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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 www.bcbsnc.com , as is the *Blue Book: Provider Manual,* available online at www.bcbsnc.com . 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 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.

Code Set Versions

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

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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, 2015, 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 8:00 p.m. to make the last processing cycle of the day.

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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, where the following Monday is a bank holiday, are assigned a receipt date of the following Tuesday.

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.

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 Notice of Consent/Surprise Billing

https://www.cms.gov/nosurprises

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 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.

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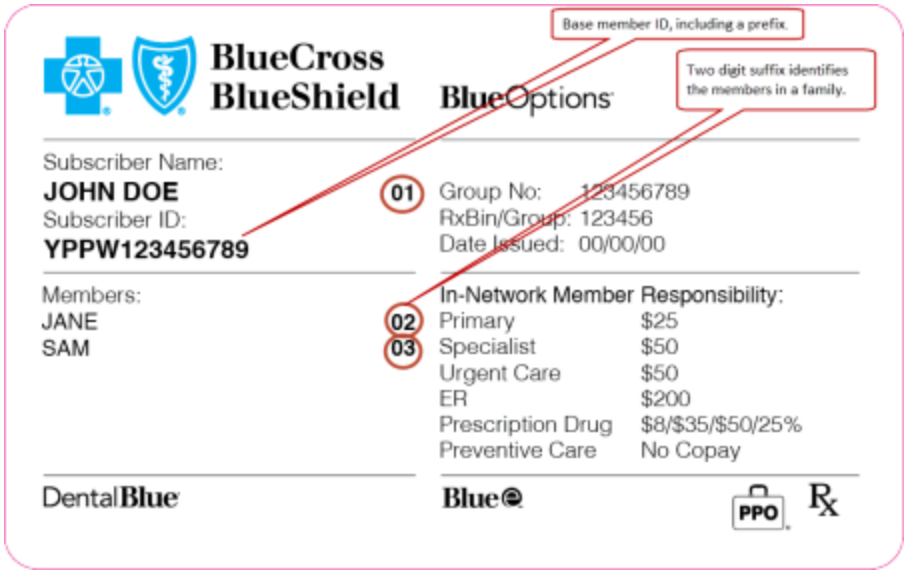
Below is a sample of a member's ID card, identifying the components: Prefix, base, suffix. All 14 positions are required when submitting a claim. BNC member claims submitted without 14 positions for the member ID are rejected.



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 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

[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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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.

Substance Use Disorder Regulations Edits

The Substance Abuse and Mental Health Services Administration (SAMHSA) has updated 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. 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 prior to submitting any protected claims, Part 2 Programs should be obtaining consent from patients to disclose their information to Blue Cross NC for the purpose of payment and healthcare operations.

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

[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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Beginning October 2021, Blue Cross NC will be validating the 837 Note segment [NTE] when present. In support of these regulations, 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 ***I-040 Please use the exact language required for Substance use related claims - 42 CFR PART 2 PROHIBITS UNAUTHORIZED DISCLOSURE OF THESE RECORDS***.

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*
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**
2010AA	NM1	Billing Provider Name				
			09	Identification Code	I-022	• NPI must be registered with BCBSNC.
2010AC	NM1	Pay-To Plan Name				
			09	Identification Code	I-043	• Pay-To Plan Name (Loop 2010AC) must be completed when BHT06 = 31
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.

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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**
2010BA	NM1	Subscriber Name				
					I-006 I-018 I-036 I-042	• BCBSNC uses 14 positions in Member ID. FEP uses 9 positions; BlueCard members may have up to 19 characters in the Member ID. • Member ID must contain a valid prefix for the date of service. • All 14 positions of the BCBSNC member ID are required. • Claims for this Member must be submitted to alternate North Carolina Payer ID - 00602
			09	Identification Code		
2010BA	DMG		02		I-038	• First Name must be valid for the Member ID submitted.
2010BA	NM1		04		I-037	• Date of birth must be valid for the Member ID
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.
2300	DTP	Statement Dates				
			03	Date Time Period	I-041	• Future Date is not allowed
2300	CL1	Institutional Claim Code				
					I-309 I-310	• 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.
			03	Patient Status Code		
2300	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.
2300	NTE	Billing Note				

