837 Professional Health Care Claim

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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

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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

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.

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

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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.

Code Set Versions

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 dates of service are greater than September 30, 2014, use ICD-10;
- If the dates of service are less than October 1, 2014, use ICD-9;
- If the dates of service span October 1, 2014, split the claim so that one claim covers the time before October 1, 2014 and the other claim covers the time from October 1, 2014 and later.

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.

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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 7:30 p.m. to make the last processing cycle of the day.

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.

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.

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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, 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 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).

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[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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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.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

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.

[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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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.***

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
	BHT	Beginning of Hierarchical Transaction				
			BHT06	Transaction Type Code	P027	BCBSNC processes a value of 31 only for Medicaid submitted claims.
2010AA	NM1	Billing Provider Name				
			NM109	Identification Code	P022	Use the valid NPI that has been registered with BCBSNC.

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

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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**
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 P018 P027 P029 P030	BCBSNC uses up to 19 characters. The Member ID Number should appear as it does on the Membership Card. If the first two positions of the Member ID Number are alpha, then the third position must be alpha also. Member id not valid for DOS. Medicare Advantage or the Medicare Supplement Subscriber ID must be valid. Alpha prefix is required. Member ID must be valid
	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.
	DMG	Demographic Information				
			DMG03	Gender Code		BCBSNC uses only the M and F values.
2010BB	NM1	Payer Name				
			NM103	Last Name or Organization Name		Use BCBSNC.
	REF	Billing Provider Secondary Identifier				
			REF02	Reference Identification	P026	For Medicaid subrogated claims only, the Billing Provider Secondary ID Qualifier must equal G2 and/or Billing Provider Secondary ID must be valid.
2010CA	NM1	Patient Name				

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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**
		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				
			NM101			
			NM103	Last Name or Organization	P337	BCBSNC processes all alpha characters, dashes, apostrophes, spaces, or periods. No other special characters are processed.
	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.
			CLM05:3	Claim Frequency Type Code	P340 P033	To indicate a **corrected** claim, select one of the following values from the National Uniform Billing Data Element Specification Types: • 5 = Late charges only claim • 7 = Replacement of Prior Claim • 8 = Void/Cancel of Prior Claim Claims requiring correction should be sent in with a value of "8" to void the claim; the subsequent revised claim should be sent in with a value of "7". A value of "6" is not accepted. NOTE: Claim Frequency Type Code of '0' is not accepted.
	DTP	Date (Onset of Current Illness/Symptom to Date – LMP)				
			DTP03	Date Time Period	P305 P306	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.
	DTP	Date (Disability Begin and Disability End)				
			DTP03	Date Time Period	P336	Disability End Date cannot be prior to Disability Begin Date.
	DTP	Date - Admission				
			DTP03	Date Time Period	P308 P310	• Date must be a valid date • When a Facility Code value of 21, 31, 51, or 61 is used on a charge line (CLM05-1 of 2300),

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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**
						Hospitalization Dates cannot be greater than current date or less than the patient's birth date.
2300	DTP	Date - Discharge				
			DTP03	Date Time Period	P309 P310	• Date must be a valid date • When a Facility Code value of 21, 31, 51, or 61 is used on a charge line (CLM05-1 of 2300), Hospitalization Dates cannot be greater than current date or less than the patient's birth date. • Hospitalization Discharge Date must be equal to or greater than the Admission Date.
	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	HI	Health Care Diagnosis Code				
			HI01:2	Industry Code	P031 P341	Claim can contain only one version of industry code; submit separate claim if using different versions of Industry Code. E-code cannot be the primary diagnosis code. (This edit will be removed 10/2014.)
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	P342	Rendering Provider ID should ONLY be sent when it is a different number from the Billing Provider NM109 in 2010AA. See the Rendering Provider section of this document for additional details on using this segment.
2310C	NM1	Service Facility Name				
			NM103 & NM109	Service Facility Name	P348	The Service Facility name and location are required to process a DME claim for the Place of Service provided. (See also

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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**
						N3 and N4)
	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	CAS	Claim Level Adjustment				
			CAS02	Monetary Amount	P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.
	AMT	COB Payer Paid Amount				
			AMT02	Monetary Amount	P331 P345	• 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. • The Paid Amount at the claim level (2320 AMT02) must match the sum of the Paid Amount(s) at the line level (SVD02).
	AMT	Remaining Patient Liability				
			AMT02	Monetary Amount	P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.
2330A	NM1	Other Subscriber Name				
			NM102	Entity Type Qualifier	P004	Use a value of 1 (Person)
2400	LX	Service Line				
			LX01	Assigned Number		BCBSNC uses LX01 as a line item control number. Use actual values instead of placeholders for this element in order to receive matching line numbers in the 835 Transaction: 2110 SVC06 and the 2110 REF Service Identification segments responses.
	SV1	Professional Service				
			SV101:2	Product/Service ID	P005	Newborn charges should not be filed on the mother's claim, but on a separate claim, under the baby's name.
			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.)

