitter Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			41	2	Howdee Hospital					46	123456789	
1000A	**Submitter EDI Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**	**PER09**	
			IC	Betty Rubble	TE	9195551111						
1000B	**Receiver Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			40	2	BCBSNC					46	987654321	
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	2	Howdee Hospital					XX	1245011012	
2010AA	**Billing Provider Address**	**N3**	**N301**									
			123 Howdee Blvd.									
2010AA	**Billing/Provider City/State/Zip Code**	**N4**	**N401**	**N402**	**N403**							
			Durham	NC	27701							
2010AA	**Billing Provider Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**		
			IC	Wilma Rubble	TE	9195551111						
2010AA	**Billing Provider Tax Identification**	**REF**	**REF01**	**REF02**								
			EI	123456789								

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Loop ID		Segment	Elements									
2000B	Subscriber Hierarchical Level	HL	HL01	HL02	HL03	HL04						
			2	1	22	0						
2000B	Subscriber Information	SBR	SBR01	SBR02	SBR03	SBR04	SBR05	SBR06	SBR07	SBR08	SBR09	
			P	18	XYZ1234567						BL	
2010BA	Subscriber Name	NM1	NM101	NM102	NM103	NM104	NM105	NM106	NM107	NM108	NM109	
			IL	1	Dough	Mary				MI	24672148306	
2010BA	Subscriber Address	N3	N301	N302								
			Box 12312									
2010BA	Subscriber City/State/Zip Code	N4	N401	N402	N403							
			Durham	NC	27715							
2010BA	Subscriber Demographic Information	DMG	DMG01	DMG02	DMG03							
			D8	19670807	F							
2010BC	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	CLM18
			2235057	200			13:A:1		A	Y	Y	N
2300	Statement Dates	DTP	DTP01	DTP02	DTP03							
			434	RD8	20100730-20100730							
2300	Institutional Claim Code	CL1	CL101	CL102	CL103							
			1	9	01							
2300	Original Reference Number	REF	REF01	REF02								
			F8	ASD0000123								
2300	Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis	HI	HI01	HI01-1	HI01-2							
				BK	25000							
2300	Other Diagnosis Information	HI	HI01	HI01-1	HI01-2							
				BF	78901							
2300	Principal Procedure Information	HI	HI01	HI01-1	HI01-2	HI01-3	HI01-4					
				BR	4491	D8	20100730					
2300	Occurrence Information	HI	HI01	HI01-1	HI01-2	HI01-3	HI01-4					
				BH	41	D8	20100501					

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Loop ID		Segment	Elements									
		HI	**HI02**	**HI02-1**	**HI02-2**	**HI02-3**	**HI02-4**					
				BH	27	D8	2010071 5					
		HI	**HI03**	**HI03-1**	**HI03-2**	**HI03-3**	**HI03-4**					
				BH	33	D8	2010041 5					
		HI	**HI04**	**HI04-1**	**HI04-2**	**HI04-3**	**HI04-4**					
				BH	C2	D8	2010041 0					
2300	**Value Information**	**HI**	**HI01**	**HI01-1**	**HI01-2**	**HI01-3**	**HI01-4**	**HI01-5**				
				BE	30			20				
2300	**Condition Information**	**HI**	**HI01**	**HI01-1**	**HI01-2**	**HI01-3**	**HI01-4**	**HI01-5**				
				BG	01							
2310A	**Attending Physician Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			71	1	Smith	Elizabeth	AI			34	9898989 89	
2400	**Service Line Number**	**LX**	**LX01**									
			1									
2400	**Institutional Service Line**	**SV2**	**SV201**	**SV202-1**	**SV202-2**	**SV203**	**SV204**	**SV205**	**SV206**	**SV207**	**SV208**	
			0300	HC	81000	120	UN	1				
2400	**Service Line Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**							
			472	D8	20100730							
2400	**Service Line Number**	**LX**	**LX01**									
			2									
2400	**Institutional Service Line**	**SV2**	**SV201**	**SV202-1**	**SV202-2**	**SV203**	**SV204**	**SV205**	**SV206**	**SV207**	**SV208**	
			0320	HC	76092	50	UN	1				
2400	**Service Line Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**							
			472	D8	20100730							
2400	**Service Line Number**	**LX**	**LX01**									
			3									
2400	**Institutional Service Line**	**SV2**	**SV201**	**SV202-1**	**SV202-2**	**SV203**	**SV204**	**SV205**	**SV206**	**SV207**	**SV208**	
			0270	HC	J1120	30	UN	1				
2400	**Service Line Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**							
			472	D8	20100730							
	TRANSACTION SET TRAILER	**SE**	**SE01**	**SE02**								
			38	0034								

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Appendix: BCBSNC Business Edits for the 837 Institutional 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 Claims Error Listing*.

