Blue Cross Blue Shield Massachusetts

Health Care Claim 837 Companion Guide

Version 1.3.1

Refers to the following Technical Report Type 3 Guides:

- **ASC X12N 837 Institutional** (version 005010X223A2)
- **ASC X12N 837 Professional** (version 005010X222A1)
- **ASC X12N 837 Dental** (version 005010X224A2)
- **Companion Guide Version Number: 1.2.6**

Preface

This is a companion guide to the *ASC X12N Implementation* guides that were adopted under the Health Insurance Portability and Accountability Act (HIPAA). This guide clarifies and specifies the data content needed to electronically exchange with Blue Cross Blue Shield of Massachusetts (Blue Cross).

Transmissions based on this guide, used with the *X12N Technical Report Type 3* guides, are compliant with both X12 syntax and those guides. This guide shares information that is within the framework of the *ASC X12N Implementation Guides* adopted under HIPAA.

This guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the *Implementation Technical Report Type 3* guides.

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1. Introduction

What is HIPAA?

The Health Insurance Portability and Accountability Act - Administration Simplification (HIPAA-AS) requires that Blue Cross Blue Shield of Massachusetts (Blue Cross), Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The *ASC X12N Implementation Guide 837* version 5010 and the *Addenda (A1) for Health Care Claims* have been established as the standard for claims transactions compliance.

Purpose of the ASC X12N Implementation Guide

The *ASC X12N Implementation Guide,* version 5010, and the *Addenda (A1) for Health Care Claims* (837), *Health Care Claim Acknowledgement* (277CA), and *Health Care Claim Payment/Advice* (835) have been established as the standard for claims transactions compliance. Although the *ASC X12N Implementation Guide* contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health benefit payers. There are separate transactions for Health Care Claims: **Institutional** (837I), **Professional** (837P), and **Dental** (837D).

Loops

Loop usage within ASC X12N transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

The **usage designator** of a **loop's beginning segment** indicates the usage of the loop. If a loop is used, the first segment (initial segments) of that loop is **required** *even if it is marked situational*.

If…	Then…
The usage of the first segment in a loop is marked **required…**	• The loop must occur at least once, unless it is nested in a loop that is not being used. • A note on the required initial segment of a nested loop will indicate dependency on the higher level loop.
The first segment is **situational…**	• There will be a segment note addressing use of the loop. • Any required segments in loops beginning with a situational segment occur only when the loop is used.

Purpose of the Blue Cross Blue Shield of Massachusetts Companion Guide

This document has been prepared as the *Blue Cross Blue Shield of Massachusetts* specific Companion Guide to the ASC X12N Implementation Guide. The goals of the Blue Cross Companion Guide are to describe:

1. How to become an EDI Trading Partner with *Blue Cross Blue Shield of Massachusetts*
2. How to set up, test, and make operational a Trading Partner relationship with *Blue Cross Blue Shield of Massachusetts*
3. When conditional data elements and segments must be used with *Blue Cross Blue Shield of Massachusetts* transactions,
4. Codes and data elements that are not applicable to Blue Cross Blue Shield of Massachusetts transactions.

This Companion Guide document *supplements* but does not contradict any requirements in the ASC X12N version 5010 Implementation Guide or the Addenda.

How to obtain copies of these guides:

- The *ASC X12N Implementation Guides* adopted for use for HIPAA transactions are available for purchase at: www.wpc-edi.com/HIPAA .
- The *Blue Cross Blue Shield of Massachusetts Companion Guide* is available electronically on the Provider Central website at: www.bluecrossma.com/provider

Intended Audience

The intended audiences for this document are:

- An officer of the corporation
- The provider's billing office
- The technical area responsible for submitting electronic claims transactions to *Blue Cross Blue Shield of Massachusetts*

1.2. NPI Information

Additional information and the most up-to-date National Provider Identifier (NPI) billing instructions are available on the Provider Central website at **bluecrossma.com/provider.** After logging on to the site, click on Office Resources from the Welcome page where you will find links to billing instructions by provider type.

1.3. Establishing a Trading Partner Agreement with Blue Cross

You must execute a **Trading Partner Agreement** in order to take advantage of the transactions and communication services offered by Blue Cross Blue Shield of Massachusetts. To start the process, talk with one of our EDI specialists (see Contacts).

We will send you our **starter kit** which will include:

Form Name:	**Distribute to:**
The Provider Trading Partner Agreement	An Officer of the Corporation empowered to enter a contract on behalf of the Corporation.
The Trading Partner Enrollment Form	Your billing office and information technology area (they should collaborate to fill out the form).
The Secure File Transfer Account Request Form	Your information technology group and agents of your billing office.

We require that two signed hard copies of the *Provider Trading Partner Agreement* be delivered to:

Blue Cross and Blue Shield of Massachusetts, Inc. AND
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.,
25 Technology Drive
Hingham, MA 02043
Mail Stop 03-02
Attention: Scott Howard

Director, Provider Operations & EDI Services

You may **email** both the *Trading Partner Enrollment Form* and *Secure File Transfer Account Request Form* to EDISupport@bcbsma.com. Please use "Enrollment and Security Forms" in the subject line of the e-mail.

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2. Establishing Connectivity with Blue Cross

The purpose of this section is to identify the process for establishing connectivity to transmit and receive electronic transactions with Blue Cross Blue Shield of Massachusetts. *It is important to note the difference between using **http** and **https** when accessing the servers.*

Contacts

Type of Contact	Area Contact	Telephone Number
Technical	Blue Cross EDI Support Team – edisupport@bcbsma.com	800-771-4097 Option 2

2.2. Setting up your connection

Providers will deliver and pick up files via Blue Cross's **Tumbleweed Secure File Transfer** server:

Blue Cross Tumbleweed Secure File Transfer Server	DNS
Test	staging.sftp.bluecrossma.com
Production	sftp.bluecrossma.com

The types of file transmissions include:

- Submitting 837s
- Retrieving 277CA's, 999s, TA1s, Submitter Reports and 835's

2.3. Checklist: Before you can submit transactions

You must:

- Contact the EDI Support team (EDISUPPORT@bcbsma.com)
- Complete and return the following authorization forms:
  - *Provider Trading Partner Agreement*
  - *Trading Partner Enrollment Form* (which will include your submitter ID)
  - *Secure File Transfer Account Request Form* listing:
    - Your server. Please include your primary and secondary contacts
    - Your *primary* system administrator contact
    - Your *secondary* system administrator contact
    - Each individual business user requiring access

When Blue Cross has processed these forms, you will receive:

- Tumbleweed **mailbox and supporting directory**
- Tumbleweed **user ID** to connect your server to your Tumbleweed mailbox
- **Two individual user IDs** for users listed in Section 4 of the *Secure File Transfer Account Request Form*. The two users will be able to manually view and access their organization's

mailboxes.
- If requested, **additional individual user IDs** for business area users

2.4. NEHEN

Providers using NEHEN should contact the NEHEN contractor (Trizetto NEHEN) directly at **1-800-556-2231**.

2.5. Password reset protocol

The password for your Tumbleweed account will be system-generated. Passwords will need to be reset **every 90 days** for **individual** user accounts. For **server accounts,** the password has a **one year expiration.**

2.5.1. Server accounts

We email each registered user three notices that the password is about to expire ("registered users" are determined from the names and email addresses on the security form):

1. 10 days before expiration
2. 5 days before expiration
3. On the day of expiration.

Once one registered user has visited the site to "reset password," we will email each registered user the new password. The user must update their server to use the new password.

2.5.2. For individual user IDs

The Tumbleweed application will display an error message stating that the password has expired after 90 or 365 days (login invalid). Passwords cannot be reset after expiration. Users must contact the EDI Production Support team at **EDISupport@bcbsma.com** to have the password reset.

The **manage your password** function can be used to:

- Reset a password before the 90 or 365 day expiration.
- Obtain a new password if a password has been forgotten.

2.6. Security

Blue Cross Blue Shield of Massachusetts is dedicated to maintaining the confidentiality of personal health information (PHI) and safeguarding member information as if it were our own. Associates are required to safeguard member privacy by using reasonable measures during all phases of the information-handling process: from collection and storage, to disclosure and disposal. This policy applies to the PHI of all applicants and past or present members. Information may be in the form of data in storage or in transit, on paper or in electronic format.

Due to its sensitivity, the use and disclosure of PHI is restricted, except in circumstances where permitted or required by law or where appropriate authorization for use or disclosure is obtained. Access to PHI is limited to those with a business need to know the information for treatment, payment, or health care operations, or as otherwise permitted or required by law.

2.7. Maintenance

Blue Cross allows transmission of 837 claim files 24 hours a day, seven days a week. For unscheduled maintenance (system abnormalities, outages), users will be notified via the contact information supplied on the Secure FTP Account Request Form. To avoid possible claim errors, please do not submit any files to Blue Cross during these periods.

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3. Testing

Blue Cross requires **testing** for all sites submitting HIPAA claim submissions for the first time, as well as any claims processing changes related to Blue Cross Specific Data Elements prior to actual submission to the production environment. To help you achieve a successful test, please follow the appropriate format specifications (listed in this guide) and submission directions. To receive approval to move from test to production you must receive a minimum 95% "correct rate" for the test file submitted. Testing is an iterative process; Blue Cross will accept only one submission for each iteration of testing.

