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of the Blue Cross and Blue Shield Association

April 2009

Dear EDI submitters,

We recently published a revised copy of the EDI User Guide on the BCBSM Web site at:  
[bcbsm.com/pdf/edi\\_userGuide.pdf](http://bcbsm.com/pdf/edi_userGuide.pdf).

The table below summarizes the changes made for the EDI User Guide

Section	Description of Change	Page(s)
Electronic Data Interchange Department Contacts	Deleted Options 2 and 3. Revised Option 5.	2
Connection Instructions	Revised 2 <sup>nd</sup> paragraph – changed Option 2 to Option 5.	11

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

Sincerely,

Handwritten signature of Wanda Brideau in black ink.

Wanda Brideau  
Manager, ETP Service and Support  
EDI Business

Handwritten signature of John Bialowicz in black ink.

John Bialowicz  
Manager, ETP Contracting and Relations  
EDI Business



# EDI User Guide

Blue Cross Blue Shield of Michigan  
Electronic Data Interchange



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## EDI User Guide

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### Introduction

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

This document provides information about EDI transactions. The EDI User Guide is available in PDF format for download from our website: [http://www.bcbsm.com/pdf/edi\\_userGuide.pdf](http://www.bcbsm.com/pdf/edi_userGuide.pdf)

All instructions were written as known at the time of publication and are subject to change. As information changes, we will update the user guide.

### Verification required when contacting us

When you contact the Help Desk, we need to make sure of your identity before we can release any sensitive data, such as membership, benefit or claim information.

BCBSM will request the following information from you when you contact the Help Desk in order to verify your identity and ensure the privacy and confidentiality of health care data of our members and providers:

1. Caller name
2. Name of provider, facility or submitter/software developer office
3. Reason for call
4. Member contract number (if applicable)
5. Name of member (if applicable)
6. Providers, submitters and software developers

Professional (includes vision, hearing):	BCBSM provider identification number or BCBSM-assigned submitter ID or software developer
Facility:	BCBSM facility code or Federal tax ID
Dental:	Federal tax identification number

### Electronic Data Interchange Department Contacts

Customer inquiries should be made to the Customer Support Help Desk at 800-542-0945. The following telephone prompts should be followed:

Option 1: Trading Partner Agreement and NPI or Provider Number Authorization questions including TPA and Authorization Login and Password IDs.

Option 4: New customers or vendors who wish to obtain Submitter ID or electronic submission information

Option 5: Questions on edits, remittances, Internet claim tool software support, SFTP Password resets and connections, transmission issues, recreates and Payer ID listings.

### Fax Machine:

248-486-2214

### BCBSM Mailing Address:

BCBSM Electronic Business  
Interchange Group  
Mail Code: L858  
53200 Grand River  
New Hudson, MI 48165



**Note:** Telecommunication lines are available 7 days 24 hours a day. We recommend that you submit claims more than once a week.

Visit Blue Cross Blue Shield of Michigan web site at: [www.bcbsm.com](http://www.bcbsm.com)

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### Processing Flow of Claims Submitted electronically in the 837 format

1. Biller submits electronic claim data to BCBSM for processing.
2. Claim data is edited for validation.
3. Files/claims that do not pass the front end edit compliance validation will receive either a 997 Functional Acknowledgement (file errors) or Unsolicited 277 Claim Status transaction/report, which details why the file/claim was rejected without further processing.
4. Claims that pass front-end edit validation are forwarded to the applicable payer for processing through their system.
5. Claim is paid or denied and a voucher is returned to submitter. Submitters can also elect to receive the 835 Remittance from some payers, including BCBSM, BCN, FEP, Medicare and Medicaid.

