MASSACHUSETTS

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HEALTH CARE CLAIM

837 COMPANION GUIDE

Version 1.3.3

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)

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 details 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 adheres to 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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INTRODUCTION

What is HIPAA?

The Health Insurance Portability and Accountability Act - Administration Simplification (HIPAA-AS) requires that Blue Cross Blue Shield of Massachusetts, 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, 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. Carefully 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 is 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 maintain 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 *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 in HIPAA transactions are available for purchase at: **wpc-edi.com/HIPAA**
- The *Blue Cross Blue Shield of Massachusetts Companion Guide* is available electronically on the Provider Central website at: **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

NPI information

The most up-to-date National Provider Identifier (NPI) billing instructions are available on the Provider Central website at **bluecrossma.com/provider.** Log on and click on Office Resources

to find links to billing instructions by provider type.

Establishing a trading partner agreement with Blue Cross

You must set up 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, speak with our EDI specialists (see Contacts).

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

Form name:	Distributed 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. at:

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 email.

ESTABLISHING CONNECTIVITY WITH BLUE CROSS

This section explains 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	1-800-771-4097 option 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 277CAs, 999s, TA1's, Submitter Reports and 835s

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

NEHEN

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

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.**

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. Ten days before expiration
2. Five 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.

For individual user IDs

The Tumbleweed application will display an error message ("login invalid"), indicating that the password has expired after 90 or 365 days. 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

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 protect 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 appropriately authorized. 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.

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.

TESTING

Prior to submission to the product environment, 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. 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 "correct rate" of 95% 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.

Testing support is available Monday through Friday, 8:30 a.m. to 3:30 p.m. ET. Refer to the **Contacts** section for help.

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 transactions, acknowledgments, or reports related to your health care claim submissions, please contact Blue Cross EDI Support.

Phone: 1-800-771-4097 (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: bluecrossma.com/provider

BLUE CROSS CLAIM SUBMISSION GUIDELINES

Claim files submitted for **testing/production** must meet the guidelines listed below.

Available communication folders

For each submitter ID that you can access, your security will allow you permission to two folders: *inbound* and *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.

File name extension (.837)

Claim files submitted to the *inbound* folder must have an extension of **.837**. You may continue to use your conventions and multiple nodes for the file name, but we can only process files from the *inbound* folder if its extension is .837.

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 report.

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.

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).

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

Duplicate file transactions

Blue Cross will not process an 837 transaction submitted with duplicate ISA13 control numbers. Please submit all transactions with unique ISA13 control numbers that have not been submitted to Blue Cross in previous transactions.

BLUE CROSS IDENTIFICATION NUMBER REQUIREMENTS

	Alpha	Numeric/alphanumeric
Massachusetts Blue Cross	Three letter alpha prefix	Nine *(without prefix)* numeric or twelve *(with prefix)* alphanumeric characters
Out-of-state Blue Cross	Three letter alpha prefix	Alphanumeric characters (typically 12-14)
Federal Employee Plan (FEP)	The letter **R**	Eight numeric characters

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

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.

Report overview

Blue Cross generates the following list of reports. 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 notifies 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>.	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

SubmitterReport.<datetime>**.PDF**	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, this transaction will be sent to your mailbox once claims have been adjudicated.

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~

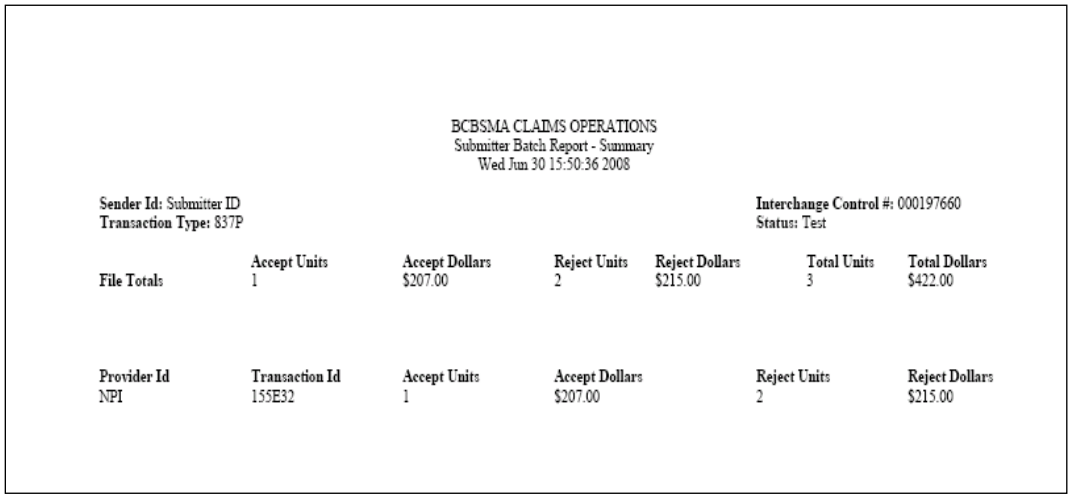
GE*1*35~

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.