Claims Testing Process Overview

Testing consists of the following stages:

1. **File Submission**
   Coordinate with a Blue Cross EDI Support representative (see the **Contacts** section of this guide). For testing, we are not able to process a normal day of your production. However, the claims in your test file should simulate claims from normal business. Submit your test file to Blue Cross's Tumbleweed Secure File Transfer test server. A Blue Cross EDI Support analyst reviews the file for HIPAA compliance and Blue Cross segment requirements.
2. **Test Results**
   A Blue Cross EDI Support analyst will contact you by phone with results of your most recent test. Additionally, you must retrieve your reports from the test Blue Cross Tumbleweed Secure File Transfer server.
   Note: Stages 1 and 2 will repeat until you achieve a minimum 95% "correct rate" for the most recent file submitted.
3. **Approval**
   When your latest test iteration has achieved the "correct rate," production move approval will be sent to the primary contact email address listed on your *Trading Partner Enrollment Form*. You may then submit and retrieve your files from the production Tumbleweed Secure File Transfer server.

Blue Cross provides testing support Monday through Friday, 8:30AM to 3:30PM EST.

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4. Blue Cross Provider Support

If you cannot find the answers to your questions in this guide, please use the contact information below to reach the appropriate support area in Blue Cross.

1. **Blue Cross EDI Support**
   For technical questions or help related to any of the transactions, acknowledgments, or reports related to your health care claim submissions, please contact Blue Cross EDI Support.
   Phone: 800-771-4097 (option 2)
   Email: EDISupport@bcbsma.com

2. **Provider Central website**
   Provider Central provides information on our products, policies, and procedures, as well as FAQs and companion guides for various electronic transactions. Please refer to online documentation for the most current materials.

   Website: http://www.bluecrossma.com/provider

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5. Blue Cross Claim Submission Guidelines

Claim files submitted for **testing/production** must meet the following:

5.2. Available communication folders

Your security will allow you permission to two folders for each submitter ID that you can access. One folder will be *inbound* and the other will be *outbound*. Use the *inbound* folder to submit your ANSI 837 claim files and the *outbound* folder to retrieve the ANSI acknowledgement files and submitter report for each submitted ANSI 837 file.

5.3. File name extension (.837)

Claim files submitted to the *inbound* folder must have an extension of **.837**. You may continue to use your conventions for the file name and multiple nodes may be present in the file name, but our trigger to process the file from the *inbound* folder is an extension of .837.

5.4. The usage indicator (ISA15) must be appropriate.

The usage indicator in the Interchange Control Header (ISA15) must be appropriate for the claim submission environment.

Submissions for…	Must have ISA15 as…
Testing	**T**
Production	**P**

The result of an inappropriate usage indicator is reported only in an ANSI TA1 and no other reports are generated.

5.5. Professional/Dental and Institutional

Test Claim Files	Should contain a minimum of 25 claims and not exceed 50 claims in any one transaction set (batch). For testing, we are not able to process a normal day of your production. However, the claims in your test file should simulate claims associated with your normal business.
Production Claim Files	Must not exceed **4,999** claims in any one transmission. You may send multiple transmissions per day but each must not exceed 4,999 claims.

5.6. Special characters in claims data

Avoid the use of special characters in the claim data itself. Punctuation—comma (,), period (.), colon (:), semicolon (;), and hyphen (-)—should be avoided in the claims data (e.g. names, addresses, identifiers).

5.7. Delimiters

Delimiters are characters used to separate data and component elements or to terminate a segment. The following delimiters should be used when submitting an 837 claim file:

Character	Name
*	Asterisk data element separator
^	Carat repetition separator
:	Colon component element separator
~	Tilde segment terminator

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5.8. Duplicate File Transactions

Blue Cross will not process an 837 transaction submitted with duplicate ISA13 control numbers. If a transaction has been submitted to BCBSMA in test or production for the submitter, another transaction submitted with the same ISA13 control number will not be processed. Please submit all transactions with unique ISA13 control numbers that have not been submitted to BCBSMA in previous transactions.

6. Blue Cross Identification Number Requirements

	Alpha	Numeric/alpha-numeric
Massachusetts Blue Cross	Three letter prefix	Nine *(without prefix)* numeric or twelve *(with prefix)* alpha/numeric characters
Out-of-state Blue Cross	Three letter prefix	Fourteen alpha-numeric characters
Federal Employee Plan (FEP)	The letter **R**	Eight numeric characters

Note: Member IDs should not contain hyphens, spaces, or any special characters.

7. Reporting

This section describes the reports that are available to you from Blue Cross. The reports are stored for up to fourteen days for retrieval.

7.2. Report Overview

The following table lists the reports generated by Blue Cross. The quick reference table is followed by a description and sample of each report. For questions about any of the reports, use the **Contacts** section of this guide.

Report Name	About the Report
TA1 BCBSMA.<submitter ID>. InterchangeAck.<datetime>**.TA1**	The **TA1** or **Interchange Acknowledgment** is a reply to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. This report lets us notify you of problems that were encountered in the

	interchange control structure. It acknowledges that we have *received or rejected* an entire transmission.
999 BCBSMA.<submitter ID>. FunctionalAck.<datetime>**.999**	The **999** or **Functional Acknowledgment** is a reply to the functional groups that are in any one interchange or transmission. It notifies you of our ability or inability to process the entire transaction based on ASC X12 syntax and structure rules.
277CA BCBSMA.<submitter ID>. ClaimAck.<datetime>**.277**	Our front end includes Business and HIPAA rules to pre-process your claims. We send the **277** (often referred to as the **Unsolicited 277**) to notify you of transactions that are accepted for adjudication, as well as those that are not accepted. Claims failing our front end editing process are not forwarded to the claims adjudication system. Claims passing the front end editing process are forwarded to the claims adjudication system.
PDF BCBSMA.<submitter ID>. SubmitterReport.<datetime>**.PDF**	In addition to the ANSI transactions available to you, we prepare a "user-friendly" **Submitter Batch Report** in Adobe PDF format. There are two sections – a summary and a detail. Totals are presented in the summary for each transmission. Information about each claim is available in the detail section.
835 BCBSMA.<Submitter ID>. ClaimPayment.<datetime>**.835**	If you have elected to receive your remittance advices electronically, once claims have been adjudicated, this transaction will be sent to your mailbox.

7.3. Report Samples

Below are samples of each of the claim submission reports. The generic name in parentheses appears after the report name. The report samples are random samples from different batches of claims.

TA1 (Interchange Acknowledgment)

The **TA1** report acknowledges that we have received or rejected an entire transmission. The report is delivered to your mailbox in stream format. For illustration purposes only, the report has been reformatted to show the individual segments.

```
ISA*00*       *00*       *ZZ*00200       *ZZ*<SUBMITTER ID>*080630*1550*U*00501*000000069*0*T*>~
TA1*000197660*080630*0951*A*000~
IEA*0*000000069~
```

999 (Functional Acknowledgement)

The **999** indicates **accepted and rejected transaction sets** within an interchange. For illustration purposes only, the report has been reformatted to show the individual segments.

```
ISA*00*       *00*       *ZZ*00200       *ZZ*<SUBMITTER ID>*080630*1551*U*00501*000000070*0*T*>~
GS*FA*00200*SUBMITTERID*20080630*1551*35*X*005010X223~
ST*999*0001~
AK1*HC*197665~
AK2*837*000000001~
AK5*A~
AK9*A*1*1*1~
SE*8*0001~
GE*1*35~
IEA*1*000000070~
```

277 (Acknowledgement of receipt of claim submission)