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

Error Code	Explanation Message	837 Institutional Cross-references[3]
I-004	When Other Insured's Name Qualifier (NM101) = IL, Entity Type Qualifier must equal '1'.	2330A, Other Subscriber Name, NM102
I-005	Newborn charges must be filed separately under the baby's name.	2400, Inst. Service Line, SV201
I-006	Member ID must be valid.	2010BA, NM109, Subscriber Name
I-015	The first occurrence of Claim Filing Indicator must be BL or ZZ.	2000B, Subscriber Information, SBR09
I-018	Member ID number is not valid for Date of Service (DOS).	2010BA, NM109 Subscriber /Patient Name
I-022	Provider NPI not registered with BCBSNC. Please contact Network Management at 1-800-777-1643 to resolve this matter.	2010AA, Provider ID, NM109
I-026	I026 - Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid for Medicaid submitted claims.	2010BB, Provider ID, REF02
I-027	Medicare Advantage/Medicare Supplement Member ID is invalid. Please correct and resubmit.	2010BA, Member ID, NM109
I-028	Negative Service Line Paid Amount invalid.	2430, Service Line Paid Amount, SVD02
I-029	Alpha prefix is required; please submit the member ID as it appears on the membership card.	2010BA , NM109
I-030	ID is no longer valid. Please obtain the current ID from the membership card.	2010, NM109
I-031	Claim must contain only one version of the Diagnosis Code ; Create two separate claims using appropriate code version and dates for each	2300, Diagnosis code qualifier, HIXX

[3] Cross-reference to the 837 Institutional (005010X223A1) and Companion Guide Data Element Table. The Cross Reference provides the TR3 references for Loop ID, Segment Name (or alias), and the Element ID (e.g. NM102).

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Error Code	Explanation Message	837 Institutional Cross-references[3]
I-032	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
I-033	Claim Frequency Type Code of ‘0’ is not accepted.	2300, CLM05
I-034	Invalid format for Original Claim ID. Please resubmit with valid ID.	2300, REF02, Payer Claim Control Number
I-035	Claim cannot be corrected more than 2 years from Claim’s Earliest Date of Service	2300, DTP03, Statement Dates
	BREAK IN ERROR MESSAGE NUMBERING	
I-304	Statement Covers From Date must not be greater than the Statement Covers Thru Date.	2300, DTP03, Statement Dates
I-305	Statement Covers From and Thru Dates must not be greater than current date.	2300, DTP03, Statement Dates
I-308	If present, Admission Date must not be greater than current date.	2300, DTP03, Admission Date/Hour
I-309	If Type of Bill = '112', '113', '122', '123'; Patient Status cannot be '01-07, '20', ’21’, ‘40-43’, ‘61-66’, ‘70’, or ‘81-95	2300, CL103, Institutional Claim Code
I-310	If Type of Bill = '111', '114', '121' or '124'; Patient Status cannot be ‘30’.	2300, CL103, Institutional Claim Code
I-313	If present, Occurrence Date must be less than or equal to Statement Covers From Date if Occurrence Code is 01-06, 10 or 11.	2300, HI01-4 to HI08-4, Occurrence Information
I-314	Occurrence Date must not be greater than current date.	2300, HI01-4 to HI08-4, Occurrence Information
I-316	Occurrence Date must be less than or equal to the Statement Covers From Date if the Occurrence Code is '01' thru '06', ‘10’ or ‘11'.	2300, HI01-4 to HI04-4, Occurrence Span Information
I-317	Occurrence Span Date must not be greater than current date.	2300, HI01-4 to HI04-4, Occurrence Span Information
I-319	An Inpatient Claim [TOB X1X or X2X] must contain one Accommodation Revenue Code [010X-021X or 100X].	2400, SV2 01,Revenue Code (Inst. Service Line)
I-321	HCPCS code must be present when Bill Type equals 83X with Revenue Code 49X present.	2400, SV2 02, Institutional Service Line
I-323	Service Date must be within three calendar days of Statement Covers From Date.	2400, DTP03, Service Line Date
I-325	Units of Service must be greater than zero for accommodation rate revenue codes [010X-021X].	2400, SV2 05, Institutional Service Line