### Submission of a BCBSM Trading Partner Agreement and Information Sheet

A Trading Partner Agreement and Provider Authorizations must be completed and forwarded to us prior to submitting claims. The form can be completed electronically on the web at:

<http://editest.bcbsm.com/tpalogon.html>

- The claim submitter and all providers that the submitter will be sending electronic claims for must complete a Trading Partner Agreement.
  - Providers that are implementing the Addenda version of the ANSI ASC X12 837/835 transactions must complete the TPA and Provider Authorization portions of the TPA for all payers they will be submitting electronic claims through us.
  - Providers that have never submitted claims electronically must also complete the TPA forms noted above.
  - Software developers must complete an Information Sheet for each of their submitters, indicating which transactions and formats they will be using and their mode of telecommunication. Access the Information Sheet on the web at: <http://editest.bcbsm.com/spokelogon.html>
1. If you need to request a login and password for the TPA and/or Information Sheet, send an email request with your name, billing location code (professional submitter), Tax ID (institutional submitters and providers), vendor ID (software developer) or BCBSM provider PIN (professional providers) to [EDISupport@bcbsm.com](mailto:EDISupport@bcbsm.com).

If forms are completed hardcopy, completed forms must be mailed to the address on page 2.

For quicker processing and acceptance of your contract, we recommend that the TPA and EDI Information Sheet be completed electronically via the web.
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### Submission of Input Files

To ensure that claim data will be processed on the day received we must receive files before 10:00 a.m. that same day.

If an entire transaction is rejected, the submitter is notified via the 997 functional acknowledgement transaction and a corrected file must be resubmitted. **Please note that when a transaction is rejected, claims included in the transaction have not been processed. These transactions must be corrected and resubmitted.**

### Checkwriting Schedule

Files submitted for processing on the cut-off day can miss the checkwriting cycle if errors are encountered during processing. For this reason, we encourage your submission of claims prior to the checkwriting cut-off day.

Input Mode	Input Cut-off Time	Processing Day	Checkwriting Cut-off
<b>Regular Professional (Blue Shield), Blue Care Network and FEP</b>			
Telecommunication	10:00 a.m.	Same Day	Friday
<b>Regular Blue Cross Facility, Blue Care Network and FEP</b>			
Telecommunication	10:00 a.m.	Same Day	Thursday
<b>Commercial</b>			
Telecommunication	10:00 a.m.	Same Day	None
<b>Medicaid</b>			
Telecommunication	10:00 a.m.	Same Day	Monday
<b>Medicare A &amp; B</b>			
Telecommunication	10:00 a.m.	Same Day	N/A to Med A

### 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 envelope information. We may also use this to identify duplicate files or other file level rejections. 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, to 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.

Please note that BCBSM will be returning 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.

**Providers:** For additional information regarding reading 997 transactions, please contact your software vendor. Most software vendors have programmed this transaction into a report that advises you how to interpret the information.

The segments within the 997 transaction identify the acceptance or rejection of the functional group, transaction sets or segments. If a transaction set has errors, the segments in the 997 provide information about the data elements in error.

Below is an example of a 997 showing all possible segments:

```
ISA*00*      *00*      *ZZ*123456789  *ZZ*987654321
020902*1146*U*00401*000000001*0*P*<~
GS*FA*123456789  *987654321  *020902 *1146  *000000001*X *004010~
ST*997*0001~
AK1*HC*1~
AK2*837*0001~
AK3*NM1*00300*1000*3~
AK4*1*98*7~
```

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AK5\*E\*5\*3\*23~  
AK9\*E\*1\*1\*1\*4\*5~  
SE\*16\*0001~  
GE\*000001\*000000001~  
IEA\*00001\*000000001~

### GS Segment – Functional Group Header

GS\*FA\*123456789 \*987654321 \*020902 \*1146 \*000000001\*X \*004010~

Used to start the envelope for the Functional Acknowledgement transaction sets. The application sender and receiver codes, taken from the functional group being acknowledged, are exchanged. One acknowledgement functional group responds to only those functional groups from one application receiver's code to one application sender's code. There is only one FA Transaction Set per acknowledged functional group.

### ST Segment – Transaction Set Header

ST\*997\*0001~

Mandatory segment that indicates the start of a transaction set and assigns a control number. For a 997 transaction, the value in ST01 will always be 997. The ST02 contains the control number. The ST02 and the SE02 must be identical. The control number is assigned by the originator and must be unique within the transaction set functional group.