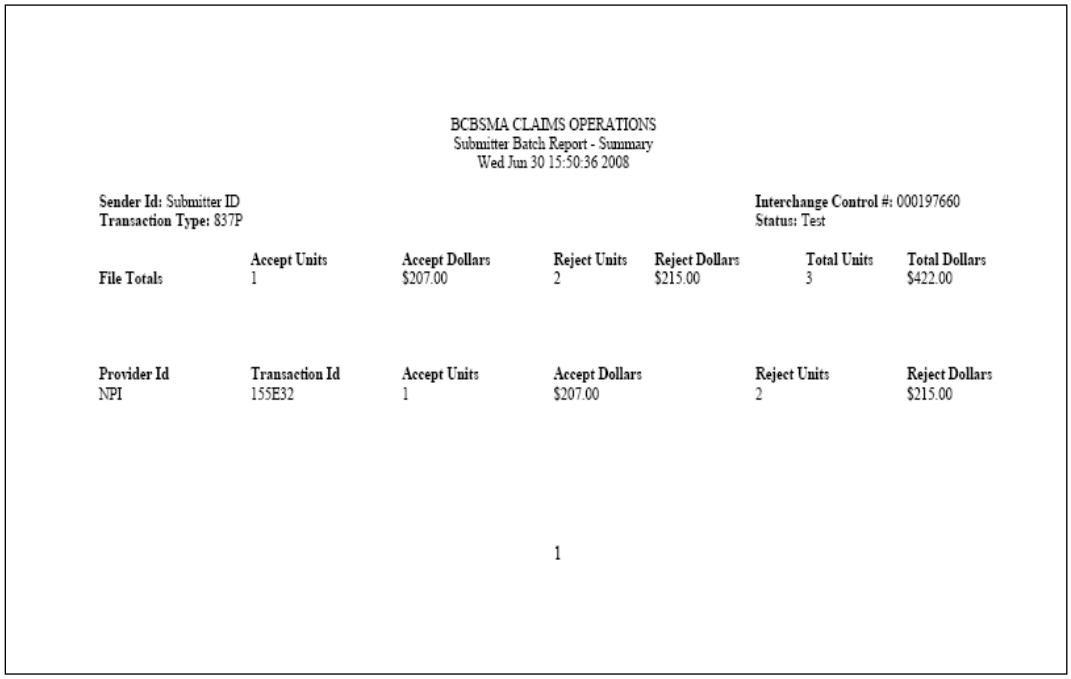
The **277** notifies you of transactions that have **passed our front end edits** and will be forwarded to the adjudication system. Also included are transactions that have **failed the front end** and will not be forwarded for adjudication. The report is delivered to your mailbox in stream format. For illustration purposes only, the report has been reformatted to show the individual segments.

```
ISA*00*          *00*          *ZZ*00200          *ZZ*SUBMITTER ID*080630*1551*^*00501*000000035*0*T*>~
GS*HN*00200*CU01*20080630*1551*35*X*005010X214~
ST*277*0001*005010X214~
BHT*0085*08*39403.1*20080630*155036*TH~
HL*1**20*1~
NM1*PR*2*MA BLUE SHIELD*****46*00200~
TRN*1*39403~
DTP*050*D8*20080630~
DTP*009*D8*20080630~
HL*2*1*21*1~
NM1*41*2*SUBMITTER NAME*****46*SUBMITTERID~
TRN*2*155E37~
STC*A1>19>>65*20080630*WQ*793~
QTY*90*4~
QTY*AA*2~
AMT*YU*578~
AMT*YY*215~
HL*3*2*19*1~
NM1*85*2*PROVIDER NAME*****XX*NPI~
TRN*1*2~
REF*EI*042888373~
QTY*QA*1~
QTY*QC*2~
AMT*YU*207~
AMT*YY*215~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*SUBSCRIBERID~
TRN*2*6608108431353~
STC*A1>19>>65*20080630*WQ*207~
REF*D9*23081081511500~
HL*5*4*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*SUBSCRIBERID~
TRN*2*6608112681460~
STC*A7>486>>65*20080630*U*81********H51000 The Procedure Code 'ADMIN' is not a valid CPT or HCPCS Code for this
Date of Service.~
REF*D9*43081124916400~
HL*6*4*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*SUBSCRIBERID~
TRN*2*6608108431346~
STC*A7>400>>65*20080630*U*134********H30011 The Sum of the SV1-02 elements is not equal to CLM-02 in the 2300
loop.~
REF*D9*43081081694500~
SE*39*0001~
GE*1*35~
IEA*1*000000035~
```

PDF (Submitter Batch Report)

The **PDF**—Submitter Batch Report—is not a technical ANSI transaction. It is delivered to your mailbox as a PDF so that you may have a visual report.

The first section is a **summary report** for the transmission.



BCBSMA CLAIMS OPERATIONS
Submitter Batch Report - Summary
Wed Jun 30 15:50:36 2008

Sender Id: Submitter ID
Transaction Type: 837P

Interchange Control #: 000197660
Status: Test

	Accept Units	Accept Dollars	Reject Units	Reject Dollars	Total Units	Total Dollars
File Totals	1	$207.00	2	$215.00	3	$422.00

Provider Id	Transaction Id	Accept Units	Accept Dollars	Reject Units	Reject Dollars
NPI	155E32	1	$207.00	2	$215.00

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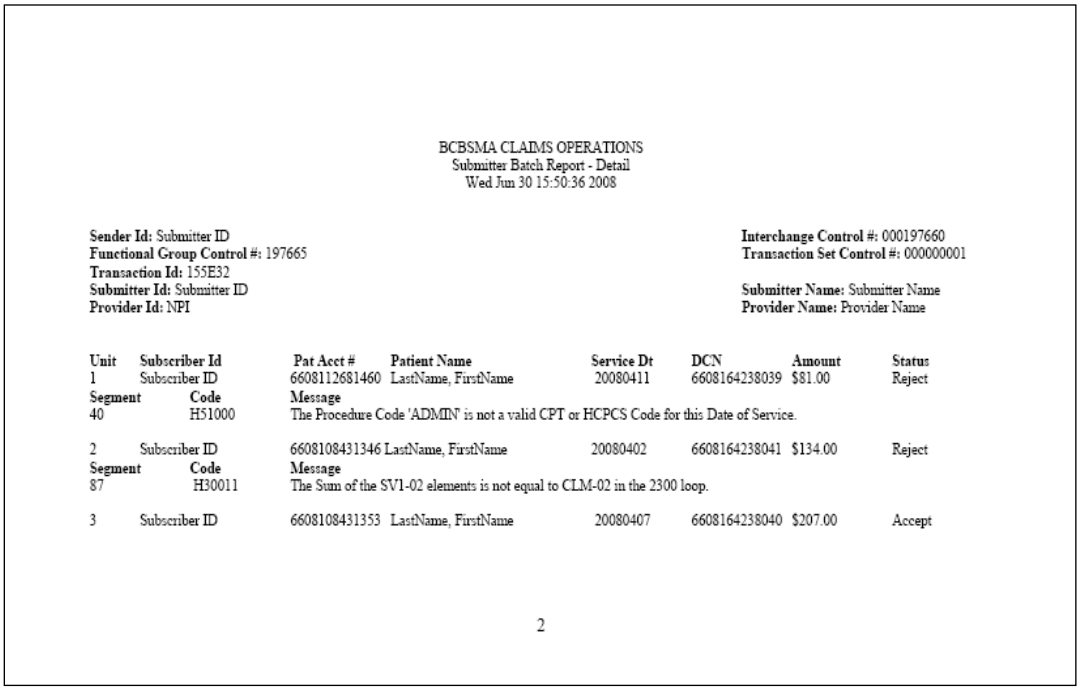
The second section provides **detail for each claim** for each provider.



BCBSMA CLAIMS OPERATIONS
Submitter Batch Report - Detail
Wed Jun 30 15:50:36 2008

Sender Id: Submitter ID
Functional Group Control #: 197665
Transaction Id: 155E32
Submitter Id: Submitter ID
Provider Id: NPI

Interchange Control #: 000197660
Transaction Set Control #: 000000001

Submitter Name: Submitter Name
Provider Name: Provider Name

Unit	Subscriber Id	Pat Acct #	Patient Name	Service Dt	DCN	Amount	Status
1	Subscriber ID	6608112681460	LastName, FirstName	20080411	6608164238039	$81.00	Reject
Segment	**Code**	**Message**					
40	H51000	The Procedure Code 'ADMIN' is not a valid CPT or HCPCS Code for this Date of Service.					
2	Subscriber ID	6608108431346	LastName, FirstName	20080402	6608164238041	$134.00	Reject
Segment	**Code**	**Message**					
87	H30011	The Sum of the SV1-02 elements is not equal to CLM-02 in the 2300 loop.					
3	Subscriber ID	6608108431353	LastName, FirstName	20080407	6608164238040	$207.00	Accept

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8. Blue Cross Specific Conditional Data Requirements

8.2. Professional Claims (837P) Data Requirements

General

This section will clarify when **conditional data elements and segments** must be used for Blue Cross *professional* claim transactions and will help you complete the 837P transaction. If you follow these guidelines, we'll be able to process your claims more accurately and efficiently.

Control Segments

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	ISA - INTERCHANGE CONTROL HEADER			
	ISA	**Interchange Control Header**	**To start and identify an interchange of zero or more functional groups and interchange-related control segments**	
	ISA01 / I01	Authorization Information Qualifier	Required	Use: ▪ **00** *(no authorization information present / no meaningful information in I02)*
	ISA02 / I02	Authorization Information	Required	Use: ▪ **10 spaces**
	ISA03 / I03	Security Information Qualifier	Required	Use: ▪ **00** *(no security information present / no meaningful information in I04)*
	ISA04 / I04	Security Information	Required	Use: ▪ **10 spaces**
	ISA05 / I05	Interchange ID Qualifier	Required, qualifies the sender in ISA06	Use: ▪ **ZZ** *(mutually defined)*
	ISA06 / I06	Interchange Sender ID	Required	Use: ▪ Your **submitter ID** *(the same code used in GS02 and loop 1000A NM109)*
	ISA07 / I07	Interchange ID Qualifier	Required, qualifies the receiver in ISA08	Use: ▪ **ZZ** *(mutually defined)*
	ISA08 / I08	Interchange Receiver ID	Required	Use: ▪ **00200** *(BCBSMA)*
	GS - FUNCTIONAL GROUP HEADER			
	GS	**Functional Group Header**	**To indicate the beginning of a functional group and to provide control information**	
	GS02 / 142	Application Sender Code	Required	Use: ▪ Your **submitter ID** (*the same code used in ISA06 and loop 1000A NM109)*

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	GS03 / 124	Application Receiver Code	Required	Use: ▪ **00200** (BCBSMA)
	GS08 / 480	Version / Release / Industry ID Code	Required	Use: ▪ **005010X222A1** (Professional Implementation Guide plus Addenda)