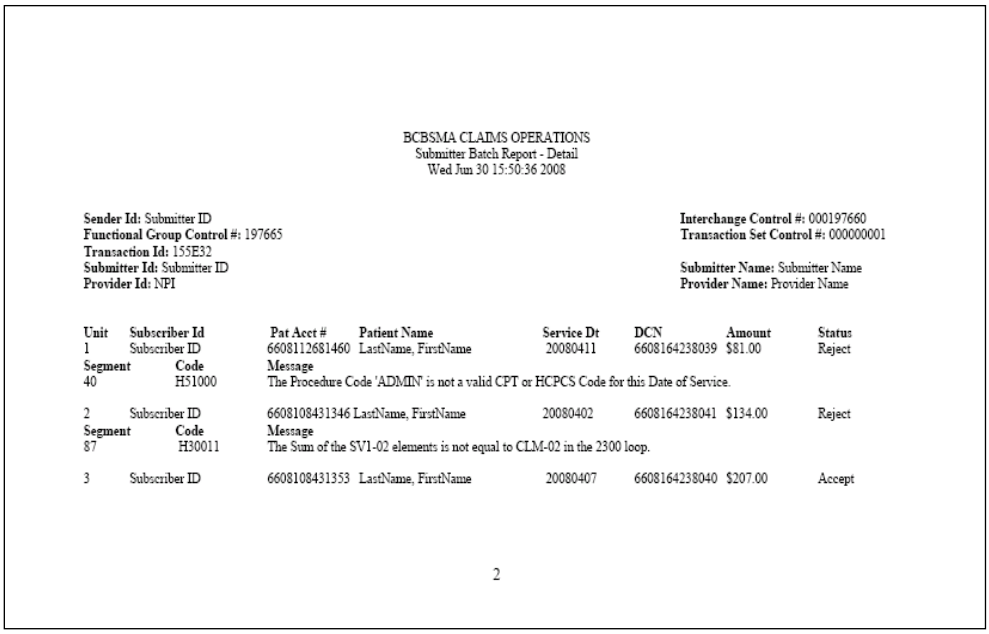
BCBSMA CLAIMS OPERATIONS
Submitter Batch Report - Summary
Wed Jun 30 15:50:36 2008

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

The second section provides **details 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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BLUE CROSS SPECIFIC CONDITIONAL DATA REQUIREMENTS

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)

837P implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
	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)
	GS03 /	Application	Required	Use:

837P implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
	124	Receiver Code		▪ **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 /	Identification	Required	Use:

	67	code		▪ **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	
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.
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	Use to identify an early intervention provider	
130	CLM12 / 1366	Special program code	Situational, but *required* if you have been instructed by Blue Cross to include the special	Use: ▪ **01** if the service relates to early & periodic screening, diagnosis and treatment

			program indicator to identify yourself as a contracted early intervention provider	(EPSDT) or child health assessment program (CHAP) Refer to Appendix C 837P Special Program Indicator
Loop	2300	Date of Accident		
135	DTP	Date, 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	If you have indicated an injury diagnosis code, the date of the injury or accident is *required*

			(another party responsible), EM (employment) or OA (other accident)	
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 than 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 different than that carried in the	Use: The name of the *service facility* where the services were rendered Refer to Appendix B Facility Code

			2010AA (billing provider) or 2010AB (pay-to provider) loops	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 Refer to Appendix B Facility Code Requirements for 837P claims for Blue Cross
270	N403 /	Address	Required when	Use:

	116	information	reporting a service facility location in NM1	▪ 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.

Loop	2400	Professional Service		
370	SV1	Professional service	To specify the claim service detail for a Health Care professional	
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 SV1 is a generic code that requires further explanation.
494	LIN03 /	Product / service	Situational, but *required* if the	Use:

Loop	2400	Professional Service		
370	SV1	Professional service	To specify the claim service detail for a Health Care professional	
	234	ID	qualifier N4 is used	▪ 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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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)

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross Blue Shield of MA instructions**
	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)
	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 /	Application receiver	Required	Use:

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross Blue Shield of MA instructions**
	124	code		▪ **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 / 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	To supply the full name of an individual or organizational	

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
		name	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)
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	To specify the primary	To supply the NPI

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
		organizational name	identification of the billing provider.	
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	

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
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 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 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

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
				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 / data 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)

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
Loop	2010BC	Payer Name		
015	NM1	Individual or organizational name	Information about the Payer	
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		
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-

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
Loop	2010BC	Payer Name		
015	NM1	Individual or organizational name	Information about the Payer	
				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 / data 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.

837I implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
				See Appendix C 837I Special Billing Instructions for Revenue Codes

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
	ISA03 / I03	Security information qualifier	Required	Use: ▪ **00** (no security information present / no meaningful

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
				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)
	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	Required	Use: ▪ Your **submitter ID** (the same

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 requirements**	**Blue Cross instructions**
		code		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

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
				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.

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
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)
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		

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
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

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
				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		
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

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
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

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
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

837D implementation guide data				Payer specific data
Position	**Segment ID / data element number**	**Description**	**837 Requirements**	**Blue Cross instructions**
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

SPECIAL BILLING INSTRUCTIONS

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), 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 Coordination of Benefits 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 837PItem 837D 837I 837P

Item	**837D**	**837I**	**837P**
Claim level			

Total charges	Loop 2300 CLM02		
Total paid amount	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.