### AK1 Segment – Functional Group Response Header

AK1\*HC\*1~

Mandatory segment that responds to the functional group header and starts the acknowledgement for a functional group. There is one AK1 segment for the functional group being acknowledged. The AK101 is the functional ID found in the GS01 of the functional group being acknowledged. The AK102 is the control number ID found in the GS06 of the functional group being acknowledged.

### AK2 Segment – Transaction Set Response Header

AK2\*837\*0001~

Used to start acknowledgement of a single transaction set. The AK2 segments appear in the same order as the transaction sets in the received functional group that is being acknowledged. The AK201 is the value of ST01 in the transaction set being acknowledged. The AK202 is the control number found in the ST segment of the transaction set being acknowledged.

### AK3 Segment – Data Segment Note

AK3\*NM1\*00300\*1000\*3~

This is an optional segment. It is dependent on if there are errors to report. It is used to report errors in a data segment and to identify the location of the data segment. The AK301 identifies the segment ID code (the 2 or 3 characters that occur at the beginning of a segment) of the segment in error. The AK302 contains the value of position of the segment in the transaction set. This is the data count. The transaction set header segment is considered position 1. The AK303 reports the loop ID number. It identifies a loop within the transaction set that is bounded by the related LS and LE segments. The AK304 is the segment syntax error code.

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The following table lists the possible codes in the AK304:

Code	Description	Action
1	Unrecognized Segment ID	Check the implementation guide for this transaction (AK201) to verify which segments can be used.
2	Unexpected Segment	Check the implementation guide for this transaction (AK201) to review segment in error.
3	Mandatory Segment Missing	Check the implementation guide for this transaction (AK201) to confirm segment usage.
4	Loop Occurs Over Maximum Times	Check the implementation guide for this transaction (AK201) to determine maximum loop amount.
5	Segment Exceeds Maximum Use	Check the implementation guide for this transaction (AK201) to determine maximum usage for segment in error.
6	Segment Not in Defined Transaction Set	Check the implementation guide for this transaction (AK201) to determine segment's use in this transaction set.
7	Segment Not in Proper Sequence	Check the implementation guide for this transaction (AK201) to determine the proper sequence for segment in error.
8	Segment Has Data Element Errors	Review AK4 Segment for details about the data element errors. Check the implementation guide for this transaction (AK201) to determine proper usage of data elements for this segment.

### AK4 Segment – Data Element Note

AK4\*8\*66\*7~

This is an optional segment and will only be provided if data element translation errors have occurred. It is used to report errors in a data element or composite data structure and to identify the location of the data element. The AK401 identifies the relative position within the segment of the element in error. The AK402 is the data element reference number used to locate the data element in the Data Element Dictionary. The AK403 contains the code indicating the error found (see table below). The AK404 provides a copy of the data element in error (not used if the error reported contains an invalid character).

The following table lists the possible codes in the AK403:

Code	Description	Action
1	Mandatory data element missing	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine which element is missing.
2	Conditional required data element missing	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine which conditional element is missing.
3	Too many data elements	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine appropriate amount of data elements.
4	Data element too short	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the amount of characters required for element in error.
5	Data element too long	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the amount of characters required for element in error.
6	Invalid character in data element	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the valid characters allowed for the element in error.
7	Invalid code value	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the valid codes allowed for the element in error.
8	Invalid date	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the valid date formats for the element in error.
9	Invalid time	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine the valid time formats for the element in error.
10	Exclusion condition violated	Check the implementation guide for this transaction (AK201) for the Segment listed in AK301 to determine which condition was violated for the element in error.