Detail Data

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**1000A**	**SUBMITTER NAME**		
020	**NM1**	**Submitter Name**	**To supply the full name of an individual or organizational entity.**	
020	**NM109 / 67**	Identification Code	Required	Use your **submitter ID (**the same code used in ISA06 and GS02)
Loop	**1000B**	**RECEIVER NAME**		
020	**NM1**	**Receiver Name**	**To supply the full name of an individual or organizational entity.**	
020	**NM109 / 67**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2000A**	**BILLING/PAY TO PROVIDER HIERARCHICAL LEVEL**		
003	**PRV**	**Billing / Pay-to Provider Specialty Information**	**To specify the identifying characteristics of a provider.**	
003	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use: ▪ **ZZ** (health care provider taxonomy code list)
003	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required.
Loop	**2010AA**	**BILLING PROVIDER NAME**		
015	**NM1**	**Billing Provider Name**	**To supply the NPI.**	

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
015	**NM108 / 66**	Identification Code Qualifier	Required	Use: ▪ **XX** (NPI)
015	**NM109 / 67**	Identification Code	Required	Use: ▪ The *billing* provider's 10-digit NPI
Loop	**2010AA**	**BILLING PROVIDER SECONDARY IDENTIFICATION**		
035	**REF**	**Reference Identification**	**To identify the Tax ID (1099 number) of the *Billing* Provider**	
035	**REF01 / 128**	Reference Identification Qualifier	Required, used to provide the tax ID number of the *billing* provider	Use: ▪ **EI (**EIN number) *OR* ▪ **SY (**SSN number)
035	**REF02 / 127**	Reference Identification	Required, used to provide the tax ID number of the *billing* provider	Use the *billing* provider's 9-digit tax ID number (without dashes)
Loop	**2000B**	**SUBSCRIBER INFORMATION**		
005	**SBR**	**Subscriber Information**	**To record information specific to the primary insured and the insurance carrier for that insured**	
005	**SBR02 / 1069**	Individual Relationship Code	Situational, but *required* if the subscriber is the patient	Use: ▪ **18** (self) if the subscriber is the patient *Important Note*: Use this code only when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.
Loop	**2010BA**	**SUBSCRIBER NAME**		
015	**NM1**	**Individual or Organizational Name**	**To supply the full name of an individual or organizational entity**	
015	**NM109 / 67**	Identification Code	Situational, but *required* if the subscriber is the patient	Use the patient's identification number that was in effect on the date of service, exactly as it appears on the BCBS ID card. You must include the appropriate **alpha prefix.** *Note:* We do not issue unique identification numbers to all individual members. When submitting claims for a dependent, submit the 2010CA loop and the dependent's demographic segments, along with the data for the actual subscriber of the policy in loop 2010BA.

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**2010BB**	**PAYER NAME**		
015	**NM1**	**Individual or Organization Name**	**Information about the Payer**	
015	**NM108**	Identification Code Qualifier	Required	Use: ▪ **PI** (Payer)
015	**NM109**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2300**	**CLAIM INFORMATION**		
130	**CLM**	**Health Claim**	**To specify basic date about the claim**	
130	**CLM12 / 1366**	Special Program Code	Situational, but *required* if you have been instructed by Blue Cross to include the special program indicator to identify yourself as a contracted early intervention provider	Use: ▪ **01** if the service relates to early & periodic screening, diagnosis and treatment (EPSDT) or child health assessment program (CHAP) ***Refer to Appendix C 837P Special Program Indicator***
Loop	**2300**	**DATE OF ACCIDENT**		
135	**DTP**	**Date or Time or Period**	**To specify any or all of a date, a time, or a time period related to an accident**	
135	**DTP01 / 374**	Date/Time Qualifier	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), AP (another party responsible), EM (employment) or OA (other accident)	Use: ▪ **439** if the service involves an accident.
135	**DTP02 / 1250**	Reference Identification	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), AP (another party responsible), EM (employment) or OA (other accident)	Use: ▪ **D8** (date expressed in format CCYYMMDD *OR* ▪ **DT** (date and time expressed in format CCYYMMDDHHMM)
135	**DTP03 – 1251**	Date Time Period	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), AP (another party responsible), EM (employment) or OA (other accident)	If you have indicated an injury diagnosis code, the date of the injury or accident is *required*

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**2310B**	**RENDERING PROVIDER NAME**		
250	**NM1**	**Rendering Provider Name**	**To supply the NPI**	
250	**NM108 / 66**	Identification Code Qualifier	Required	Use: ▪ **XX** (NPI)
250	**NM109 / 67**	Identification Code	Required, used to provide the NPI of the *rendering* provider.	Use the *rendering* provider's 10-digit NPI
255	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use: ▪ **ZZ** (health care provider taxonomy code list)
255	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required. *Refer to Appendix C837I & 837P Provider Taxonomy Codes*
Loop	**2310D**	**SERVICE FACILITY LOCATION**		
250	**NM1**	**Service Facility Location**	**Use to identify the *facility where the services were rendered***	
250	**NM101 / 98**	Entity Identifier Code	Situational, but required when the location of the health care service is different than that carried in the 2010AA (billing provider) or 2010AB (pay-to provider) loops. ****If the NPI is not different then the NPI submitted in 2010AA do not send the NPI in this loop.**	Use: One of the following values: ▪ **77** (service location – use when other codes in this element do not apply) ▪ **FA** (facility) *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
250	**NM102 / 1065**	Reference Identification Qualifier	Situational, but required when the location of the health care service is different than that carried in the 2010AA (billing provider) or 2010AB (pay-to provider) loops	Use: ▪ **2** (non-person entity) *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
250	**NM103 / 1035**	Reference Identification Qualifier	Situational, but required when the location of the health care service is	Use: The name of the *service facility* where the services were rendered

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
			different than that carried in the 2010AA (billing provider) or 2010AB (pay-to provider) loops	*Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
250	**NM108 / 66**	Reference Identification Qualifier	Situational, but required when the location of the health care service is different than that carried in the 2010AA (billing Provider) or 2010AB (pay-to provider) loops	Required, if NPI is known *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
250	**NM109 / 67**	Reference Identification	Situational, but required when the location of the health care service is different than that carried in the 2010AA (billing provider) or 2010AB (pay-to provider) loops	Required, if NPI is known *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
265	**N3**	**Service Facility Location Address**	**Use to identify the address of the *facility where the services were rendered***	
265	**N301 / 166**	Address Information	Required when reporting a service facility location in NM1	Use: ▪ Address line 1 of the *service facility* location *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
265	**N302 / 166**	Address Information	Required when reporting a service facility location in NM1	Use: ▪ Address line 2 of the *service facility* location *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
270	**N4**	**Service Facility Location City/State/ZIP**	**Use to identify the city, state, and ZIP Code of the *facility where the services were rendered***	
270	**N401 / 19**	Address Information	Required when reporting a service facility location in NM1	Use: ▪ City of the *service facility* location *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
270	**N402 / 156**	Address Information	Required when reporting a service facility location in NM1	Use: ▪ State of the *service facility* location

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
				Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross
270	**N403 / 116**	Address Information	Required when reporting a service facility location in NM1	Use: ▪ ZIP code of the *service facility* location *Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross*
271	**REF**	**Service Facility Location Secondary Identification**	**Use if a secondary number is necessary to identify the *facility where the services were rendered***	
271	**REF01 / 128**	Reference Identification Qualifier	Not required	Not required
271	**REF02 / 127**	Reference Identification	Not required	Not required
Loop	**2400**	**PROFESSIONAL SERVICE**		
370	**SV1**	**Professional Service**	**To specify the claim service detail for a Health Care professional**	
370	**SV101-1 / 235**	Product / Service ID Qualifier	Required, code identifying the type / source of the descriptive number used in product / service ID.	Use the appropriate HCPCS J-code (HC) for applicable drugs or injections. If the J-code is a generic code requiring further explanation, also report the national drug code (NDC) in the LIN segment of loop 2410
370	**SV101-3 / 1339**	Procedure Modifier	Required when a modifier clarifies / improves the reporting accuracy of the associated procedure code	Blue Cross requires standard modifiers for **technical components (TC), professional components (26),** and **community mental health centers (AF, AH, AJ, HA, HE, HH, HI, HO, HR, TD)**. In addition, use standard modifiers when other services require them. Refer to the CPT and HCPCS manuals for a complete listing of standard modifiers. *Refer to Appendix C.* 837P Community Mental Health Centers Use of Procedure Code Modifiers
Loop	**2410**	**DRUG IDENTIFICATION**		
494	**LIN**	**Item Identification**	**The NDC number used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1**	
494	**LIN02 / 235**	Product / Service ID Qualifier	Situational, but *required* if this loop is used	Use: ▪ **N4** (national drug code in 5-4-2 Format) if the J-code reported in

837P Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
				SV1 is a generic code that requires further explanation
494	**LIN03 / 234**	Product / Service ID	Situational, but *required* if the qualifier N4 is used	Use: ▪ The **NDC number** in 5-4-2 format
Loop	**2420A**	**RENDERING PROVIDER NAME**		
500	**NM1**	**Individual or Organizational Name**	**To supply the full name of an individual or organizational entity**	
500	**NM108 / 66**	Identification Code Qualifier	Required if the *rendering* provider is different from the provider identified in 2310A	Use: ▪ **XX** (NPI)
500	**NM109 / 67**	Identification Code	Required if the *rendering* provider is different from the provider identified in 2310A	Use the *rendering* provider's 10-digit NPI

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8.2.1. Institutional Claims (837I) Data Requirements

General

The purpose of this section is to clarify when conditional data elements and segments must be used for Blue Cross institutional claims transactions. The following information is designed to help you complete the 837I transaction. If you follow these guidelines, we'll be able to process your claims more accurately and efficiently.