837 Subscriber claims vs. dependent claims unique identification

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.).

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.

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

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

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 first position of TOB	And submit this value in the second position of TOB
Inpatient	1	1
Outpatient	1	3
Hospital-based community health center	7	9

For services provided in this area of the hospital	Submit this value in the first position of TOB	And submit this value in the second position of TOB
Surgical day care	8	3

837I, 837P & 837D Provider taxonomy codes

Blue Cross does not require taxonomy codes for most 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~

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

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.

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 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

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 NPI of the	Modifier required
Professional component	Rendering provider	26
Technical component	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. • If another provider within the group has rendered another service, submit the NPI of that *service rendering* provider in the **2420A** loop.	**26**

For	Instructions	Modifier
Technical component bill *Note:* 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 **2310B** 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.

837P CAA Surprise Billing (Consolidate Appropriations Act) 2022 Federal Mandate

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 the following information in the 837P for the 2022 CAA surprise billing mandate:

- The SERVICE FACILITY LOCATION NAME in loop 2310C is required when billing for professional services rendered by a non-participating provider in a participation facility.
- The PWK (CLAIM SUPPLEMENTAL INFORMATION) segment in loop 2300 must also be populated using CK (Consent Form) when the member has signed a waiver consent form.

FREQUENCY CODES 5, 7, AND 8 GUIDELINES

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* • To 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

Frequency code 7 (resubmission)

An EDI **replacement claim** request:

- Wait for the claim to process and finalize before you submit a replacement.
- Applies to one original claim (a 1:1 request).
- 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***	• When appealing or questioning *pricing, benefits, or membership coverage dates* on a claim. 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. Follow the appeal guidelines in the *Blue Book* provider manual. • For claims originally denied because *attachments were not included*, or for

When to use frequency code 7	When *not* to use frequency code 7
for the use of a frequency code value of 5*).* • When you have *corrected information* for the original claim submitted. • 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 – Correct a claim that denied for a referral or authorization, if one has been approved – We offer more details in our Replacement claim page on Provider Central, so please be sure to review the guide and share it with your IT team	services that *require additional documentation* for review. • 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. • Making changes to a bridged claim. • Changing the dates of service if the revised dates fall outside the date span of the original claim.

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Frequency code 8 (full void)

When to use frequency code 8	When *not* to use frequency code 8
When submitting for a fully voided claim • EDI 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 8 indicates Voided REF 02- Use qualifier value F8- provide original claim number to be referenced. *For example* • Must represent the entire claim—not just the line or item that you are retracting. • Must serve as a full void of the claim (a 1:1 request). You cannot submit one resubmission claim for multiple original claims.	On fully denied claims* *Exception: sometimes other plans require a full void on a denied claim. This would be done using frequency code 8.

MASSACHUSETTS 837 CLAIMS FOR OUT-OF-STATE MEDICAID AGENCIES

Effective in April 2016, NPI and NDC fields are 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

Field name	Loop	837I	837P
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) Up to 24 occurrence codes and associated dates may be reported	X	

Field name	Loop	837I	837P
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

Field name	Loop	837I	837P
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

REMITTANCE DATE

There are two options for the remittance date. It can either be on the claim level (2330B) or on the line level (2430). We typically see inpatient institutional remittance date on the claim level (2330B) and outpatient/professional on the line level (2430). A good practice when you're building an MOA segment is to pass the remit date in the 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)

NON-SPECIFIC PROCEDURE CODES REQUIRE A NARRATIVE IN SERVICE DETAIL LOOP

For non-specific procedure codes, 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. If the narrative is not submitted for the non-specific procedure codes, the claim will 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	Apr 2010	Update 837P billing instructions for professional and technical components for radiology services Enhance batch and claim submission guidelines.
1.2.1	Sep 30, 2011	Cover replaced: “HIPAA Transaction” with “Health Care Claim”
1.2.1a	Nov 1, 2011	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	Feb 3, 2012	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	May 15, 2012	7.2 Loop Specific Data – 2010BA NM1 revised for clarification.

Version	Date	Updates made
		10.2 Reworded paragraph to clarify submitter vs. dependent claims.
1.2.4	Jan 21, 2013	9 updated to include the requirement of remaining liability Amount (AMT*EAF) segment when line level adjudication information is not included
1.2.5	Nov 19, 2015	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	Mar 2016	Updated for plain language and consistent formatting
1.3	May 22, 2017	Throughout: corrected numbering (eliminated “x.1” numbers; subsections under introduction began with “x.2”) 1.3 – Revised 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

Version	Date	Updates made
		13 – New section
1.3.1	Mar 1, 2018	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
1.3.2	May 22, 2019	10.4 – Added Frequency 8 information
1.3.3	November 10, 2021	New template. Removed numbering. Minor language updates. Added section, “837P CAA Surprise Billing (Consolidate Appropriations Act) 2022 Federal Mandate”

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