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Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**BCBSNC Business Edit or Security Validation Edit Code Number[3]**	**BCBSNC Business Rules**
			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).
	DTP	Date – Service Date				
			DTP03	Date Time Period	P313 P314 P315 P330 P316 P035	• 'From Date' and 'To Date' must be consistent with Hospitalization Dates. • The "From Date" must be prior to the "To Date". • Service date must not be greater than current date. • Earliest Date of Service for all charge lines must not be prior to Patient's Birth date. • Claim cannot be corrected more than 1 year from Claim's Earliest Date of Service.
2420A	NM1	Rendering Provider Identification				
			NM109	Rendering Provider ID	P342	Rendering Provider ID should be sent in this loop ONLY if the number is different from the Rendering Provider NM109 in the 2300 loop, OR no rendering provider NM109 was sent in the 2300 loop and the Rendering Provider ID is different than the Billing Provider ID sent in 2010AA. See the Rendering Provider section of this document for additional details on using this segment.
2430	SVD	Line Adjudication Information				
			SVD02	Monetary Amount	P028 P344	Negative Service Line Paid Amount must be a valid value. The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.

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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:	Mary B Dough
Subscriber Address:	PO Box 12312, Durham, NC 27701
Sex:	F
DOB:	August 7, 1967
Employer:	Acme, Co.
Group #:	ABC123101
Payer ID Number:	987654321
Member Identification Number	24670389600
Destination Payer:	Blue Cross Blue Shield of North Carolina (BCBSNC)
Payer Address	5901 Chapel Hill Road, Durham, NC 27707
AHLIC #:	987654321
Submitter:	ABC Clearinghouse
Billing Provider:	Elizabeth Smith, MD
Address:	123 Mudd Lane, Durham, NC, 27715
TIN:	123456789
Billing Provider ID	0123456789
Contact Person & Phone Number	Wilma Flintstone 919 555-1111
Patient Account Number:	Ptacct2235057
DOS	8/1/2010
POS	Office
Services Rendered	Office visit
Charges	1st office visit - $100.50
Total charges	$100.50

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.