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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**
			02	Billing Note Text	I-040	• Please use the exact language required for Substance Abuse related claims - 42 CFR part 2 prohibits unauthorized disclosure of these records
2300	HI	Principle Diagnosis				
			01-12:9	Present on Admission Indicator	I-366	• POA required for inpatient claims
2300	HI	Other Diagnosis Information				
			01-12:9	Present on Admission Indicator	I-366	• POA required for inpatient claims
2300	HI	External Cause of Injury				
			01-12:9	Present on Admission Indicator	I-366	• POA required for inpatient claims
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.
2300	HI	Occurrence Span Information				
			01-12:4	Occurrence Span Date	I-317 I-343	• Occurrence Span Date must not be greater than current date. • 'Occurrence Span Thru' date must be greater than or equal to the 'Occurrence Span From' Date.
2300	HI	Occurrence Information				
			01-12:4	Occurrence Date	I-313 I-314	• 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.

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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**
2300	HI	Value Information				
			01:2	Value Information	I-365	• The pick-up location zip code is required for ambulance claims.
2400	SV2	Institutional Service Line				
			01	Product/Service ID	I-319 I-005 I-359	• 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. • CPT/HCPCS required for outpatient claims for specific revenue codes.
			05	Quantity (service unit count)	I-325	• Units of Service must be greater than zero for accommodation rate revenue codes [010X-021X].
2400	DTP	Service Line Date				
			03	Date Time Period	I-358 I-035	• 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 2 years 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:	123 MAIN STREET*APT G APEX*NC*276022345
Sex:	F
DOB:	19661123
Insurance ID#:	YPPW0001110001
Payer ID #:	SB810
Patient:	Same as subscriber
Primary Payer:	BCBSNC
Submitter:	CLEARINGHOUSE X
EDI #:	012345698
Receiver:	BCBSNC
EDI #:	560894904
Billing Provider:	GENERAL HOME HEALTH SERVICES
Provider #	2233445560
Address:	123 MEDICAL NURSING WAY SUITE 800 DURHAM*NC*277075811
Contact Person and Number	OFFICE MANAGER
Attending Physician:	Attending Physician
Attending Physician NPI:	0011223340
Patient Account Number:	PATIENT ACCT NUMBER
Date of Admission:	11/30/2020
Place of Service:	Hospital
Occurrence Codes and Dates:	05 on 20201109
Condition Codes:	01
ICD-9 Procedure Code and Date:	449.1, 7/30/2020
Principal Diagnosis Code:	M722
Secondary Diagnosis Codes:	M79672
Services: Institutional Services Rendered:	HC H0015
Line Item Charge Amounts	$120. $50. $30.
Total Charges:	$200.

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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.

ST*837*0001*005010X223A2~
BHT*0019*00*1318414*20201129*120640*CH~
NM1*41*2*CLEARINGHOUSE X*****46*012345698~
PER*IC*EDI OPERATIONS*TE*8885551212*EM*PRODUCTION@CLEARINGHOUSE.COM~
NM1*40*2*NORTH CAROLINA BLUE CROSS BLUE SHIELD*****46*560894904~
HL*1**20*1~
NM1*85*2*GENERAL HOME HEALTH SERVICES*****XX*2233445560~
N3*123 MEDICAL NURSING WAY*SUITE 800~
N4*DURHAM*NC*277075811~
REF*EI*123456789~
PER*IC*OFFICE MANAGER*TE*9195551212~
HL*2*1*22*0~
SBR*P*18*******BL~
NM1*IL*1*DOUGH*MARY****MI*YPPW0001110001~
N3*123 MAIN STREET*APT G~
N4*APEX*NC*276022345~
DMG*D8*19661123*F~
NM1*PR*2*BLUE CROSS*****PI*SB810~
CLM*PATIENT ACCT NUMBER*920***13:A:1**C*Y*Y~
DTP*434*RD8*20201130-20201130~
CL1*3*1*01~
REF*D9*2462713498~
HI*ABK:F1020~
HI*APR:S8992XA~
HI*ABF:S8992XA*ABF:S82142A~
HI*BH:05:D8:20201109~
NM1*71*1*PHYSICIAN*ATTENDING****XX*0011223340~
NM1*72*1*PHYSICIAN*OPERATING****XX*0011224450~
NM1*77*2*SERVICE FACILITY LOCATION*****XX*0011224499~
N3*1212 CIRCLE DRIVE*SUITE 340~
N4*DURHAM*NC*277027711~
LX*1~