### Example of an AK3 and AK4

AK3\*NM1\*000184\*NM1 ~

AK4\*03\*1035\*5 \*COMPANY NAME IS TOO LONG FOR SEGMENT~

In this example the NM103 segment on line 184 of the input data exceeds the maximum usage. By going to line 184 of the input data you can find the complete segment in error:

NM1\*85\*2\*COMPANY NAME IS TOO LONG FOR SEGMENT\*\*\*\*\*FI\*11111111\*~

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By going to the Implementation guide you can determine what the maximum usage should be for the segment in error:

**REQUIRED** NM103 **1035** **Name Last or Organization Name** O AN **1/35**

Individual last name or organizational name

*INDUSTRY: Submitter Last or Organization Name*

*ALIAS: Submitter Name* **Min/Max Length of Segment**

**NSF Reference:**  
AA0-06.0

*Found in the AK402*

### AK5 Segment – Transaction Set Response Trailer

AK5\*E\*5\*3\*23

This is a mandatory segment used to acknowledge acceptance or rejection and report errors in a transaction set. The AK501 contains the code indicating accept or reject condition of the transaction set. If a transaction is not accepted, this element is used in conjunction with the AK502 – AK506, AK3 and AK4 in determining the errors that have occurred.

The following table lists the possible codes in the AK501:

Code	Description
A	Accepted
E	Accepted But Errors Were Noted
M	Rejected, Message Authentication Code (MAC) Failed
R	Rejected
W	Rejected, Assurance Failed Validity Tests
X	Rejected, Content After Decryption Could Not Be Analyzed

AK502 – AK506 list the codes indicating the error found. The following table lists the possible codes in the AK502, AK503, AK504, AK505 and AK506:

Code	Description	Action
1	Transaction Set Not Supported	Review the AK201 to determine if a supported transaction set was sent. Transaction sets used at BCBSM are 270, 271, 276, 277, 278, 820, 834, 835 and 837.
2	Transaction Set Trailer Missing	Add SE trailer Segment.
3	Transaction Set Control Number in Header and Trailer Do Not Match	Verify that the control number in the ST and SE match for the transaction in error.
4	Number of Included Segments Does Not Match Actual Count	Verify the count of included segments.
5	One or More Segments in Error	Check the implementation guide for this transaction (AK201) and review the Segments in error. The segments in error are detailed in the AK3 segment.
6	Missing or Invalid Transaction Set Identifier	Review the AK201 to determine which transaction set was sent. Transaction sets used at BCBSM are 270, 271, 276, 277, 278, 820, 834, 835 and 837.
7	Missing or Invalid Transaction Set Control Number	Review the AK202 to determine if a control number was sent. The control number must be unique.
8	Authentication Key Name Unknown	Verify a valid Authentication Key Name was sent. Data may need to be fixed at source and resent through the appropriate flow.
9	Encryption Key Name Unknown	Verify a valid Encryption Key Name was sent.
10	Requested Service (Authentication or Encrypted) Not Available	
11	Unknown Security Recipient	
12	Incorrect Message Length (Encryption Only)	
13	Message Authentication Code Failed	
15	Unknown Security Originator	
16	Syntax Error in Decrypted Text	
17	Security Not Supported	
19	S1E Security End Segment Missing for S1S Security Start Segment	
20	S1S Security Start Segment Missing for S1E Security End Segment	

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Code	Description	Action
21	S2E Security End Segment Missing for S2S Security Start Segment	
22	S2S Security Start Segment Missing for S2E Security End Segment	
23	Transaction Set Control Number Not Unique within the Functional Group	Review the AK202 to determine control number sent. The control number must be unique within the functional group.
24	S3E Security End Segment Missing for S3S Security Start Segment	
25	S3S Security Start Segment Missing for S3E Security End Segment	
26	S4E Security End Segment Missing for S4S Security Start Segment	
27	S4S Security Start Segment Missing for S4E Security End Segment	

### AK9 Segment – Functional Group Response Trailer

AK9\*E\*1\*1\*1\*4\*5~

This is a mandatory segment used to acknowledge acceptance or rejection of a functional group. This segment reports the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group. The AK901 contains the code indicating accept or reject condition for the functional group. The transmitted functional group is considered accepted if the AK901 contains the value of "A" or "E".

