

Companion Document For
ANSI ASC X12N 837 4010A1 Claim Submission To
Blue Cross and Blue Shield of Alabama
For Professional Claims
July 23, 2008

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States, comply with the EDI standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837 implementation guides have been established as the standards of compliance for electronic claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI ASC X12N 837 implementation guides. The table contains specific requirements to be used for processing data in the Blue Cross and Blue Shield of Alabama professional claims processing system.

The use of this document is solely for the purpose of clarification. This document supplements, but does not contradict any requirements in the ANSI ASC X12N implementation guides. Additional companion documents are available for Dental 837, Institutional 837 and other HIPAA standards.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
1.	----	----	The maximum number of characters to be submitted in a dollar amount field is nine characters. Claims in excess of 9,999,999.99 will be rejected.
2.	----	----	Blue Cross and Blue Shield of Alabama will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the professional processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
3.	----	----	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
4.	----	----	The incoming 837 transactions utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), and (pipe). Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected. Preferred delimiters are: ~ (tilde) for segment separators, * (asterisk) for data element separators and : (colon) or > (greater than) for component data element separators. The usage of these characters within text data elements in the incoming 837 transaction may cause problems with creation of subsequent transactions, including the outbound 837 and the 835.
5.	----	----	Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected and not sent for processing consideration.
6.	----	----	All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
7.	----	----	Blue Cross and Blue Shield of Alabama will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).

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8.	-----	-----	Blue Cross and Blue Shield of Alabama will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
9.	-----	-----	Blue Cross and Blue Shield of Alabama will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
10.	-----	-----	Blue Cross and Blue Shield of Alabama will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guide.
11.	-----	-----	We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission. A TA1 segment (Interchange Acknowledgment) will be returned in the 997.
12.	-----	-----	Compression of files is supported for transmissions between the submitter and Blue Cross and Blue Shield of Alabama. Any compression software compatible with PKZIP by PKWARE, Inc. is supported.
13.	-----	-----	Use the following format when submitting Blue Cross and Blue Shield of Alabama provider numbers: 0(leading zero) + plan code + provider number (i.e. 051012345
14.	-----	-----	When submitting text in free format fields, such as name and address, a hyphen (-) is the only special character allowed. Any names with apostrophes (') can be submitted with or without a space in the place of the apostrophe.
15.	-----	Interchange Control Header	Use your 8-character Submitter ID assigned by Blue Cross and Blue Shield of Alabama followed by 7 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID. The Submitter ID reported in ISA06 must match the Submitter ID reported in GS02. The Submitter ID reported in these records will be the directory in which the remittance and Electronic Report Files (ERF) will be returned.
16.		Interchange Control Header	Use ZZ in ISA07 as the Interchange ID Qualifier.
17.	-----	Interchange Control Header	Use 00510BS followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID.

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18.	-----	Functional Group Header	Use your 8-character Submitter ID assigned by Blue Cross and Blue Shield of Alabama in GS02 as the Application Sender's Code. The Submitter ID reported in this segment must match the Submitter ID submitted in ISA06.
19.	-----	Functional Group Header	Use 00510BS in GS03 as the Application Receiver's Code.
20.	1000A	Submitter Name	Use your 8-character Submitter ID in NM109.
21.	1000B	Receiver Name	Use 00510BS in NM109 as the Receiver Name Code
22.	2000A	Billing/Pay-to Provider Specialty Information	Use ZZ in PRV02 and the appropriate taxonomy code in PRV03 (Only necessary when the provider is submitting claims as a VA, Military, or Children's Rehabilitation employee- more scenarios may be required in the future)
23.	2010AA	Billing Provider Name	The Billing NPI and Tax ID must be included in this loop.
24.	2010AA	Billing Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
25.	2010AA	Billing Provider Address	Include address information for the billing provider in N3
26.	2010AA	Billing Provider City/State/Zip Code	Include the city, 2-character state code, and 9-digit zip code for the billing provider in N4
27.	2010AA	Billing Provider Secondary Identification	Use EI in REF01 and the Tax ID (9 numeric) in REF02
28.	2010AB	Pay-to Provider Name	If submitted, the NPI and Tax ID must be included in this loop.
29.	2010AB	Pay-to Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
30.	2010AB	Pay-to Provider Address	Include address information for the pay-to provider in N3
31.	2010AB	Pay-to Provider City/State/ Zip Code	Include the city, 2-character state code, and 9-digit zip code for the pay-to provider in N4
32.	2010AB	Pay-to Provider Secondary Identification	Use EI in REF01 and the Tax ID (9 numeric) in REF02
33.	2000B	Subscriber Hierarchical Level	The HL segments must be in order from one, by one (+1) and must be numeric.