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SV2*0906*HC:H0015*230*UN*1~
DTP*472*D8*20201130~
REF*6R*16887757~
LX*2~
SV2*0906*HC:H0015*230*UN*1~
DTP*472*D8*20201130~
REF*6R*16939156~
LX*3~
SV2*0906*HC:H0015*230*UN*1~
DTP*472*D8*20201130~
REF*6R*17058198~
LX*4~
SV2*0906*HC:H0015*230*UN*1~
DTP*472*D8*20201130~
REF*6R*17104804~
SE*47*0001~

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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	0001	005010X223A2~							
	BEGINNING OF HIERARCHICAL TRANSACTION	**BHT**	**BHT01**	**BHT02**	**BHT03**	**BHT04**	**BHT05**	**BHT06**				
			0019	00	1318414	20201129	120640	CH				
1000A	**Submitter Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			41	2	CLEARING HOUSE X					46	012345698	
1000A	**Submitter EDI Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**	**PER09**	
			IC	EDI OPERATIONS	TE	8885551212	EM	PRODUCTION@CLEARINGHOUSE.COM				
1000B	**Receiver Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			40	2	NORTH CAROLINA BLUE CROSS BLUE SHIELD					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	2	GENERAL HOME HEALTH SERVICES					XX	223344560	
2010AA	**Billing Provider Address**	**N3**	**N301**	**N302**								
			123 MEDICAL NURSING WAY	SUITE 800								

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Loop ID		Segment	Elements									
2010AA	**Billing/Provider City/State/Zip Code**	**N4**	**N401**	**N402**	**N403**							
			DURHAM	NC	277075811							
2010AA	**Billing Provider Tax Identification**	**REF**	**REF01**	**REF02**								
			EI	123456789								
2010AA	**Billing Provider Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**		
			IC	OFFICE MANAGER	TE	9195551212						
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							BL	
2010BA	**Subscriber Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			IL	1	DOUGH	MARY				MI	YPPW000111000 1	
2010BA	**Subscriber Address**	**N3**	**N301**	**N302**								
			123 MAIN STREET	APT G								
2010BA	**Subscriber City/State/Zip Code**	**N4**	**N401**	**N402**	**N403**							
			APEX	NC	276022345							
2010BA	**Subscriber Demographic Information**	**DMG**	**DMG01**	**DMG02**	**DMG03**							
			D8	19661123	F							
2010BC	**Payer Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			PR	2	BLUE CROSS					PI	SB810	
2300	**Claim Information**	**CLM**	**CLM01**	**CLM02**	**CLM03**	**CLM04**	**CLM05**	**CLM06**	**CLM07**	**CLM08**	**CLM09**	**CLM18**
			PATIENT ACCT NUMBER	920			13:A:1		C	Y	Y	
2300	**Statement Dates**	**DTP**	**DTP01**	**DTP02**	**DTP03**							
			434	RD8	20201130-20201130							
2300	**Institutional Claim Code**	**CL1**	**CL101**	**CL102**	**CL103**							
			3	1	01							
2300	**Original Reference Number**	**REF**	**REF01**	**REF02**								
			D9	2462713498								
2300	**Principal Diagnosis**	**HI**	**HI01:1**	**HI01:2**								