The following table lists the possible codes in the AK901:

Code	Description
A	Accepted
E	Accepted But Errors Were Noted
M	Rejected, Message Authentication Code (MAC) Failed
P	Partially Accepted, At Least One Transaction Set Was Rejected
R	Rejected
W	Rejected, Assurance Failed Validity Tests
X	Rejected, Content After Decryption Could Not Be Analyzed

The AK902 contains the total number of transaction sets included in the functional group terminated by the trailer containing this data element. The AK903 reports the total number of transaction sets received. The AK904 is the total number of accepted transaction sets in a functional group. If there are errors in the Functional group AK905 – AK909 contain the error codes.

AK905 – AK909 list the codes indicating the error found. The following table lists the possible codes in the AK905, AK906, AK907, AK908 and AK909:

Code	Description	Action
1	Functional Group Not Supported	Verify the functional group is supported.
2	Functional Group Version Not Supported	Determine the Version sent in GS08 is valid.
3	Functional Group Trailer Missing	Verify that the GE exists. If so, communications may have failed during transmission. Resend data.
4	Group Control Number in the Functional Group Header and Trailer Do Not Agree	Verify that the control number in the GS and GE match for the group in error. Data may need to be fixed at source and resent through the appropriate flow.
5	Number of Included Transaction Sets Does Not Match Actual Count	Verify the count of included Transaction Sets.
6	Group Control Number Violates Syntax	Verify the group control number syntax.
10	Authentication Key Name Unknown	Verify a valid Authentication Key Name was sent.
11	Encryption Key Name Unknown	Verify a valid Encryption Key Name was sent.
12	Requested Service (Authentication or Encrypted) Not Available	
13	Unknown Security Recipient	
14	Unknown Security Originator	
15	Syntax Error in Decrypted Text	

Code	Description	Action
16	Security Not Supported	
17	Incorrect Message Length (Encryption Only)	
18	Message Authentication Code Failed	
23	S3E Security End Segment Missing for S3S Security Start Segment	
24	S3S Security Start Segment Missing for S3E Security End Segment	
25	S4E Security End Segment Missing for S4S Security Start Segment	
26	S4S Security Start Segment Missing for S4E Security End Segment	

### SE Segment – Transaction Set Trailer

SE\*16\*0001~

Mandatory segment that indicates the end of a transaction set. The SE01 contains the total number of segments included in a transaction set including the ST and SE. The SE02 identifies the transaction set control number. This number must be unique within the transaction set functional group and should be identical to the ST02.

### GE Segment – Functional Group Trailer

GE\*000001\*000000001~

Indicates the end of the functional group and provides control information. The GE01 contains the total number of transaction sets included in the functional group. The GE02 contains the control number and must match the GS06.

### Interchange Acknowledgement (TA1)

The TA1 Interchange Acknowledgement is generated in Step 2 of the Receipt Inbound/Outbound ANSI Transaction Flow (R5). The TA1 verifies the envelopes only. It is a single segment and is transmitted without the GS/GE envelope structure. It can be included in an interchange with other functional groups and transactions. The TA1 is used by BCBSM to notify the ETP of problems that were encountered in the interchange control structure or, that a duplicate file was submitted.

Below is an example of an Interchange Acknowledgement:

```
ISA*00*      *00*      *ZZ*123456789  *ZZ*987654321
*020903*1851*U*00401*000000010*0*P*>~
TA1*000000010*020902*1005*R*025~
IEA*0*000000010~
```

### TA1 Segment – Interchange Acknowledgement

TA1\*000000010\*070902\*1005\*R\*025~

This segment reports the status of processing a received interchange header and trailer. The TA101 contains the interchange control number. This should be the original interchange that this TA1 is acknowledging. The TA102 contains the date of the original interchange being acknowledged. The format is YYMMDD. The TA103 contains the time of the original interchange being acknowledged. The format is HHMM. The TA104 provides the Interchange Acknowledgement Code indicating the status of the receipt of the interchange control structure.

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The following table lists the possible codes in the TA104:

Code	Description
A	Interchange accepted with no errors.
E	Interchange accepted, but errors are noted. Sender must NOT resend this data.
R	Interchange rejected because of errors. Sender must resend data.

The TA105 is the Interchange Note Code indicating the error found processing the interchange control structure.