Control Segments

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Blue Shield of MA Instructions**
ISA – INTERCHANGE CONTROL HEADER				
	ISA	**Interchange Control Header**	**To start and identify an interchange of zero or more functional groups and interchange-related control segments**	
	ISA01 / I01	Authorization Information Qualifier	Required	Use: ▪ **00** (no authorization information present / no meaningful information in I02)
	ISA02 / I02	Authorization Information	Required	Use: ▪ **10 Spaces**
	ISA03 / I03	Security Information Qualifier	Required	Use: ▪ **00** (no security information present / no meaningful information in I04)
	ISA04 / I04	Security Information	Required	Use: ▪ **10 Spaces**
	ISA05 / I05	Interchange ID Qualifier	Required, qualifies the sender in ISA06	Use: ▪ **ZZ** (mutually defined).
	ISA06 / I06	Interchange Sender ID	Required	Use: ▪ Your **submitter ID** (the same code used in GS02 and loop 1000A NM109)
	ISA07 / I07	Interchange ID Qualifier	Required, qualifies the receiver in ISA08	Use: ▪ **ZZ** (mutually defined)
	ISA08 / I08	Interchange Receiver ID	Required	Use: ▪ **00200** (Blue Cross)

Control Segments

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	GS – FUNCTIONAL GROUP HEADER			
	GS	**Functional Group Header**	**To indicate the beginning of a functional group and to provide control information**	
	GS02 / 142	Application Sender Code	Required	Use: ▪ Your **submitter ID** (the same code used in ISA06 and loop 1000A NM109)
	GS03 / 124	Application Receiver Code	Required	Use: ▪ **00200** (Blue Cross)
	GS08 / 480	Version / Release / Industry Identifier Code	Required	Use: ▪ **005010X223A2** (Institutional Implementation Guide plus Addenda)

Detail Data

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**1000A**	**SUBMITTER NAME**		
020	**NM1**	**Submitter Name**	**To supply the full name of an individual or organizational entity**	
020	**NM109 / 67**	Identification Code	Required	Use your **submitter ID** (the same code used in ISA06 and GS02)
Loop	**1000B**	**RECEIVER NAME**		
020	**NM1**	**Receiver Name**	**To supply the full name of an individual or organizational entity**	
020	**NM109 / 67**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2000A**	**BILLING / PAY-TO-PROVIDER SPECIALTY INFORMATION**		
003	**PRV**	**Provider Information**	**To specify the identifying characteristics of a provider**	
003	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use : ▪ **ZZ** (health care provider taxonomy code list)

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
003	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required. *Refer to Appendix C 837I & 837P Provider Taxonomy Codes*
Loop	**2010AA**	**BILLING PROVIDER NAME**		
015	**NM1**	**Individual or Organizational Name**	**To specify the primary identification of the billing provider.**	**To supply the NPI**
015	**NM108 / 66**	Identification Code Qualifier	Required	Use: ▪ **XX** (NPI)
015	**NM109 / 67**	Identification Code	Required	Use: ▪ The *billing* provider's 10-digit NPI
Loop	**2010AA**	**BILLING PROVIDER SECONDARY ID**		
035	**REF**	**Reference Identification**	**Use if a secondary number is necessary to identify the *billing* provider**	
035	**REF01 / 128**	Reference Identification Qualifier	Required, used to provide the tax ID number of the *billing* provider	Use: ▪ **EI** (EIN number) or **SY** (SSN number)
035	**REF02 / 127**	Reference Identification	Required, used to provide the tax ID number of the *billing* provider	Use: ▪ The ***billing*** provider's 9-digit tax ID number (without dashes)
Loop	**2000B**	**SUBSCRIBER INFORMATION**		
005	**SBR**	**Subscriber Information**	**To record information specific to the primary insured and the insurance carrier for that insured**	
005	**SBR02 / 1069**	Individual Relationship Code	Situational, but *required* if the subscriber is the patient	Use: ▪ **18** (self) if the subscriber is the patient *Important Note*: Use this code only when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.
Loop	**2010BA**	**SUBSCRIBER NAME**		
015	**NM1**	**Individual or Organization**	**To supply the full name of an individual or organizational entity**	

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
		Name		
015	**NM109 / 67**	Identification Code	Situational, but *required* if the subscriber is the patient	Use the patient's identification number that was in effect on the date of service, exactly as it appears on the Blue Cross ID card. You must include the appropriate **alpha prefix.** *Note:* We do not issue unique identification numbers to all individual members. When submitting claims for a dependent, submit the 2010CA loop and the dependent's demographic segments, along with the data for the actual subscriber of the policy in loop 2010BA.

Detail Data

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**2010BC**	**PAYER NAME**		
015	**NM1**	**Individual or Organizational Name**	**Information about the Payer**	
015	**NM108**	Identification Code Qualifier	Required	Use: ▪ **PI** (payer identification)
015	**NM109**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2300**	**CLAIM INFORMATION**		
130	**CLM**	**Health Claim**	**To specify basic data about the claim**	
130	**CLM05-1 / 1331**	Facility Code Value	Required	Required. For acute care hospitals, Blue Cross will crosswalk your NPI using this field as a secondary qualifier to your NPI.
Loop	**2310A**	**ATTENDING PHYSICIAN NAME**		

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**2010BC**	**PAYER NAME**		
015	**NM1**	**Individual or Organizational Name**	**Information about the Payer**	
250	**NM1**	**Individual or Organizational Name**	**Use if it is necessary to identify the *attending* provider**	
250	**NM108 / 66**	Identification Code Qualifier	Required, if loop is submitted	Use: ▪ **XX** (NPI)
250	**NM109 / 67**	Identification Code	Required, if loop is submitted	Use: ▪ The attending physician's 10-digit NPI
Loop	**2310A**	**ATTENDING PHYSICIAN NAME**		
255	**PRV**	**Provider Information**	**To specify the identifying characteristics of an *attending* provider**	
003	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use the code **ZZ** to indicate the health care provider taxonomy code list.
003	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required. *Refer to Appendix C 837I & 837P Provider Taxonomy Codes*

Detail Data

837I Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Date Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**2310B**	**OPERATING PHYSICIAN SECONDARY ID**		
271	**REF**	**Reference Identification**	**Use if a secondary number is necessary to identify the *operating physician* provider**	

271	**REF01 / 128**	Reference Identification Qualifier	Not required	Not required
Loop	**2310C**	**OTHER PROVIDER SECONDARY ID**		
271	**REF**	**Reference Identification**	**Use if a secondary number is necessary to identify the *other provider***	
271	**REF01 / 128**	Reference Identification Qualifier	Not Required	Not Required
Loop	**2400**	**INSTITUTIONAL SERVICE LINE**		
375	**SV2**	**INSTITUTIONAL SERVICE LINE**	**To specify the claim service detail for a Health Care institution**	
375	**SV201 / 234**	Product/Service ID	Required	Required. Blue Cross has issued special billing instructions when billing for vent beds or complex rehabilitation stays. *See Appendix C* 837I Special Billing Instructions for Revenue Codes

8.2.2. Dental Claims (837D) Data Requirements

General

The purpose of this section is to clarify when conditional data elements and segments must be used for Blue Cross Blue Shield of Massachusetts dental claims transactions. The following information is designed to help you complete the 837D transaction. If you follow these guidelines, we'll be able to process your claims more accurately and efficiently.

Control Segments

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	ISA – INTERCHANGE CONTROL HEADER			
	ISA	**Interchange Control Header**	**To start and identify an interchange of zero or more functional groups and interchange-related control segments**	
	ISA01 / I01	Authorization Information Qualifier	Required	Use: ▪ **00** (no authorization information present / no meaningful information in I02)
	ISA02 / I02	Authorization Information	Required	Enter: ▪ **10 spaces**

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	ISA03 / I03	Security Information Qualifier	Required	Use: ▪ **00** (no security information present / no meaningful information in I04)
	ISA04 / I04	Security Information	Required	Enter: ▪ **10 spaces**
	ISA05 / I05	Interchange ID Qualifier	Required, this ID qualifies the Sender in ISA06	Use: ▪ **ZZ** (mutually defined)
	ISA06 / I06	Interchange Sender ID	Required	Use: ▪ Your **submitter ID** (the same code used in GS02 and loop 1000A NM109)
	ISA07 / I07	Interchange ID Qualifier	Required. This ID qualifies the receiver in ISA08	Use: ▪ **ZZ** (mutually defined)
	ISA08 / I08	Interchange Receiver ID	Required	Use: ▪ **00200** (BCBSMA)

Control Segments

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
	GS – FUNCTIONAL GROUP HEADER			
	GS	**Functional Group Header**	**To indicate the beginning of a functional group and to provide control information**	
	GS02 / 142	Application Sender Code	Required	Use: ▪ Your **submitter ID** (the same code as used in ISA06 and Loop 1000A NM109)
	GS03 / 124	Application Receiver Code	Required	Use: ▪ **00200** (BCBSMA)
	GS08 / 480	Version / Release / Industry Identifier Code	Required	Use: ▪ **005010X224A2~** (Dental Implementation Guide plus Addenda)

