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of the Blue Cross and Blue Shield Association

June 2010

Dear Software Developer,

We recently published a revised copy of the *BCBSM EDI Dental 837 Companion Document* at the following location on the BCBSM Web site: http://www.bcbsm.com/pdf/dental_edi_837den.pdf.

The table below summarizes the changes made.

| Section | Description of Change | Page(s) |
|--|--|---------|
| Table of Contents | Replaced table of contents. | TOC |
| Data Clarifications for the Dental 837 (004010X097A1) Transaction Set | | |
| Loop 2010BA, NM109 | Removed "or 2010CA" and Revised Instruction. | 12 |

If you have any questions regarding this information, please call our Electronic Data Interchange department at 800-542-0945.

Sincerely,

Handwritten signature of Wanda Brideau in black ink.

Wanda Brideau
Senior Manager
e-Business Interchange Group

Handwritten signature of John Bialowicz in black ink.

John Bialowicz
Manager, ETP Contracting and Relations
e-Business Interchange Group

Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document
American National Standards Institute (ANSI) ASC X12N 837 (004010X097A1) Dental Health
Care Claim and 835 (004010X091A1) Health Care Claim Payment/Advice

Published June 2002



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Introduction

This document is the property of Blue Cross Blue Shield of Michigan (BCBSM) and is for use solely in your capacity as a Trading partner health care transactions with BCBSM.

This document provides information related to specific elements within the Addenda version of the ANSI ASC X12N 837 transaction, but does not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.¹

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N Dental 837 and 835 transaction set Addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, companion documents, physician’s manuals, and/or other billing guidelines published by our clearinghouse payers, including BCBSM and FEP. Implementation Guides can be downloaded from the Washington Publishing Company web site at www.wpc-edi.com.

This document is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the BCBSM web site: www.bcbsm.com.

Appropriate steps must be taken before submitting production Addenda ANSI ASC X12N transactions, such as testing, completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please contact the EDI Help Desk at 1-800- 542-0945.

¹Standards for Electronic Transactions, *Federal Register*, Vol. 65, No. 160, August 17, 2000 pg. 50368

ANSI ASC X12N Dental 837 (004010X097A1) – Reporting Instruction Clarifications

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The Addenda version of the ANSI ASC X12 837 transaction set has been selected as the format to meet HIPAA requirements for the electronic submission of dental health care claims. The BCBSM EDI Clearinghouse only accepts ANSI ASC X12N 837 addenda version dental transactions for Blue Cross Blue Shield of Michigan and the Federal Employee Program. Acceptance of 837 and return of 835 transactions will occur in batch mode and will not be accommodated in the real-time environment.

- BCBSM EDI may reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and BCBSM EDI Companion Document requirements.
- BCBSM EDI may edit data submitted beyond the requirements defined in the HIPAA Implementation Guide.
- BCBSM EDI will reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.
- BCBSM EDI will reject a file that is determined to be a duplicate of a previously submitted file.

Trading partners should note that if the information associated with any of the claims in the 837 ST-SE batch is not correctly formatted from a syntactical perspective, all claims between the ST-SE would be rejected. Providers should consider this possible response when determining the size of their transactions.

Hierarchical Structure

The 837 format incorporates a hierarchical structure to make the submission of health care claims as efficient as possible. A hierarchical structure identifies relationships between the provider, subscriber, and patient and can eliminate repetitious reporting of data. One example of this is the ability to report claims for both the subscriber and dependents without repeating the subscriber information.

A subordinate dependent hierarchical level should not be included when the subscriber is also the patient and no additional claims are being sent for the subscriber's dependents. Additional patient information should be reported at the dependent level when the dependent is the patient or when there is a combination of claims for the subscriber and their dependents. Address and demographic segments are only required for the patient/dependent when there are only dependent claims submitted for a subscriber.

The dependent hierarchical level should be used when there are only claims for dependents or claims for both the subscriber and dependents.

Maximums/Limitations

- Report a maximum of 50 services per claim. Claims submitted with more than twelve service lines will be split into multiple claims with twelve service lines or less.
- Report up to 100 claims per subscriber/patient combination.
- Submit a maximum of 5,000 claims per transaction set.
- Up to ten other carriers can be identified in addition to the destination payer.