The following table lists the possible codes in the TA105:

Code	Description	Action
000	No error	None
001	The Interchange Control Number in the header and trailer do not match. The value from the header is used in the acknowledgement.	The value in the ISA13 does not match the IEA02. The ISA and IEA envelopes for the TA1 show the value contained in the ISA13 of the Interchange in error. The ISA13 and IEA02 must always be identical. If the TA104 is an R, the ETP needs to correct the data and resend.
002	The Standard as noted in the control standards identifier is not supported.	The ISA11 does not contain a valid code. This code should be U (U.S. EDI Community of ASC X12, TDCC, and UCS). If the TA104 is an R, the ETP needs to correct the data and resend.
003	This version of the controls is not supported.	The ISA12 does not contain a supported version (e.g., 00410). If the TA104 is an R, the ETP needs to correct the data and resend.
004	The segment terminator is invalid.	The data does not have a valid segment terminator. If the TA104 is an R, the ETP needs to correct the data and resend.
005	Invalid Interchange ID qualifier for Sender.	The ISA05 is not a valid ID qualifier. BCBSM is using ZZ for the Sender ID qualifier. If the TA104 is an R, the ETP needs to correct the data and resend.
006	Invalid Interchange Sender ID.	The ISA06 is not a valid Sender ID.
007	Invalid Interchange ID qualifier for Receiver.	The ISA07 is not a valid ID qualifier. BCBSM is using ZZ for the Receiver ID qualifier. If the TA104 is an R, the ETP needs to correct the data and resend.
008	Invalid Interchange Receiver ID.	The ISA08 is not a valid Receiver ID. The ETP needs to be provided with a valid Receiver ID for BCBSM. If the TA104 is an R, the ETP needs to correct the data and resend.
009	Unknown Interchange Receiver ID.	The ISA08 cannot be matched in the Trading Partner profile. If the TA104 is an R, the ETP needs to enter the correct Interchange Receiver ID in the ISA08 and resend.
010	Invalid Authorization Information Qualifier Value.	The value in ISA01 should be 00 for BCBSM. If the TA104 is an R, the ETP needs to correct the data and resend.
011	Invalid Authorization Information Value.	If the value in ISA01 is 00, the value in ISA02 should be all spaces. If the TA104 is an R, the ETP needs to correct the data and resend.
012	Invalid Security Information Qualifier Value.	The value in ISA03 should be 00 for BCBSM. If the TA104 is an R, the ETP needs to correct the data and resend.
013	Invalid Security Information Value.	If the value in ISA03 is 00, the value in ISA04 should be all spaces. If the TA104 is an R, the ETP needs to correct the data and resend.
014	Invalid Interchange Date Value.	The ISA09 date is not in the proper format (YYMMDD). If the TA104 is an R, the ETP needs to correct the data and resend.
015	Invalid Interchange Time Value.	The ISA10 time is not in the proper format (HHMM). If the TA104 is an R, the ETP needs to correct the data and resend.
016	Invalid Interchange standards identifier value.	The ISA11 does not contain a valid code. This code should be U (U.S. EDI Community of ASC X12, TDCC, and UCS). If the TA104 is an R, the ETP needs to correct the data and resend.
017	Invalid Interchange version ID value.	The ISA12 does not contain a valid version (e.g., 00410). If the TA104 is an R, the ETP needs to correct the data and resend.
018	Invalid Interchange control number value.	The value in the ISA13 is not a valid control number. It may be a duplicate or out of sequence. If the TA104 is an R, the ETP needs to correct the data and resend.
019	Invalid acknowledgement requested value.	The ISA14 must be either 0 (No Acknowledgement Requested) or 1 (Interchange Acknowledgement Requested). If the TA104 is an R, the ETP needs to enter the proper value in ISA14 and resend.
020	Invalid test indicator value.	The ISA15 must be either a P (Production Data) or T (Test Data). If the TA104 is an R, the ETP needs to enter the proper value in ISA15 and resend.
021	Invalid number of included groups' value.	The IEA01 does not contain a valid count of the functional groups contained in the interchange. If the TA104 is an R, the ETP needs to correct the data and resend.
022	Invalid control structure.	The control numbers in the ISA13 and IEA02 are not valid. If the TA104 is an R, the ETP needs to correct the data and resend.

