

Companion Document For
ANSI ASC X12N 837 4010A1 Claim Submission To
Blue Cross and Blue Shield of Alabama
For Institutional Claims
March 15, 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 institutional 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 use Professional 837, Dental 837 and other HIPAA standards.

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1.	-----	-----	Blue Cross will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Blue Cross processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
2.	-----	-----	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional 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.
3.	-----	-----	The incoming 837 transactions utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), (pipe), and ^ (carrot). 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.
4.	-----	-----	Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
5.	-----	-----	All dates that are submitted on an incoming 837 claim transaction must 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).
6.	-----	-----	Blue Cross 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).
7.	-----	-----	Blue Cross will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
8.	-----	-----	Blue Cross 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.
9.	-----	-----	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.

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10.	-----	-----	Compression of files is supported for transmissions between the submitter and Blue Cross. Any compression software compatible with PKZIP by PKWARE, Inc. is supported.
11.	-----	Interchange Control Header	Use your 8-character CLIENTID assigned by Blue Cross and Blue Shield of Alabama in followed by 7 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID.
12.	-----	Interchange Control Header	Use 00010BC followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID.
13.	-----	Functional Group Header	Use your 8-character CLIENTID assigned by Blue Cross and Blue Shield of Alabama in GS02 as the Application Sender's Code.
14.	-----	Functional Group Header	Use 00010BC in GS03 as the Application Receiver's Code.
15.	2000B	Subscriber Hierarchical Level	The hierarchical level (HL segment) must be incremented by one beginning with one.
16.	2010AA	Billing Provider Name	Use XX in NM108 and the appropriate NPI number in NM109.
17.	2010AA	Billing Provider Address	Include address information for the billing provider in N3.
18.	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.
19.	2010AA	Billing Provider Secondary Identification	Use EI in REF01 and Tax ID in REF02.
20.	2010AB	Pay-to Provider Name	If applicable, use XX in NM108 and the appropriate NPI number in NM109.
21.	2010AB	Pay-to Provider Address	If 2010AB NM1 is present, include address information for the pay-to provider in N3.
22.	2010AB	Pay--to Provider City/State/Zip Code	If 2010AB NM1 is present, include the city, 2-character state code, and 9-digit zip code for the pay-to provider in N4.
23.	2010AB	Pay-to Provider Secondary Identification	If 2010AB NM1 is present, use EI in REF01 and Tax ID in REF02.
24.	Multiple (2300, 2320, 2400)	Various	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV203), Service Unit Count (2400 Loop, SV205), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102)

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25.	2300	Claim Information	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).
26.	2300	Health Care Diagnosis Code	Up to fifteen (15) Diagnosis Codes may be sent. Principal, Admitting and an E-Code may come in one (1) HI segment, and up to twelve (12) other diagnosis codes may be sent in a second HI segment.
27.	2300	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5) bytes. Blue Cross does not accept decimal points in diagnosis codes.
28.	2400	Professional Service	You may send up to four modifiers; however, the last two modifiers may not be considered. The Blue Cross processing system will only use the first two modifiers for adjudication and payment determination of claims.
29.	2310A	Attending Physician Name	If applicable, use XX in NM108 and the appropriate NPI number in NM109.
30.	2310B	Operating Physician Name	If applicable, use XX in NM108 and the appropriate NPI number in NM109.
31.	2310E	Service Facility Name	If applicable, use XX in NM108 and the appropriate NPI number in NM109.
32.	2310E	Service Facility Address	If 2310E NM1 is present, include address information for the service facility in N3.
33.	2310E	Service Facility City/State/Zip Code	If 2310E NM1 is present, include the city, 2-character state code, and 9-digit zip code for the service facility in N4.
34.	Multiple (2300, 2400)	Paperwork	Any data submitted in the PWK (Paperwork) segment will not be considered for processing.
			<p>SECONDARY CLAIM BILLING: <u>When Primary Payer IS Medicare:</u> Note: Usage of the data elements below cause the 2330A and 2330B loops to be required.</p>
35.	2300	Claim Total Submitted Charge	CLM02 must be equal to the sum of the line items. Claim total and submitted charge.
36.	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.
37.	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.

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38.	2320	Claim Primary Payer Paid Amount	AMT02 where AMT01=N1.
39.	2320	Claim Primary Payer Allowed Amount	AMT02 where AMT01=B6.
40.	2320	Claim Primary Payer Discount Amount	CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO.
			<p><u>When Primary Payer is Not Medicare:</u></p> <p>Note: Usage of the data elements below cause the 2330A and 2330B loops to be required.</p>
41.	2300	Claim Total Submitted Charge	CLM02 Must be equal to the sum of the line items.
42.	2320	Claim Primary Payer Paid Amount	AMT02, where AMT01=C4.
43.	2320	Claim Primary Payer Discount Amount	2320 CAS Monetary Amount (03, 06, 09, 12, 15, 18), where CAS01=CO.