- Decimal data reported in data element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied place for cents (implied value of 00 after the decimal point). Note: the decimal point and leading sign, if sent are not part of the character count.

Claim Reporting Clarifications

- When reporting dollar amounts of zero, report that amount (do not leave blank) in the transaction. If required amount elements are left blank, they will be rejected. When reporting percentages in amount elements, be sure to indicate the percentage as a decimal. For example, 50% is .5, 25% is .25.
- Segments submitted at the claim level apply to the entire claim unless overridden by information submitted at the service line level.
- At the claim and service levels, numerous date, reference information, and amount segments allow reporting of applicable information. Information common to the entire claim can be reported at the claim level only. If the same data is reported at the service level, it overrides the claim level information for that service.
- CDT procedure codes are supported and up to four modifiers can be reported and will be validated for reported dates related to the service.
- National Standard Tooth Numbering System codes are used to report the tooth that was treated.
- A maximum of five tooth surfaces can be reported.

Enhancements for Dental Claims

- BCBSM can now accommodate submission of void and replacement Dental claims. The following elements are required for these types of claims:
 - Adjustment claims must have a Claim Frequency Type Code (Loop 2300 CLM05-3) of 7 (replacement) or 8 (cancel/void).
 - An ‘Original Reference Number’ must be present (Loop 2300, REF02 equal ‘F8’).
 - FEP void and replacement claim submissions are excluded.
- Up to 4 NTE segments (Loop 2300 or Loop 2400 (NTE02) are now allowed for adjudication purposes.
- Alpha character prefix is allowed on subscriber contract numbers.

Character Set Requirement

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field.

| | | | | | | | | |
|-------|-------|---|---|---|---|---|---|-------|
| A...Z | 0...9 | ! | “ | & | , | (|) | + |
| ' | - | . | / | ; | ? | = | @ | Space |

Provider Identification Numbers

The employer identification number (EIN) or the Social Security Number (SSN) are currently the primary identifiers for providers. Provider Taxonomy codes are required, as applicable. Secondary identifiers such as Blue Shield provider numbers and state license numbers can also be reported. Refer to the data clarification section for specific reporting requirements.

National Identifiers

BCBSM now supports a 'dual-acceptance' environment for electronic Dental claims. We can accept the National Provider Identifier as long as there is a corresponding tax identification number submitted with it. The NPI is currently being used for informational purposes to track your identifier for future claims processing verification.

National Identifiers will eventually be implemented and required for reporting provider and plan IDs. These identifiers are not in place at this time. Note and adhere to the instructions below for any elements within the 837 that apply:

The applicable loops where a corresponding Tax Identification Number is required are as follows:

- 2010AA and 2010AB
- In all other applicable loops the Tax Identification Number and National Provider Identifier are only required if known.

Qualifier XX – HCFA National Provider ID - Use if NPI is submitted.

Qualifier XV – HCFA National Plan ID - Not used at this time. Do not use qualifier XV in any elements until further notice.

Claim Editing

All dental claims are validated based on HIPAA reporting, medical code set requirements for CDT-4 and modifiers (HCPCS) and BCBSM/FEP specific requirements. These requirements have been identified in the comment area of each affected field within the data clarification section.

Information regarding claims generating these edits will be returned in either an X12 Unsolicited 277 transaction or report file and affected claims will not be forwarded for processing. Edit messages and an example of the report are available in the Unsolicited 277 companion document on the BCBSM web site at: www.bcbsm.com

ANSI ASC X12N Dental 835 (004010X091A1) Remittance Clarifications

The Addenda version of the ANSI ASC X12N 835 transaction set has been selected as the format to meet HIPAA requirements for the electronic return of health care remittance advice. One 835 transaction set reflects a single payment advice or check. Multiple claims can be referenced within one 835. This document refers only to 835's for BCBSM and FEP. BCBSM is not performing electronic funds transfer at this time.

835 Balancing

Three levels of balancing occur within the 835 transaction:

- **Transaction Set Balancing** – The total payment equals the sum of claim payments minus the sum of provider level adjustments.
- **Claim Level Balancing** – The total claim payment equals the submitted claim charge minus the sum of claim and service adjustments.
- **Service Level Balancing** – The service line payment equals the submitted service line charge minus the sum of service line adjustments.

Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments (CAS) or Provider Adjustment Segments (PLB) decrease the payment when the adjustment amount is positive, and increase the payment when the adjustment amount is negative.

Service detail will be reported in the 835 for all dental claims or any time payment adjustments are related to specific line items from the original submitted claim. If any service detail is reported in the claim payment, all services for the claim payment will be reported.

All reductions are documented at the service level. They are also used to differentiate between the units that were reported and the actual units that were used to adjudicate the claim/service. The adjustment group is also indicated. The nature of the adjustment is identified by a standard list of adjustment reason codes published by the Washington Publishing Company (www.wpc-edi.com).

Provider level adjustments include remittance information that is not specific to the claim(s)/service(s) contained in the prior level of the 835 transaction. These provide for reporting increases or reductions to the amount remitted. Reference numbers are used for further identification and reconciliation.

The total payment will agree with the remittance detailing that payment.

Maximums/Limitations

The total payment amount will not exceed ten numeric characters (9999999.99). The 835 will not be issued for less than zero dollars. There is a recommended maximum of 10,000 claim payment segments per transaction set.

Provider Identification Numbers

The employer identification number (EIN), Social Security Number (SSN) and NPI are currently the primary identifiers for providers. Secondary identifiers may also be present, but specific identifiers to qualify the code such as Blue Cross or Blue Shield provider codes are not supported at that level. The identifiers supported are the state license number or a generic Payee Identification, which will be used to return our provider number. Provider numbers will also be used to define a rendering provider Control / Reference Numbers.

If you have registered your NPI with BCBSM's Provider Enrollment area, it will currently be returned within the 835 along with your BCBSM assigned Provider identifier.

Claim and Service Level Information

- A Claim Status Code is used to identify the status of the entire claim as assigned by the payer. Possible status codes describe the following conditions: Processed as primary secondary or tertiary
 - Denied, reversal of previous payment
 - Predetermination pricing only
 - Processed as primary, secondary or tertiary and forwarded to additional payer(s) and not our claim, forwarded to additional payer(s).
- Patient Responsibility Amount will balance to supporting claim/service level adjustments.
- The individual claim payment may be zero or less than zero but, the 835 total payment will not be issued for less than zero dollars.
- Corrected insured name or identification number is provided when available.
- The status of a non-adjudicated claim will be returned in an Unsolicited 277 Health Care Claim Status Notification Transaction Set. This transaction is not mandated by HIPAA legislation.
- When the current payer believes that another payer has priority for making a payment, the name and ID number of that payer will be returned, if available.
- If reported in the claim, the line item control number will be returned in the electronic remittance file. When not reported in the claim, the original service line number may be returned as the line item control number.

Bundling and Unbundling

Bundled and unbundled information will be reported back if applicable. When codes are bundled, the code submitted, adjudicated code and total payment amount would be reported. All other lines will contain the code submitted, adjudicated code and payment amount of \$0.

Claim/Service Adjustments

- Only Service Adjustment Segments will be used to provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s).
- A standardized list of claim adjustment reason codes is used for the Claim Adjustment and Service Adjustment segments. These codes provide the 'explanation' for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835.
- A Claim Adjustment Group Code categorizes the adjustment reason codes that are contained in a particular adjustment segment. Up to six different adjustments related to a particular Claim Adjustment Group may be reported per segment.

Claim Interest and Prompt Payment Discounts

Payer-provider level interest and prompt payment discounts refer to adjustments that specific payer and provider contractual agreements require. Such adjustments are financially independent from the formula for determining benefit payments and are reported at the provider adjustment level. This information will also be provided in an amount segment at the claim level without affecting balancing.

Provider Withholds

If a provider declines the option of returning monies owed, BCBSM would then withhold payment up to the amount in a future check with a “Withhold” message in the PLB segment. Payments will not be negative. The payment amount reflected in the remittance advice will be adjusted to \$0. If there is an additional balance owed to BCBSM, this amount will be moved forward into the next payment cycle. If the amount owed is less than the amount scheduled to be paid, a manual check will be issued for the balance along with a letter of explanation to the provider.