Detail Data

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
Loop	**1000A**	**SUBMITTER NAME**		
020	**NM1**	**Submitter Name**	**To supply the full name of an individual or organizational entity**	
020	**NM109 / 67**	Identification Code	Required	Use: ▪ Your **submitter ID** (the same code as used in ISA06 and GS02)
Loop	**1000B**	**RECEIVER NAME**		
020	**NM1**	**Receiver Name**	**To supply the full name of an individual or organizational entity**	
020	**NM109 / 67**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2000A**	**BILLING / PAY-TO-PROVIDER SPECIALTY INFORMATION**		
003	**PRV**	**Provider Information**	**To specify the identifying characteristics of a provider**	
003	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use: ▪ The code **ZZ** to indicate the health care provider taxonomy code list.
003	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code.	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required.
Loop	**2010AA**	**BILLING PROVIDER NAME**		
015	**NM1**	**Individual or Organizational Name**	**To supply the NPI**	
015	**NM108 / 66**	Identification Code Qualifier	Required	Use: ▪ **XX** (NPI)
015	**NM109 / 67**	Identification Code	Required	Use: ▪ The *billing* provider's 10-digit **NPI**
Loop	**2010AA**	**BILLING PROVIDER SECONDARY IDENTIFICATION**		
035	**REF**	**Reference Identification**	**Use to identify the Tax ID (1099 number) of the *billing* provider**	
035	**REF01 / 128**	Reference Identification Qualifier	Required, used to provide the tax ID number of the *billing* provider	Use: ▪ **EI** (EIN Number) *OR* ▪ **SY** (SSN number)

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
035	**REF02 / 127**	Reference Identification	Required, used to submit the tax ID number of the *billing* provider	Use: ▪ The *billing* provider's 9-digit tax ID number (without dashes)
Loop	**2000B**	**SUBSCRIBER INFORMATION**		
005	**SBR**	**Subscriber Information**	**To record information specific to the primary insured and the insurance carrier for that insured**	
005	**SBR02 / 1069**	Individual Relationship Code	Situational, but *required* if the subscriber is the patient	Use: ▪ **18** (Self) if the subscriber is the patient *Important Note:* If the subscriber is *not* the patient, do not use this data element. Refer to the appropriate patient segments.
Loop	**2010BA**	**SUBSCRIBER NAME**		
015	**NM1**	**Individual or Organizational Name**	**To supply the full name of an individual or organizational entity**	
015	**NM109 / 67**	Identification Code Qualifier	Situational, but *required* if the subscriber is the patient	Use the patient's identification number that was in effect on the date of service, exactly as it appears on the BCBS ID card. You must include the appropriate **alpha prefix.** *Note:* We do not issue unique identification numbers to all individual members. When submitting claims for a dependent, submit the 2010CA loop and the dependent's demographic segments, along with the data for the actual subscriber of the policy in loop 2010BA.
Loop	**2010BB**	**PAYER NAME**		
015	**NM1**	**Individual or Organizational Name**	**Information about the Payer**	
015	**NM108**	Identification Code Qualifier	Required	Use: ▪ **PI** (payer identification)
015	**NM109**	Identification Code	Required	Use: ▪ **00200** (BCBSMA)
Loop	**2300**	**DATE OF ACCIDENT**		

837D Implementation Guide Data				Payer Specific Data
Position	**Segment ID / Data Element Number**	**Description**	**837 Requirements**	**Blue Cross Instructions**
135	**DTP**	**Date or Time or Period**	**To specify the date of an accident**	
135	**DTP01 / 374**	Date/Time Qualifier	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), EM (employment) or OA (other accident)	Use: ▪ **439** if the service involves an accident
135	**DTP02 / 1250**	Reference Identification	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), EM (employment) or OA (other accident)	Use: ▪ **D8** (date expressed in format CCYYMMDD
135	**DTP03 - 1251**	Date Time Period	Situational, but *required* if CLM11-1, CLM11-2, or CLM11-3 = AA (auto accident), EM (employment) or OA (other accident)	If you have indicated a diagnosis code value greater than 80000 (injury), the date of the injury or accident is *required.*
Loop	**2300**	**CLAIM NOTE**		
190	**NTE**	**Note/Special Instruction**	**To transmit information in a free-format, if necessary, for comment or special instruction**	
190	**NTE01 / 363**	Note Reference Code	Situational, but *required* for reporting periodontal charting information	Use: ▪ **ADD** (Additional Information) Blue Cross *requires* this segment for periodontal services in order to report the periodontal case type
190	**NTE02 / 352**	Description	Situational, but *required* for reporting periodontal charting information	Required when billing for the following periodontal procedures: **D4341** and **D4910** Use the following values to report periodontal case types: ▪ **PERI1**: Case type I - gingival disease ▪ **PERI2**: Case type II - early periodontitis ▪ **PERI3**: Case type III - moderate periodontitis ▪ **PERI4**: Case type IV - advanced periodontitis

Loop	**2310B**	**RENDERING PROVIDER NAME**	
250	**NM1**	**Rendering Provider Name**	**To supply the NPI**

250	**NM108 / 66**	Identification Code Qualifier	Required	Use: ▪ **XX** (NPI)
250	**NM109 / 67**	Identification Code	Required, used to provide the NPI of the *rendering/treating* provider.	Use the *rendering* provider's 10-digit NPI
255	**PRV02 / 128**	Reference Identification Qualifier	Required when taxonomy code is submitted in PRV03	Use: ▪ **ZZ** (health care provider taxonomy code list)
255	**PRV03 / 127**	Reference Identification	Required when adjudication is known to be impacted by the provider taxonomy code	In general, provider taxonomy code is *not* required for Blue Cross claims. However, if you have been instructed by Blue Cross to submit your provider taxonomy code in order to crosswalk your NPI, it is required. *Refer to Appendix C 837I & 837P Provider Taxonomy Codes*

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9. Special Billing Instructions

9.1 Coverage Secondary to Medicare or Other Payers

If the 837 claim transaction reports that Blue Cross Blue Cross Blue Shield Massachusetts is the secondary payer to Medicare or another payer (Coordination of Benefits information), please review the following to ensure the data is populated correctly. Refer to the appropriate 837 Technical Type 3 Report Guide for further clarification.

Blue Cross realizes that the depth of COB information returned to you in the Primary Payer's remittance may be less than ideal, but we ask you to work with these payers so that we may properly adjudicate your claim. The following information is required by Blue Cross:

- SBR01 = "S" in Loop 2000B if BCBSMA is the Secondary Payer.
- SBR01 = "P" in Loop 2320 for Primary Carrier Payment information.
- CAS segment(s) in Loop 2320 required on Inpatient Institutional Claims.
- AMT segments within Loop 2320 required on all Secondary Claims.
- SVD02 element in Loop 2430 required for all 837 Professional, Dental and Outpatient Institutional Claims.

- CAS segment(s) in Loop 2430 required for all 837 Professional, Dental, and Outpatient Institutional Claims.

In addition to the data outlined above, providers should also verify that Loop 2330A (Other Subscriber Name) and Loop 2330B (Other Payer Name) are populated with all the required information for the various segments included within these loops.

When submitting claims where Medicare is the Primary Payer, BCBSMA requires that SBR09 equals "MA" (Medicare Part A) or "MB" (Medicare Part B) within Loop 2320 (Other Subscriber Information).

Loop 2000B (SBR01 = S)
Loop 2320 (SBR01 = P)

Example: SBR*P*01***MB****MB~

Item	837D	837I	837P
Claim Level			
Total Charges		**Loop 2300 CLM02**	
Total Paid Amt.		**Loop 2320 AMT02 (Where AMT01 = "D")**	
Total Deductible Amount*	**N/A**	Loop 2320 | CAS03 (where CAS01 = "PR" and CAS02 = "1")	**N/A**
Total Co-insurance Amount*	**N/A**	Loop 2320 | CAS03 (where CAS01 = "PR" and CAS02 = "2")	**N/A**
Line Level	**837D**	**837I**	**837P**
Line Charges	Loop 2400 | SV302	Loop 2400 | SV203 ***OutPatient***	Loop 2400 | SV102
Line Payment		2430 SVD02	
Line Deductible Amount*		Loop 2430 | CAS03 (where CAS01 = "PR" and CAS02 = "1")	
Line Co-insurance Amount*		Loop 2430 | CAS03 (where CAS01 = "PR" and CAS02 = "2")	

Note: If Deductible amount and Co-insurance amount are both available, do not present them in two CAS segments. Instead, use a single "Patient Responsibility" CAS segment.

9.2. 837 Subscriber claims vs. dependent claims unique identification to all BCBSMA

Segments in the subscriber loop if the claim is for a dependent. You must submit a **2010BA** loop with the actual subscriber of the Blue Cross policy for all claims submitted regardless of whether the services are for the subscriber or for a dependent.

Because we do not issue unique identification numbers to all Blue Cross members, we require that the 2010BA loop (subscriber name) be used when submitting subscriber only claims along with the demographic segments for the subscriber of the policy.

When submitting claims for a dependent of the subscriber, you must also submit the 2010CA loop along with the dependent demographic segments (do not submit the demographic segments in the subscriber loop if the claim is for a dependent). You must submit a 2010BA loop with the actual subscriber of the BCBS policy in loop 2010BA for all claims submitted to Blue Cross regardless of if the services are for the subscriber or the subscriber's dependent (spouse, child, etc.).