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Error Code	Explanation Message	837 Institutional Cross-references[3]
~~I-331~~	~~If the Principal Diagnosis Code is between ‘800’ and ‘995’, one of the Occurrence Codes in Form Locators 32-36 must contain 01, 02, 03, 04, 05 or 06.~~ Removed for October 2012.	~~2300, HIXX-2, Principal, Admitting, E-Code, etc.~~
I-333	~~For Outpatient claims, Principal Procedure Date must fall within three days of the Statement Covers Dates.~~	~~2300, HI01-4, Principal Procedure Info.~~
I-334	Principal procedure codes and dates must be entered for Revenue Code 036X.	2300, HIXX Principal Procedure Info.
I-335	Principal Procedure Date must not contain a future date.	2300, HI01-4, Principal Procedure Info.
I-337	~~For Outpatient claims, Other Procedure Date must fall within three days of the Statement Covers Date.~~	~~2300, HIXX-4, Other Procedure Info. - p. 168, 2300, DTP03 Statement Dates~~
I-338	Other Procedure Date must not contain a future date.	2300, HIXX-4, Other Procedure Date
I-340	Admitting Diagnosis Qualifier must equal 'BJ' for inpatient claim only.	2300, HI02-2, Principal, Admitting… DX
I-343	Occurrence Span From Date must not be greater than the Occurrence Span Thru Date.	2300, HI XX-4, Occurrence Span Info.
I-348	Claim contains greater than 998 charge lines	2400, LX01, Service Line Number
I-353	The Revenue Code is not valid for BCBSNC.	2400, Institutional Service Line, SV2-01
I-357	For Inpatient claims, Principal Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period.	2300, HI 01-2, Principal Procedure Information
I-358	For Inpatient claims, Other Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period.	2400, DTP03, Service Line Date
I-359	CPT/HCPCS required for outpatient claims for specific revenue codes. (See NUBC Revenue Code list for applicable codes)	2400, SV202-1
I-360	HIPPS RUG required for inpatient SNF with rev code 0022.	2400, SV202-1
I-361	Claim must contain only one version of Inpatient Procedure Codes; Create two separate claims using appropriate code version and dates for each.	2300, HIXX-1 (multiple segments possible)
I-362	The ICD version for Diagnosis and Inpatient Procedure Code(s) must be equal. Please resubmit the claim with the same code versions	2300, HIXX-1 (multiple segments possible)
I-363	If the Occurrence Code equals ‘55’, Patient Status must equal ‘20’, ‘40’, ‘41’, or ‘42’.	2300, CL103, Patient Status Code (see edit I-364)
I-364	If Patient Status equals ‘20’, ‘40’, ‘41’, or ‘42’, Occurrence Code ‘55’ must be present.	2300, HI xx-2, Occurrence Code (see edit I-363)

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Error Code	Explanation Message	837 Institutional Cross-references[3]
I-365	The pick-up location zip code is required for ambulance claims.	2300, HI xx-5, Zip Code

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
Throughout the document Appendix	Addition of Medicare Advantage and Medicare Supplemental Claims processing Information Removal of business edits that are tracked by EDIFECs; in 5010 transmissions, these edits are no longer necessary.	01/04/2011	2
Appendix	Addition of I-027	05/05/2011	2.1
Appendix	• Removal of edits I-326 and I-307 • Addition of I-028 for implementation in **November 12, 2011** • Removal of references to 997 Acknowledgements, which will not be returned	10/2011	2.2
Appendix and 837 Institutional Elements Table	Addition of business edits I-359 and I-360	11/2011	2.3
Appendix 837 Institutional Elements Table	Addition of business edits I-029, I-030, I-031, I-334, I-361, and I-362 Removal of I-331	Changes go into affect 10/2012	2.4
Appendix 837 Institutional Elements Table	Addition of business edits I-363 and I364	Changes go into affect 10/2012	2.5
Appendix 837 Institutional Elements Table	Correction of business edits I-363 and I-364 – replacement of occurrence code 21 with 20	Changes go into affect 10/2012	2.6
Appendix 837	Business Edit I-357 changed from “For Inpatient claims, Principal Procedure Date must	April 1, 2013	2.7

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Chapter Section	Change Description	Date of Change	Version
Institutional Elements Table	fall within three calendar days of the Admission Date" to "For Inpatient claims, Principal Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period."		
Appendix 837 Institutional Elements Table	Business Edit I-358 changed from "For Inpatient claims, Other Procedure Date must fall within three calendar days of the Admission Date" to "For Inpatient claims, Other Procedure Date must fall within three calendar days prior to the Admission Date or within the Statement Covers Period."within the Statement Covers Period."	April 1, 2013	2.7
Appendix 837 Institutional Elements Table	Removal of I-333 and I-337, which are no longer invoked as business edits; this edit is enforced by HIPAA frontend edits.	April 1, 2013	2.7
Appendix; 837 Institutional Elements Table; Code Set Version	• Amend edit I-309 from *If Type of Bill = '112', '113', '122', '123'; Patient Status cannot be '01-08', '20', '21', '40-43', '61-66' or '70'* to *If Type of Bill = '112', '113', '122', '123'; Patient Status cannot be '01-07, '20', '21', '40-43', '61-66', '70', or '81-95';* • Addition of Edit I-032 • Update the Code Set Version section	Effective October 2013	2.8
Appendix; 837 Institutional Elements Table	• Removal of Security Validation section; these edits are no longer returned. • Revised I-022; 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 Business Rule I-033 : 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; 837 Institutional Elements Table	Addition of Business Rule I-034 – for corrected claims: Invalid format for Original Claim ID. Please resubmit with valid ID.	June 2015	3.2
837 Institutional Elements Table	Addition of Business Rule I-035 – 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. • Modifcation to edit I-035 from 1 to 2 years allowed – applicable March 2017 • Added I-365 edit (see Appendix)	January 2017	3.4

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