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34.	2010BB	Payer Name	Use the PI qualifier in NM108 followed by 00510 as the Identification Code
35.	2300	Claim Information	The only valid values for CLM05-3 (Claim Frequency Type Code) of the Health Care Service Information data element are '1' (ORIGINAL), '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.
36.	2300	Health Care Diagnosis Code	You may send up to eight diagnosis codes per claim; however, the last four diagnoses codes will not be considered in processing.
37.	2300	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5) bytes. Blue Cross and Blue Shield of Alabama does not accept decimal points in diagnosis codes. Any claims submitted with diagnosis codes containing decimal points will reject.
38.	2300		<u>CORRECTED CLAIMS:</u> CLM05 Claim Frequency Type Code = 7 REF01 Original Claim number qualifier = F8 REF02 Original Claim number = Actual original claim number.
39.	2310A (2420F)	Referring Provider	If submitted, the loop must contain the NPI in the NM1 segment and at least one REF segment with a 1G qualifier along with the valid corresponding ID.
40.	2310A (2420F)	Referring Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
41.	2310A (2420F)	Referring Provider Secondary Identification	Use 1G in REF01 and the provider's UPIN number in REF02
42.	Multiple (2310B, 2420A)	Rendering Provider Name Secondary Identification	If submitted, the loop must contain the NPI in the NM1 segment, a REF segment with a EI qualifier and corresponding ID.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
43.	2310B (2420A)	Rendering Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
44.	2310B (2420A)	Rendering Provider Specialty Information	Use ZZ in PRV02 and the appropriate taxonomy code in PRV03*(See Note)
45.	2310B (2420A)	Rendering Provider Secondary Identification	Use EI in REF01 and the Tax ID (9 numeric) in REF02
46.	2310C (2420B)	Purchased Service Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
47.	2310D (2420C)	Service Facility Location	Use XX in NM108 and the NPI (10 numeric) in NM109
48.	2310D (2420C)	Service Facility Location Address	Include address information for the service location in N3
49.	2310D (2420C)	Service Facility Location City/State/Zip Code	Include the city, 2-character state code, and 9-digit zip code for the service location in N4
50.	2310E (2420D)	Supervising Provider Name	Use XX in NM108 and the NPI (10 numeric) in NM109
51.	2400	Professional Service	Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
52.	Multiple (2300, 2400)	Paperwork	Any data submitted in the PWK (Paperwork) segment will not be considered for processing.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
			<p>SECONDARY CLAIM BILLING:</p> <p><u>When Blue Shield is the Secondary Payer and the Primary Payer IS Medicare:</u></p> <p>Note: Usage of the data elements below cause the 2330A and 2330B loops to be required.</p>
53.	2300	Claim Total Submitted Charge	CLM02 Must be equal to the sum of the line items.
54.	2320	Claim Deductible Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), with CAS01=PR and CAS Claim Adjustment Reason Code (02, 05, 08, 11, 14, 17) = 1 or 126. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
55.	2320	Claim Co-Payment Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), with CAS01=PR and CAS Claim Adjustment Reason Code (02, 05, 08, 11, 14, 17) = 2, 3 or 127. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
56.	2320	Claim Primary Payer Paid Amount	AMT02, where AMT01=D. NOTE: <i>If line item data is available, report this data at the line level.</i>
57.	2320	Claim Primary Payer Allowed Amount	AMT02, where AMT01=B6. NOTE: <i>If line item data is available, report this data at the line level.</i>
58.	2320	Claim Primary Payer Discount Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
59.	2400	Line Submitted Charge	SV102, Monetary Amount.

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60.	2400	Line Primary Payer Allowed Amount	AMT02, where AMT01=AAE. NOTE: <i>If line item data is available, report this data at the line level.</i>
61.	2430	Line Primary Payer Paid Amount	SVD02. NOTE: <i>If line item data is available, report this data at the line level.</i>
62.	2430	Line Deductible Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), with CAS01=PR and CAS Claim Adjustment Reason Code (02, 05, 08, 11, 14, 17) = 1 or 126. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
63.	2430	Line Co-payment Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), with CAS01=PR and CAS Claim Adjustment Reason Code (02, 05, 08, 11, 14, 17) = 2, 3 or 127. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
64.	2430	Line Primary Payer Discount Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>
			<u>When Blue Shield is the Secondary Payer and the Primary Payer is NOT Medicare:</u> Note: Usage of the data elements below cause the 2330A and 2330B loops to be required.
65.	2300	Claim Total Submitted Charge	CLM02 Must be equal to the sum of the line items.
66.	2320	Claim Primary Payer Paid Amount	AMT02, where AMT01=D. NOTE: <i>If line item data is available, report this data at the line level.</i>
67.	2320	Claim Primary Payer Discount Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>

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68.	2400	Line Submitted Charge	SV102, Monetary Amount.
69.	2430	Line Primary Payer Paid Amount	SVD02. NOTE: <i>If line item data is available, report this data at the line level.</i>
70.	2430	Line Primary Payer Discount Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO. NOTE: <i>If line item data is available, report this data at the line level. This information is required if it is received from the primary payer.</i>