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Code	Description	Action
023	Improper (Premature) End-of-File (Transmission).	An IEA segment is missing from the interchange in error. Possibly caused from incomplete communication. If the TA104 is an R, the ETP needs to resend.
024	Invalid Interchange content (e.g., Invalid GS segment).	The interchange in error contains invalid data. If the TA104 is an R, the ETP needs to correct the data and resend.
025	Duplicate Interchange control number.	The ETP has sent data once using the control number in the ISA13. If the TA104 is an R, the ETP needs to verify the data is not duplication, correct the ISA13 and resend.
026	Invalid data element separator.	The data element separator is not different from the segment terminator or component element separator, or is an invalid character. If the TA104 is an R, the ETP needs to correct the data and resend.
027	Invalid component element separator.	The component element separator (ISA16) is not different from the segment terminator or data element separator, or is an invalid character. If the TA104 is an R, the ETP needs to correct the data and resend.
028	Invalid Delivery date in deferred delivery request.	Date is most likely not in proper format. If the TA104 is an R, the ETP needs to correct the data and resend.
029	Invalid Delivery time in deferred delivery request.	Time is most likely not in proper format. If the TA104 is an R, the ETP needs to correct the data and resend.
030	Invalid Delivery time code in deferred delivery request.	Time code used is not valid. If the TA104 is an R, the ETP needs to correct the data and resend.
031	Invalid grade of service code.	Grade of service code used is not valid. If the TA104 is an R, the ETP needs to correct the data and resend.

**Detailed instructions on the structure and interpretation of the 997 are located in Appendix B of all HIPAA Implementation guides available from [www.wpc-edi.com/](http://www.wpc-edi.com/). Users that have questions about their 997 or availability of the 997 should contact their software vendor.**

### Connection instructions

While setting up the connection information in any SFTP software product, you will need the following information:

IP address of the BCBSM - EDDI - SFTP site:	167.242.55.40
Protocol or Port number:	SFTP or Port 22 (SSH)
Your EDDI Login ID:	<Your ID> (c0xxx Prof; f0xxx or s0xxx Fac/Instit)
Your EDDI password:	<obtained via the EDI Help Desk>

Please call the EDI Help Desk at 800-542-0945, option 5 to have your connection environment set to SFTP and a new non-expiring password issued.

**Firewalls may cause problems with the connection. Please check your firewall before having password reset.**

**It is recommended that you read the tutorial for the product you select. BCBSM can not assist with setup issues on your system; please contact your vendor or technical staff.**

### 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

### MDCH (Medicaid) Provider Types

To avoid claim rejections the MDCH (Medicaid) Provider Type code must be reported followed by the seven-digit MDCH (Medicaid) provider code in all provider identification fields used to report the MDCH provider code. The following is a list of provider type codes and their description:

<u>Code</u>	<u>Description</u>
18	Ambulance
77	Children's Multidisciplinary Specialty Clinic
14	Chiropractor
21	Community Mental Health
12	Dental
23	Family Planning Clinic
10, 11, 13, 77	Federally Qualified Health Center
90	Hearing Aid Dealer
80	Hearing and Speech Center
15	Home Health Agency
30	Hospital
62	Hospital LTC Unit
65	Intermediate Care Facility Dev. Disable IP
16	Laboratory
77	Maternal and Infant Support Services
61	Medical Care Facility
64	Medical Care Facility OP
77	Medical Clinic
87	Medical Supplier
10	Nurse Anesthetist
10	Nurse Midwife
10, 11, 13, 77	Nurse Practitioner
60	Nursing Home
63	Nursing Home Pediatric
86	Optical Company
95	Optical House
94	Optometrist
85	Orthotist and Prosthetist
40	Outpatient Hospital
98	Oxygen Supplier
50	Pharmacy
10, 11	Physician
13	Podiatrist
10	Physical Therapist/Certified Rehab Agency
41	Private Mental Hospital (Facility)
68	Private Mental Hospital (Practitioner)
71	Private Nursing Home Mental Illness & Developmentally Disabled
72	Private Nursing Home Mental Illness
22	Psychiatric Facility
73	Psychiatric Unit
75	Psychiatric Unit
10, 11, 13, 77	Rural Health Clinic
77	School Based Clinic
88	Shoe Store
69	State Institution Mental Illness IP
70	State Institution Mental Illness OP
31	Substance Abuse Clinic