9.3. 837 Atypical Providers

The **NM108** and **NM109** elements within specific loops that refer to NPI enumeration will not be used because most atypical providers do not have an NPI. Instead, atypical providers should submit their Blue Cross Legacy provider number in element **REF02** within the 2010BB loops. Please note that within those loops, element **REF01** should equal "**G2.**" Instructions are also located in Section 6.1 and Section 6.2 within the 837P and 837I Loop Specific Data tables respectively.

9.4. Loop/Segment used by Atypical Providers Segment Name

2010BB | REF Billing provider secondary identification
2310B | REF (Claim Level)* Rendering provider secondary identification
2420A | REF (Service Line Level)* Rendering provider secondary identification

9.4. Facility Code Requirements for 837P claims for Blue Cross

The service facility location loop (**2310E**) is required when the location of health care service is different than that carried in the **2010AA** (billing provider) or **2010AB** (pay-to provider) loops.

The service facility location loop (**2310E**) supplies information of where care was delivered to our member. It is not required for services delivered in the patient's home or for laboratory services.

Blue Cross needs only the following data elements for claims adjudication:

NM1*FA*2*FACILITY NAME*****XX*1234567890~ <= NPI of service site in NM109.
N3*STREET ADDRESS~ <= service site street address, using standard USPO codes.
N4*CITY*ST*ZIPCD~ <= service city, state and zip code.

Example:
NM1*FA*2*GENERAL HOSPITAL*****XX*1234567890~
N3*123 ANY ST ~
N4*ANYTOWN*MA*12345~

General Information on special billing instructions

9.5. 837I Type of Bill (TOB) Convention

Blue Cross recognizes all NUBC approved type of bill values. However, most claims for our facility partners require only a limited set of these codes. To crosswalk to the acute care hospital Legacy provider identification, we use two significant digits from the TOB as a secondary qualifier to your NPI. This value is taken from your submission in the facility code value of your claim (2300 CLM05-1).

For services provided in this area of the hospital:	Submit this value in the 1st position of TOB	And submit this value in the 2nd position of TOB
Inpatient	1	1
Outpatient	1	3
Hospital-based community health center	7	9
Surgical day care	8	3

9.6. 837I, 837P & 837D Provider Taxonomy Codes

Blue Cross does not require taxonomy codes for the majority of claims. However, in certain limited conditions, a taxonomy code is used as a secondary qualifier to your NPI in our crosswalk.

Example:
2000A — BILLING PROVIDER HIERARCHICAL LEVEL
PRV✻BI✻PXC✻207Q00000X~

2310B — RENDERING PROVIDER NAME
PRV✻PE✻PXC✻1223G0001X~

9.7. 837I Special Billing Instructions for vent beds or complex rehab stays

Blue Cross has issued special billing instructions for revenue code use when billing **vent beds** or **complex rehabilitation stays**.

For services provided in this area of the hospital	Please submit this revenue code
SNF/Vent bed	0129
Complex rehab stays	0139

9.8. Ambulatory Surgi-Centers (ASC) & Observation Services

When billing revenue codes for ASC or observation services, Blue Cross requires that the charge amount for the service must *be greater than zero* ($0). Additional information and the most up-to-date billing instructions are available on our Provider Central website at **bluecrossma.com/provider.**

9.9. 837P Community Mental Health Centers (CMHC) Use of Procedure Code Modifiers

Blue Cross requires that a CMHC submit a procedure code *modifier* specific to the specialty of the rendering staff provider on each line of the claim.

Blue Cross requires that the billing NPI contracted for community mental health centers to also be submitted in the rendering/servicing provider loop (2310B or 2420A).

Values to enter in the modifier field

Modifier	Licensure Level
AF	Psychiatrist
AH	Psychologist
AJ	Licensed independent clinical social worker
HA	Child psychiatrist
HE	Psychiatric nurse practitioner
HH	Licensed Alcohol and Drug Counselors
HI	Applied Behavioral Analysis (ABA) Therapist
HO	Licensed mental health counselor
HR	Licensed marriage & family therapist
TD	Clinical nurse specialist

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9.10. 837P Billing instructions for radiology services (professional and technical components)

If you are a provider contracted to perform radiology services using the modifiers of 26 (professional) and TC (technical), please bill your claims using these guidelines.

You may be contracted to render and bill technical services with your individual NPI or your billing NPI.

When billing for	On rendering provider line put	Modifier required
Professional component	The NPI of the rendering provider.	26
Technical component	The NPI of the provider contracted to render technical services.	TC

Separate bills for professional and technical components

For	Instructions	Modifier
Professional component bill	• Submit the NPI and the tax ID of the *billing* provider in the **2010AA** loop. • Submit the NPI (and optionally, the tax ID) of the *rendering* provider in the **2310B** loop.	**26**

For	Instructions	Modifier
	• If another provider within the group has rendered another service, submit the NPI of that *service rendering* provider in the **2420A** loop.	
Technical component bill *Note* in order to correctly adjudicate the technical component service, you must identify the provider that is contracted with Blue Cross to perform the technical service.	• Submit the NPI and the Tax ID of the *billing* provider in the **2010AA** loop. • If the NPI of the *billing* provider is **contracted** with Blue Cross to perform the technical service, no other provider loops are required. Our ANSI translator is in accordance with the ANSI standard and will apply the *billing* provider to each technical service. If your software requires it, you may re-submit the NPI of the *billing* provider in the *rendering* (**2310B**) loop. • If the NPI of the *billing* provider is **not contracted** with Blue Cross to perform the technical service, submit the NPI (and optionally, the tax ID) of the provider contracted to perform the technical service in the *rendering* (**2310B**) loop.	**TC**

One bill for professional and technical components

To correctly adjudicate the technical component service, you must use the NPI of the provider contracted with Blue Cross as the rendering provider NPI for the technical service.

1. Submit the NPI and the tax ID of the *billing* provider in the **2010AA** loop.
2. The ANSI Standard allows you to submit the NPI of the rendering provider in the **2310**B loop. The standard applies that NPI as the rendering provider to all services. Remember, the technical component service (modifier TC) will adjudicate correctly only if the rendering provider is contracted with Blue Cross to provide the technical service.

Option	Description	Actions
1	Identify the contracted *technical component* provider in the **2310B** loop.	• Submit the NPI (and, optionally, the tax ID) of the provider contracted with Blue Cross to perform the technical service in the *rendering* (**2310B)** loop. • For each service other than the technical component service, submit the NPI of the rendering provider in the *service rendering* (**2420A)** loop.
2	Identify the *professional component* provider in the **2310B** loop.	• Submit the NPI (and, optionally, the tax ID) of the provider rendering the professional component in the *rendering* (**2310B)** loop. • For the technical component service, submit the NPI of the provider contracted with Blue Cross to render the technical component in the *service rendering* (**2420A)** loop.

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10. Frequency Codes 5 and 7 Guidelines

10.2. Frequency Code 5 (Late Charges) Institutional 837I claims. You can use frequency 5 code on all claims, except Medicare Advantage claims.

A **late charge** claim request:

- Applies to one original claim (a 1:1 request) and must include only the additional services and/or charges that were not initially included on the original claim.
- Must follow the same timely filing submission guidelines currently in place for original claims for any newly added services or late charges. Please refer to the *Blue Book* provider manual, for detailed information about timely filing submission guidelines.

When to use frequency code 5:	**When *not* to use frequency code 5:**
• When *adding services that were not billed on the original transaction*. • Add units of service. • EDI late charge requests require two fields at the **loop 2300** level to be coded to process through the Blue Cross claims adjudication system. ○ **Claim** segment, field **CLM05-3** • Value **5** indicates a late charge *Note:* Alpha values are not acceptable for late charges ○ **NTE** segment, with qualifier **ADD** and the narrative that explains what is being added. *For example*: "Add 3 new charges and add units of services to CPT or HCPCS code xxx".	• On claims *originally denied for exceeding the timely filing limit*. Refer to our timely filing appeals guidelines in the Blue Book. • If the original claim is processed and the late charges exceed the filing limit as outlined in the Blue Book • To change the **type of bill** on either a professional or facility claim, from inpatient to outpatient, or from outpatient to inpatient. • On an 837P professional claim. • For claims adjudication/resubmission if the claim is *rejected on the EDI front end*. You must resubmit this type of claim as a new-day claim with **frequency code 1**. • For *subscriber ID corrections*. To correct a subscriber ID, please submit a new day claim with **frequency code 1**. • On **Medicare Advantage** claims, according to Section 110, Chapter 4 of the CMS Claims Processing Manual. Use **frequency code 7** instead.

10.3. Frequency Code 7 (Resubmission)

An EDI **replacement claim** request for a **fully** or **partially** denied claims:

- Wait for the claim to process and deny before you submit a replacement.
- Applies to one original claim (a 1:1 request) or a **fully** or **partially** denied claim.
- You cannot submit one replacement claim for multiple original claims.
- Must be used to change previously submitted information.
- Can be used for claims that include changes to the original claim, in addition to charges for services not previously submitted. However, it must meet the timely filing guidelines outlined in the *Blue Book* provider manual.
- Requires 3 fields at the loop 2300 level to be coded in order to process through our claims adjudication system.
  - **Claim segment**, field **CLM05-3**
    - Values **7** for Blue Cross replacement requests

    Note: Alpha values are not acceptable for replacement claims.
  - **REF segment**, use qualifier value **F8**. Provide the original claim number to be referenced. This is the claim number that Blue Cross assigned to your original submission.