Reversals and Corrections

Reversals and corrections will be handled by reversing the original claim payment and re-sending the corrected data.

Claim Splitting by Payers

When the adjudication system requirements result in services submitted within one claim being split into multiple claims, the payer will retain and return basic original claim information in each of the adjudicated claims. The original Claim Submitter’s Identifier and line item control numbers will be returned.

Additional Information

TA1 Interchange Acknowledgements

Interchange Acknowledgements are used to reply to an interchange or transmission that has been sent. This acknowledgement provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure and verifies the envelopes only. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the TA1 Interchange Acknowledgement. Interchange Acknowledgement (TA1) transactions are only provided when requested in the Interchange Control Header, identify interchange control structure errors or to identify duplicate interchanges.

997 Functional Acknowledgements

Functional Acknowledgements are used to facilitate control of EDI. Segments within the 997 are used to identify the acceptance or rejection of functional groups, transaction sets or segments. Data elements in error can also be identified. The sending trading partner can determine if the receiving trading partner has received the

transaction sets that they sent. Use of this process is essential for successful reconciliation and follow-up of EDI. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the 997 Functional Acknowledgement.

Note: BCBSM will be return 997 functional acknowledgements upon receipt of files from trading partners and expects to receive 997 functional acknowledgements from trading partners to acknowledge receipt of files that BCBSM has sent to them. Such usage of the 997 is necessary for reconciliation purposes.

Unsolicited Claim Status (277)

The Unsolicited Claim Status (277) transaction or a report file will be used by EDI to notify submitters of front end claim editing conditions encountered on claims submitted within the 837 transaction. An EDI companion document for this transaction is available on our web site at www.bcbsm.com. The Standard Implementation Guide for 3070 Unsolicited 277 and Standard Health Care Claim Status Codes will be used in the Unsolicited 277 are available from the Washington Publishing Company web site at www.wpc-edi.com.

Dental 837 and 835 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for transmitting to BCBSM EDI are:

| Transaction Set | Element | Instruction | Pg # |
|--|---|---|-------------|
| Dental 837 Health Care Claim | ISA05 – Interchange ID Qualifier | Report ZZ. | B.4 |
| Dental 837 Health Care Claim | ISA06 – Interchange Sender ID | Report the Federal Tax Identification number of the submitter. Must be registered with BCBSM EDI. | B.4 |
| Dental 837 Health Care Claim | ISA07 – Interchange ID Qualifier | Report ZZ. | B.4 |
| Dental 837 Health Care Claim | ISA08 – Interchange Receiver ID | Report 382069753. | B.5 |
| Dental 837 Health Care Claim | GS02 – Application Sender’s Code | Report the Federal Tax ID of the submitter of the file. | B.8 |
| Dental 837 Health Care Claim | GS03 – Application Receiver’s Code | Report 382069753. | B.8 |
| Dental 837 Health Care Claim | GS08 – Version/Release/Industry ID Code | Report 004010X09871 | B.8 |
| Dental 835 Health Care Claim Payment Advice | | | |
| Dental 835 Health Care Claim Payment Advice | ISA05 – Interchange ID Qualifier | ZZ will be returned from EDI. | B.4 |
| Dental 835 Health Care Claim Payment Advice | ISA06 – Interchange Sender ID | 382069753 will be returned from EDI. | B.4 |
| Dental 835 Health Care Claim Payment Advice | ISA07 – Interchange ID Qualifier | ZZ will be returned from EDI. | B.4 |
| Dental 835 Health Care Claim Payment Advice | ISA08 – Interchange Receiver ID | The provider designated Federal Tax ID will be reported. Providers that submit claims through multiple billers are required to designate a single receiving entity. | B.5 |
| Dental 835 HealthCare Claim Payment Advice | GS02 – Application Sender’s Code | One of the following application system identifiers will be reported for BCBSM-related functional groups: BCBSM LOCAL DEN BCBSM NASCO (NASCO and FEP) | B.8 |
| Dental 835 Health Care Claim Payment Advice | GS03 – Application Receiver’s Code | The Federal Tax ID number reported on the corresponding 837 will be returned from EDI. | B.8 |
| Dental 835 Health Care Claim Payment Advice | GS08 – Version/Release/Industry ID Code | 004010X09871 will be returned | B.8 |