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Loop ID		Segment	Elements									
			ABK	F0120								
2300	**Patient's Reason for Visit**	**HI**	**HI01:1**	**HI01:2**								
			APR	S8992XA								
2300	**Other Diagnosis Information**	**HI**	**HI01:1**	**HI01:2**	**HI02:1**	**HI02:2**						
			ABF	S8992XA	ABF	S82142A						
2300	**Occurrence Information**	**HI**	**HI01:1**	**HI01:2**	**HI01:3**	**HI01:4**						
			BH	05	D8	20201109						
2310A	**Attending Physician Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			71	1	PHYSICIAN	ATTENDING				XX	0011223340	
		NM1	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			72	1	PHYSICIAN	OPERATING				XX	0011224450	
		NM1	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**	
			77	2	SERVICE FACILITY LOCATION					XX	0011224499	
		N3	**N301**	**N302**								
			1212 CIRCLE DRIVE	SUITE 340								
		N4	**N401**	**N402**	**N403**							
			DURHAM	NC	277027711							
2400	**Service Line Number**	**LX**	**LX01**									
			1									
2400	**Institutional Service Line**	**SV2**	**SV201**	**SV202:1**	**SV202:2**	**SV203**	**SV204**	**SV205**	**SV206**	**SV207**	**SV208**	
			0906	HC	H0015	230	UN	1				
2400	**Service Line Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**							
			472	D8	20201130							
2400	**Line Item Control Number**	**REF**	**REF01**	**REF02**								
			6R	16887757								
2400	**Service Line Number**	**LX**	**LX01**									
			2									
2400	**Institutional Service Line**	**SV2**	**SV201**	**SV202:1**	**SV202:2**	**SV203**	**SV204**	**SV205**	**SV206**	**SV207**	**SV208**	
			0906	HC	H0015	230	UN	1				
2400	**Service Line Date**	**DTP**	**DTP01**	**DTP02**	**DTP03**							

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Loop ID		Segment	Elements									
			472	D8	20201130							
2400	Line Item Control Number	REF	REF01	REF02								
			6R	16939156								
2400	Service Line Number	LX	LX01									
			3									
2400	Institutional Service Line	SV2	SV201	SV202:1	SV202:2	SV203	SV204	SV205	SV206	SV207	SV208	
			0906	HC	H0015	230	UN	1				
2400	Service Line Date	DTP	DTP01	DTP02	DTP03							
			472	D8	20201130							
	Line Item Control Number	REF	REF01	REF02								
			6R	17058198								
	Service Line Number	LX	LX01									
			4									
	Institutional Service Line	SV2	SV201	SV202:1	SV202:2	SV203	SV204	SV205	SV206	SV207	SV208	
			0906	HC	H0015	230	UN	1				
	Service Line Date	DTP	DTP01	DTP02	DTP03							
			472	D8	20201130							
	Line Item Control Number	REF	REF01	REF02								
			6R	17104804								
	TRANSACTION SET TRAILER	SE	SE01	SE02								
			47	0001								

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Appendix A: 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-005	Newborn charges must be filed separately under the baby's name.	2400, Institutional Service Line, SV201
I-006	Member ID must be valid.	2010BA, Subscriber Name, NM109
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, Subscriber Name, NM109
I-022	Provider NPI not registered with BCBSNC. Please contact Network Management at 1-800-777-1643 to resolve this matter.	2010AA, Billing Provider Name, NM109
I-028	Negative Service Line Paid Amount invalid.	2430, Line Adjudication Information, SVD02
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, Claim Information, CLM05:3
I-034	Invalid format for Original Claim ID. Please resubmit with valid ID.	2300, Payer Claim Control Number, REF02
I-035	Claim cannot be corrected more than 2 years from Claim's Earliest Date of Service	2300, Statement Dates, DTP03
I-036	Full 14 positions of Member ID are required.	2010BA, Subscriber Name, NM109
I-037	Date of birth not valid for Member ID.	2010BA or 2010CA, Subscriber/Patient Name, DMG02