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```
ISA*00*          *00*          *01*9012345720000  *01*9088877320000
*100822*1134*U*00200*000000007*0*T*:~
GS*HC*901234572000*908887732000*20100822*1615*7*X*005010X222~
ST*837*0007*005010X222~
BHT*0019*00*123BATCH*20100822*1615*CH~
NM1*41*2*ABC CLEARINGHOUSE*****46*123456789~
PER*IC*WILMA FLINTSTONE*TE*9195551111~
NM1*40*2*BCBSNC*****46*987654321~
HL*1**20*1~
NM1*85*1*SMITH*ELIZABETH*A**M.D.*XX*0123456789~
N3*123 MUDD LANE~
N4*DURHAM*NC*27701~
REF*EI*123456789~
HL*2*1*22*0~
SBR*P*18*ABC123101******BL~
NM1*IL*1*DOUGH*MARY*B***MI*24670389600~
N3*P O BOX 12312~
N4*DURHAM*NC*27715~
DMG*D8*19670807*F~
NM1*PR*2*BCBSNC*****PI*987654321~
CLM*PTACCT2235057*100.5***11::1*Y*A*Y*N~
REF*EA*MEDREC11111~
HI*BK:78901~
LX*1~
SV1*HC:99212*100.5*UN*1*12**1**N~
DTP*472*D8*20100801~
SE*24*0007~
GE*1*7~
IEA*1*000000007~
```


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837 Professional File Map

Loop ID	Segment Name	Segment ID	Elements								
	TRANSACTION SET HEADER	**ST**	**ST01**	**ST02**	ST03						
			837	0007	005010X222~						
	BEGINNING OF HIERARCHICAL TRANSACTION	**BHT**	**BHT01**	**BHT02**	**BHT03**	**BHT04**	**BHT05**	**BHT06**			
			0019	00	123batch	20100822	1615	CH~			
1000A	**Submitter Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			41	2	ABC Submitter					46	123456789 ~
1000A	**Submitter EDI Contact Information**	**PER**	**PER01**	**PER02**	**PER03**	**PER04**	**PER05**	**PER06**	**PER07**	**PER08**	**PER09**
			IC	Wilma Flintstone	TE	919555111 1~					
1000B	**Receiver Name**	**NM1**	**NM101**	**NM102**	**NM103**	**NM104**	**NM105**	**NM106**	**NM107**	**NM108**	**NM109**
			40	2	BCBSNC					46	987645432 1~
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	Smith	Elizabeth	A			XX	989898989 ~
2010AA	**Billing Provider Address**	**N3**	**N301**								
			123 Mudd Lane~								
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~					
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	246703896

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Loop ID	Segment Name	Segment ID	Elements								
											00
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~							

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Appendix: 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]
P004	When Other Insured's Entity Code (NM101) = IL, Entity Qualifier must equal '1'.	2330A, Other Subscriber Name, NM102
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, Patient Name, NM109
P022	Provider NPI not registered with BCBSNC. Please contact Network Management at 1-800-777-1643 to resolve this matter.	2010AA, Provider ID, NM109
P026	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
P027	Medicare Advantage/Medicare Supplement Member ID is invalid. Please correct and resubmit.	2010BA, Member ID, NM109
P028	Negative Service Line Paid Amount invalid.	2430, Service Line Paid Amount, SVD02

[4] This column is cross-referenced to the 837 Professional (005010X222) 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.

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Error Code*	Explanation Message	837 Professional Cross-references[4]
P029	Alpha prefix is required; please submit the member ID as it appears on the membership card.	2010BA , NM109
P030	Member ID is no longer valid. Please obtain the current ID from the membership card.	2010BA, NM109
P031	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
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
P033	Addition of Business Rule I-033 : Claim Frequency Type Code of '0' is not accepted.	2300, CLM05
P034	Invalid format for Original Claim ID. Please resubmit with valid ID.	2300, REF02, Payer Claim Control Number
P035	Claim cannot be corrected more than 2 years from Claim's Earliest Date of Service.	2400 DTP03
	BREAK IN ERROR MESSAGE NUMBERING for 837P	
P301	Invalid Subscriber Name as submitted. Contains special characters other than dashes, apostrophes, spaces or periods.	2010 BA, Subscriber Name, NM103
P310	If a Facility Code Value of 21, 31, 51 or 61 (CLM05-1) is used on a charge line, Hosp. Dates cannot be greater than current date or less than patient's DOB.	2300, Date- Admission or Date Discharge, DTP03
P313	From Date inconsistent with Hospitalization dates.	2400, Date – Service Date, DTP03
P314	To Date inconsistent with Hospitalization dates.	2400, Date – Service Date, DTP03
P315	To Date prior to From Date.	2400, Date – Service Date, DTP03
P316	Earliest Date of Service for all charge lines must not be prior to Patient's Birth Date.	2400, Date – Service Date, 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
~~P319~~	~~Accident Diagnosis Codes [800-995] require Date of Onset (DTP01 =431) or Date of Current Injury (DTP01 = 439).~~	~~2300, HC Diagnosis Code, HI01:2 in reference to 2300, Date of Onset, or Accident Date, or 2300 LMP, DTP01~~

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Error Code*	Explanation Message	837 Professional Cross-references[4]
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
P329	Hospitalization Discharge Date must be equal to or greater than the Admission Date.	2300, Date – Discharge, DTP03
P330	Service Date cannot be greater than current date.	2400, Date – Service, DTP03
P331	Negative Payer Amount Paid invalid.	2320, Payer Amount Paid, AMT02
P335	Facility Type Code 99 invalid for BCBSNC business.	2300, Facility Type Code, CLM05-1
P336	Disability End Date cannot be prior to Disability Begin Date.	2300, Date – Disability Begin, DTP03 and p. 203, 2300, Date- Disability End, DTP03.
P337	Invalid Patient Name as submitted – contains special characters other than dashes, apostrophes, spaces or periods.	2010CA, Patient Name, NM103 and/or NM104.
P340	Claim Frequency Type Code of "6" is not accepted.	2300 Claim Information, CLM05-3, p. 173
P341	E-code cannot be the primary diagnosis code. (This edit will be removed 10/1/2014.)	2300 Health Care Diagnosis Code, HI01-2 (when HI01-1 = ABK
P342	NPI submitted is not registered with BCBSNC.	2310B or 2430A , Rendering Provider Name, , NM109; Rendering Provider Identification Code
P344	The sum of all line level payments and patient responsibility line level adjustments, must match the claim level payment and patient responsibility adjustments.	2320,COB Payer Paid Amount, AMT02 (when AMT01=D); Line Adjudication Information, 2430, SVD02 , 2320 and 2430: CAS01=PR and AMT01=EAF,
P345	The Paid Amount at the claim level must match the sum of the Paid Amount(s) at the line level.	2320, COB Payer Paid Amount, AMT02 (when AMT01=D); Line Adjudication Information 2430, SVD02

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Error Code*	Explanation Message	837 Professional Cross-references[4]
P346	Please file claim with the Local Plan as defined for ancillary claims.	2010BA or 2010CA, Subscriber/Patient Address, N402, and for 2310C, Service Facility Location City, State, Zip Code, N402
P347	Referring Provider information required to process ancillary claims.	2310A, Referring Provider Name, NM103, NM104, NM109 (when NM101 = DN)
P348	Service Facility Location required to process DME for Place of Service provided.	2310C, Service Facility Address N301, N302,N401, N402, N403 (when NM101 = 77)
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	**For Senior Segment products only** (MedSup and MedAdvantage): Quantity for anesthesia codes should be reported using the 'MJ' qualifier to identify minutes submitted.	2400, SV103

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

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Chapter Section	Change Description	Date of Change	Version
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
Data Element 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 business edit P035 from 1 to 2 years allowed for timely filing • Addition of business edit P350 (see Appendix)	January 2017	3.4

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