Data Clarifications for the Dental 837 (004010X097A1) Transaction Set

| Loop | Segment/Element | Instruction | Industry/Element Name |
|--------|------------------------|--|---|
| 1000A | NM109 | Report the Federal Tax ID of the submitter. BCBSM EDI will validate the reported submitter ID. | Submitter Primary ID Number |
| 1000B | NM103 | Report BCBSM as the receiver name. | Name Last/Org Name |
| 1000B | NM109 | Report BCBSM's Federal Tax ID# 382069753 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer. | ID Code |
| 2000A | All | <p>Use the Billing Provider HL to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB.</p> <p>The Billing/Pay-to Provider HL may also contain information about the pay-to provider entity. If the pay-to provider entity is the same as the billing provider entity, then only use Loop ID-2010AA.</p> <p>If the billing or pay-to provider is also the rendering provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (billing or pay-to) is the rendering provider.</p> <p>BCBSM & FEP – Any entity reported other than the billing provider will not be recognized. Payments will continue to be directed to the provider indicated in corporate provider databases. If reported, the Pay-to provider will not be recognized/used.</p> | Billing/Pay-to Provider Hierarchical Level Loop |
| 2000A | CUR Segment | For proper adjudication, we recommend not reporting a CUR segment. Foreign currency claims should be reported using a paper submission. | Currency Segment |
| 2010AA | NM108, NM109, | Required for Michigan Group Providers, Individual Providers, and Out of State Providers. Report the billing provider primary ID in NM108/NM109 of this loop (Qualifier 24- EIN, or Qualifier 34 – SSN). Report either the 9 numeric character Social Security Number (SSN) or Tax Identification Number (EIN) of the billing provider. Once the National Provider Identification (NPI) is mandated (which will need to be reported with qualifier XX in the NM108 and NPI in NM109)), then either the EIN or SSN of the provider must be reported in the REF01/REF02 segments of this loop. | Billing Provider ID |
| 2010AA | N301, N401, N402, N403 | Must be reported for all Out of State Dental Providers. | Billing Provider Address |

| Loop | Segment/Element | Instruction | Industry/Element Name |
|--------|-----------------|--|---|
| 2010AA | REF01 & REF02 | <p>The REF segment is required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/NM109 in this loop. If a NPI (NM109) is used an XX qualifier must be utilized in the NM108. Also, a secondary REF must be available with the Employer Identification Number (EIN) or Social security Number (SSN). Use a qualifier of EI or SY (REF01 along with the appropriate ID in the REF02).</p> <p>If a NPI is not used, follow all current guidelines.</p> <p>Required for reporting payer-assigned Blue Shield Provider Number and Billing Provider State License Number. Michigan Group Providers: Required to report their Group PIN in REF02 using qualifier 1B in REF01. The Blue Shield Provider Number is required when the provider is a group practice with multiple facilities.</p> <p>In addition Group Providers must report another REF segment with their State License Number in REF02. The State License Number (qualifier 0B in REF01) should be reported as follows: The first two positions must contain the initials of the first and last name of the physician followed by his state license number. If the license number is less than 6 characters, precede the number with zeros to make it 6 Characters (e.g., AB012345).</p> <p>Individual: Not required to report their PIN or license number, but if reporting must follow requirements for Group Providers.</p> <p>Out of State Providers: Report the license number of the billing provider. Out of State Providers can use qualifier LU.</p> <p>If additional numbers are needed the REF segment can be repeated up to 8 times.</p> <p>BCBSM EDI will validate the Billing Provider's Secondary Identification Number. To avoid unnecessary claim rejections, report all applicable identification numbers associated with the claims submitted in this transaction set.</p> | Billing Provider Secondary ID Segment |
| 2010AA | REF01 & REF02 | All Payers – Credit/Debit card information may not be used to bill any insurance payer. | Claim Submitter Credit/Debit Card Information |
| 2010BA | NM102 | BCBSM – Use Code 1 (Person) BCBSM only recognizes a person as the subscriber. | Entity Type Qualifier Code |
| 2000B | SBR09 | Claim Filing Indicators determine the destination payer by the EDI Clearinghouse. For proper claim routing and adjudication use only the following codes: BL – BCBSM FI – FEP | Claim Filing Indicator |
| 2010BA | NM109 | BCBSM – Report the subscriber's 9-digit contract number. FEP – FEP contract number must begin with an R followed by the eight-digit FEP contract number. | Subscriber Identification |
| 2010BB | NM103 | Report BCBSM as the payer name. | Payer Name |
| 2010BB | NM108 | Report PI, prior to National Plan ID Mandate Implementation. | Identification Code Qualifier |

Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document
 American National Standards Institute (ANSI) ASC X12N 837 (004010X097) Dental Health Care Claim
 and 835 (004010X091) Health Care Claim Payment/Advice

| Loop | Segment/Element | Instruction | Industry/Element Name |
|--------|---|---|---|
| 2010BB | NM109 | Report 382069753 as BCBSM's Payer ID. | Payer ID |
| 2010BC | NM101-NM109 | All Payers – Credit/Debit card information may not be used to bill any insurance payer. | Credit/Debit Card Holder Name |
| 2010BC | N201 & N202 | All Payers – Credit/Debit card information may not be used to bill any insurance payer. | Additional Credit/Debit Card Holder Information |
| 2300 | CLM05-1 | Use codes 11, 21 or 22. Claims containing codes 12, 31 or 35 could result in rejection. | Facility Type Code or Place of Service |
| 2300 | PWK01/PWK02, NTE01/NTE02 | BCBSM – BCBSM prefers that claim attachments are available on request at provider site. The NTE segment should be used when, in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set. | Report Type Code and Report Transmission Code (attachments) |
| 2300 | AMT01 & AMT02 | All Payers – Credit/Debit card information may not be used to bill any insurance payer. | Credit/Debit Card Maximum Amount |
| 2310B | NM1 | BCBSM & FEP – Used when rendering provider is different than the billing provider. Refer to 2010AA NM108/NM109 for specific reporting instructions. | Rendering Provider Name |
| 2310B | REF02 | BCBSM & FEP – Used when rendering provider is different than the billing provider. Refer to 2010AA REF02 for specific reporting instructions. | Rendering Provider Secondary Identification |
| 2320 | SBR Segment Other Subscriber Information | Required if other payers could potentially be involved in payment of this claim. SBR01 is used to identify the payment responsibility of the other payer. | Other Subscriber Information Segment |
| 2400 | SV301-2 | Procedure code will be validated for reported dates relating to the service. | Product / Service ID |
| 2400 | SV301-3 through SV301-6 | Modifiers will be validated for reported dates relating to the service. | Procedure Modifier |
| 2430 | CAS02 | BCBSM & FEP – Must contain the applicable Claim Adjustment Reason Code to identify the reason that the primary payer reduced the charge submitted. | Claim Adjustment Reason Code |

General EDI Terminology

Addenda – Refers to a version of the HIPAA mandated transaction sets which correct identified implementation issues noted in the original implementation guide.

ANSI X12 835 v4010 – HIPAA standardized ANSI X12 transaction format for the claims remittance data.

ANSI X12 837 v4010 – HIPAA standardized ANSI X12 transaction format for the claims submission data. All lines of business will use this transaction with the exception for retail pharmacy.

Data Segment – Corresponds to a *record* in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

Data Element – Corresponds to a *field* in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are:

| | |
|----|--|
| Nn | Numeric (with an assumed number of decimal positions) |
| R | Decimal Real Number (including decimal or negative sign) |
| ID | Identifier |
| AN | Alphanumeric string |
| DT | Date |
| TM | Time |

Delimiter – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI – An acronym for Electronic Data Interchange.

Electronic Data Interchange – the application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.

HCFA – An acronym for Health Care Finance Administration.

Implementation guides – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: www.wpc-edi.com.

Interface – The point at which two systems connect to pass data.

Loops – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Routing – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading partners – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Translation Software – Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

X12 Transaction Set – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837-transaction set is equivalent to one claim file.

X12N – An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.