[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-038	First name not valid for Member ID.	2010BA or 2010CA, Subscriber/Patient Name, NM104
I-040	Please use the exact language required for Substance Abuse related claims - 42 CFR part 2 prohibits unauthorized disclosure of these records.	2300, Billing Note, NTE02
I-041	Future Date is not allowed	2300, Statement Dates, DTP03
I-042	Claims for this Member must be submitted to alternate North Carolina Payer ID - 00602	2010BA, Subscriber Name, NM109
I-043	Pay-To Plan Name (Loop 2010AC) must be completed when BHT06 = 31	2010AC, Pay-To Plan Name, NM109
I-044	Claims for this Member must be submitted elsewhere	2010BA, Subscriber Name, NM109
	BREAK IN ERROR MESSAGE NUMBERING	
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, Institutional Claim Code, CL103
I-310	If Type of Bill = '111', '114', '121' or '124'; Patient Status cannot be '30'.	2300, Institutional Claim Code, CL103
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, Occurrence Information, HI01:4 to HI08:4
I-314	Occurrence Date must not be greater than current date.	2300, Occurrence Information, HI01:4 to HI08:4
I-317	Occurrence Span Date must not be greater than current date.	2300, Occurrence Span Information, HI01:4 to HI04:4
I-319	An Inpatient Claim [TOB X1X or X2X] must contain one Accommodation Revenue Code [010X-021X or 100X].	2400, Institutional. Service Line, SV201
I-325	Units of Service must be greater than zero for accommodation rate revenue codes [010X-021X].	2400, Institutional Service Line, SV205
I-334	Principal procedure codes and dates must be entered for Revenue Code 036X.	2300, Principal Procedure Information, HIxx
I-359	CPT/HCPCS required for outpatient claims for specific revenue codes.	2400, Institutional. Service Line, SV202:1
I-365	The pick-up location zip code is required for ambulance claims.	2300, Value Information (Zip Code), HIxx:5
I-366	POA is required for inpatient claims	2300, Principal, Other Diagnosis, External Cause of Injury (Present on Admission), HIxx:9

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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 inconsistent 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 patient's age.
AMAZ	The procedure/revenue code is inconsistent with the patient's 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 modifier 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.
AMVQ	Invalid or missing required claims data.

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Error Code	Explanation Message
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 procedure 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.

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

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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	• Removal of edits I-326 and I-307 • 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 I-364	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 Institutional Elements Table	• Business Edit I-357 changed from “For Inpatient claims, Principal Procedure Date must fall within three calendar days of the Admission Date” to “For Inpatient claims,	April 1, 2013	2.7

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Chapter Section	Change Description	Date of Change	Version
	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. • Modification 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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Chapter Section	Change Description	Date of Change	Version
837 I Data Element Table; Business Scenario;837 Institutional File Map	• Removal of multiple business edits that are being replaced by frontend (EDIFECS) edits. This will provide more immediate response to submitters on problem data. Business edits removed are: I-004, 026-7, 029-31, 304-5, 308, 316, 323, 335-364.	January 2018	4.0
Appendix	• Reinstated I-359	March 2018	4.1
Time Frames for Claims Processing Appendix A: BCBSNC Business Edits for the 837 Institutional Health Care Claim	• Clarification of a claim's posted receipt date • Advising implementation of new business edits to be effective in February 2019 requiring the user of all 14 positions of the member's ID: I-036, I-037, I-038 • Modifications in 837 Institutional: Data Element Table to reflect the addition of new edits	October 2018	5
Appendix 837 Institutional Elements Table	• Addition of business edit I-366	August 2020	5.2
Substance Use Disorder Regulations Edits	• Addition of business edit I-040	September 2020	5.2
837 Institutional: Data Element Table	• Addition of business edit I-041 • Addition of business edit I-042 • Addition of business edit I-043	August 2021	5.3
Notice of Consent/Surprise Billing	• Addition of Notice of Consent/Surprise Billing instructions	December 2021	5.4
837 Institutional: Data Element Table	• Addition of business edit I-044 • Clean-up of prior edits (I-317, I-359, I-365)	November 2022	5.5

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