When to use frequency code 7:	**When *not* to use frequency code 7:**
• When you have *corrected information* for the original claim submitted. • If in addition to correcting information on the original claim you are *adding services* that were not billed on the original transaction. Use **code 7** to update information in a field on the claim. ***(If only adding late charges, please see separate instructions for the use of a frequency code value of 5**.)* • Here are some examples of reasons you may request a payment adjustment: – Corrected date of service – Revise previously submitted diagnosis codes, procedure or modifiers – Correct patient data, except the Blue Cross Blue Shield of Massachusetts subscriber ID. – Change the billed amount on the original claim.	• When appealing or questioning *pricing, benefits, or membership coverage dates* on a claim. Please follow the appeal guidelines in the *Blue Book* provider manual. • On claims originally denied for *timely filing*. Our Provider Service department manages timely filing appeals. You must follow instructions as outlined in our Blue Book provider office manual. • For claims originally denied because *attachments were not included*, or for services that *require additional documentation* for review. If the claim denied for the primary payer's explanation of benefits or for medical notes, please follow the existing appeals process as outlined in the Blue Book to submit the required information for review and processing. • When submitting for ***late charges only***. Please see separate instructions for the use of a **frequency code value of 5.** • To *change the type of bill* on a professional or facility claim from outpatient to inpatient, or from inpatient to outpatient. • For claims adjudication and resubmission if the claim is rejected on the EDI front end. You must resubmit this type of claim as a new-day claim, with claim frequency = 1 (**CLM05-3**) • For *subscriber ID corrections*. To correct a subscriber ID, please submit a new day claim with claim frequency = 1 (**CLM05-3**) referenced. • Making changes to the billing NPI.

– Correct a claim that denied for a referral or authorization, if one has been approved. – We offer more details in our Replacement claim request out on Provider Central, so please be sure to review the guide and share it with your IT team.	• Making changes to a bridge claim. • Changing the dates of service if the revised dates fall outside the date span of the original claim.

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11. Massachusetts 837 claims for out-of-state Medicaid agencies

Effective in April 2016, NPI and NDC fields will be systematically required for participating providers. Use the table below to determine which loops are required for 837I and 837P.

Field Name	Loop	837I	837P
National Drug Code	2410 LIN03	X	X
Rendering Provider Identifier (NPI)	2310B NM109 unless overridden when reported in loop 2420A NM109 *only* when rendering is different from loop 2010AA billing provider		X
Rendering Provider Identifier (NPI)	2310D NM109 unless overridden when reported in loop 2420C NM109 *only* when rendering is different from loop 2310A attending Provider	X	
Billing Provider NPI	2010AA NM109	X	X
Billing Provider (Second) Address Line	2010AA N302	X	X
Billing Provider Middle Name or Initial	2010AA NM105	X	X
Billing Provider Taxonomy Code	2000A PRV03	X	X
Rendering Provider Taxonomy Code	2310B PRV03 unless overridden when reported in loop 2420A PRV03		X
Service Laboratory or Facility Postal Zone or Zip Code	Loop 2310C N403 unless overridden when reported in loop 2420C N403		X
Service Laboratory or Facility Postal Zone or Zip Code	Loop 2310E N403	X	
Ambulance transport distance	2300 CR106 unless overridden when reported in loop 2400 CR106		X
Ambulance transport distance	2400 SV205 with applicable revenue code	X	
Service laboratory facility name	2310C NM103 unless overridden when reported in loop 2420C NM103		X
Service laboratory facility name	2310E N402	X	
Value code amount	2300 HI in 5th position within the composite data element (value information HI) Up to 24 value codes may be reported with a corresponding amount	X	
Value code	2300 HI in 2nd position within the composite data element (value information HI) Up to 24 value codes may be reported	X	
Condition code	2300 HI in 2nd position within the composite data element (condition information HI) Up to 24 condition codes may be reported	X	X
Occurrence codes and dates	2300 HI in 2nd and 4th positions within the composite data element (occurrence information HI)	X	

Field Name	Loop	837I	837P
	Up to 24 occurrence codes and associated dates may be reported		
Occurrence span codes and dates	2300 HI in 2nd and 4th positions within the composite data element (occurrence span information HI) Up to 24 occurrence codes and associated dates may be reported	X	
Referring provider identifier and identification code qualifier	2310A NM108/09 or REF01/02 unless overridden when reported in loop 2420F NM108/09 or REF01/02		X
Referring provider identifier and identification code qualifier	2310F NM108/09 or REF01/02 unless overridden when reported in loop 2420D NM108/09 or REF01/02	X	
Attending provider NPI	2310A NM109		X
Operating physician NPI	2310B NM109 unless overridden when reported in loop 2420A NM108/09	X	
Claim or line note text	2300 NTE02 unless overridden when reported in loop 2400 NTE02 (Line Note NTE)	X	X
Certification condition applies indicator and condition indicator (Early and periodic screening diagnosis and treatment (EPSDT)	2300 CRC02, CRC03 (EPSDT Referral CRC) loop 2300 CRC04 and CRC05 are used when additional conditions apply	X	X
Service facility name and location Information	2310E	X	
Ambulance transport information patient weight ambulance transport	2300 CR102		X
Reason code round trip purpose description stretcher purpose description	CR104 CR109 CR110		X
Ordering provider identifier and identification code qualifier	2420E NM108/09 or REF01/02 when a different from the service line rendering provider		X

12. Remittance Date

There are two options for the Remittance Date. It can either be on the claim level (2330B) or at the line level (2430). We typically see inpatient institutional Remittance Date on claim level (2330B) and outpatient/professional at the line level (2430). For a rule of thumb, If you're building an MOA segment then pass the remit date in 2430 loop. If you are building an MIA segment then pass it in the 2330B loop.

- DTP01 = 573
- DTP02 = D8
- DTP03 = CCYYMMDD (Adjudication or Payment Date)

13. Non- Specific Procedure Codes require a Narrative in Service Detail Loop

When submitting a Non- Specific procedure code HIPAA requires a narrative to be submitted in the Narrative field in the service line loop/ Segment for the appropriate transaction, 837I, 837P or 837D transactions. If the narrative is not submitted for the non-specific procedure codes the claim will be reject back to the submitter stating that the sub-element for the narrative field is missing.

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Revision History

Version:	Date:	Updates made:
1.2	April 2010	• Update 837P billing instructions for professional and technical components for radiology services • Enhance batch and claim submission guidelines.
1.2.1	9/30/11	• Cover replaced: “HIPAA Transaction” with “Health Care Claim”
1.2.1a	11/1/11	• 8.1 Corrected “Loop 2320” to “Loop 2430” for line deductible amount and line co-insurance amount items in Blue Cross Blue Shield of Massachusetts • Coordination of Benefits Quick Reference table. • 5.4 Added NEW section 5.4 Delimiters
1.2.2	2/3/12	• Added new section 6 – Blue Cross Identification Number Requirements • 7.1 Loop Specific Data – Added note to Loop 2310B (rendering provider name) with specific instructions • 7.2 Loop Specific Data – Added new Loop 2310D (rendering provider name) with specific instructions • 7.2 Loop Specific Data – HI Segment updated with language to include DTP segment (DTP01 = 435) if patient’s reason for visit is submitted on transaction • 7.2 Loop Specific Data – HI Segment (present on admission) added to clarify differences between 5010 and 5010 submission. • 10.1 Added new section 10.1 – Medicare as primary payer
1.2.3	5/15/12	• 7.2 Loop Specific Data – 2010BA NM1 revised for clarification. • 10.2 Reworded paragraph to clarify submitter vs. dependent claims.
1.2.4	1/21/13	• 9 updated to include the requirement of remaining liability • Amount (AMT*EAF) segment when line level adjudication information is not included
1.2.5	11/19/15	• Update 837P & 837I billing instructions for frequency codes 5 *(late charges)* & 7 *(resubmissions)* • Update 837P & 837I billing instructions for in-state participating providers and submission of Medicaid out-of-state agency claims

1.2.6	March 2016	• Updated for plain language and consistent formatting
1.3	5/22/2017	Throughout: corrected numbering (eliminated "x.1" numbers; subsections under introduction began with "x.2") • 1.3 – Replaced Kim Karbott's information with Scott Howard's • 2.2 – Removed the type of file transmission, "Broadcast messages" • 2.4 – Updated NEHEN section with Trizetto NEHEN information • 5.8 – Added new section • 8.2 – Corrected code by removing extra "X" in 005010X222A1 (Professional Implementation Guide plus Addenda) • 8.2 - For Service Facility Location, added the note "**If the NPI is not different then the NPI submitted in 2010AA do not send the NPI in this loop." For NM101 / 98 • 8.2.1 - Corrected code by removing extra "X" in 005010X223A2 (Institutional Implementation Guide plus Addenda) • 8.2.1 0 – New table for Rendering Provider • 12 – New section • 13 – New section
1.3.1		• 9.1–Updated to include information on COB Medicare submission of electronic claims • 10.2– Revised Frequency 5 information • 10.3– Revised Frequency 7 information

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