### **837 Professional Health Care Claim Information**

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 professional health care claims. The BCBSM clearinghouse accepts ANSI ASC X12N 837 addenda version professional transactions for Blue Cross Blue Shield of Michigan, Blue Care Network, the Federal Employee Program, Medicare Advantage, Medicare B, MDCH (Medicaid) and commercial carriers. For BCN and commercial claims, the destination payer must be the primary payer. BCBSM vision and hearing claims can also be submitted

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within the 837 transaction. Acceptance of 837 and return of 835 transactions will occur in batch mode and will not be accommodated in the real-time environment.

For detailed technical/reporting information, see the associated EDI Companion Document. The companion document is located at the following URL:

[http://www.bcbsm.com/pdf/systems\\_resources\\_prof\\_837\\_835.pdf](http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf)

### **Professional 837 Electronic Claim Exclusions**

Although BCBSM is currently working toward eliminating the need for any type of hardcopy claim submissions, additional system renovation is required to eliminate all of the electronic exclusions that exist today.

The exclusion list below will be updated as the exclusions listed are removed. Please note that items on the list below cannot be submitted electronically until further notice:

- BCBSM, FEP and BCN Claims requiring hardcopy documentation
- BCBSM, FEP and BCN tertiary claims
- Commercial secondary or tertiary payer claims
- BCN status inquiry for secondary claims
- FEP COB and status inquiry claims
- BCBSM COB that are auto or employment related
- BCBSM rural health supplemental claims where the primary payer processed as a facility claim and the supplemental portion needs to be processed by BCBSM as professional. The primary payer (Medicare Part A) paid an amount higher than the original total charge.

### **Submission of BCBSM/BCN Status Inquiry Claims**

Electronic BCBSM status inquiry claims should be submitted when the provider disagrees with the initial determination for a claim, or for a particular service within a claim. In order for a status inquiry claim to be properly adjudicated, the following information must be included in your electronic claim in addition to all regularly required fields. When submitting a status inquiry on a supplemental or COB claim, all required fields for those types of claims must be submitted in addition to the fields required for submission of a status inquiry claim.

Providers can perform electronic inquiries on the disposition of a previously submitted claim with an ANSI ASC X12N 276 Claim Status Request transaction. Based on the response the submitter receives on a 277 transaction, providers may send BCBSM a second 837 selecting one of the following values for CLM05-3 (if applicable):

- Use claim frequency code of 7 to indicate payment other than anticipated (POTA)
- Use claim frequency code of 7 for corrected claims.
- Use claim frequency code of 8 to indicate replacement of a previously rejected claim
- Use claim frequency code of 1 to indicate COMP NPR and submit as an original claim.

If a code value of 7 or 8 is submitted, the original claim reference number ICN/DCN must be reported in Loop 2300, REF segment (Qualifier F8).

For electronic BCN status inquiry claims where a service was denied or the payment received is other than anticipated, use a claim frequency code of 7. To void a claim use a claim frequency code of 8. If a claim frequency code of 7 or 8 is submitted, the original claim reference number ICN/DCN (must start with an E, M, or 0 (zero) followed by 11 digits) must be reported in Loop 2300, REF segment (Qualifier F8).

BCN will accept value codes of 7 or 8 for primary claims; secondary claims with value codes of 7 or 8 must be submitted on paper as noted in the Exclusions.

For electronic Medicare Advantage/Medicare Plus Blue status inquiry claims use a claim frequency code of 7 to indicate a replacement or void of a previous claim. If a claim frequency code of 7 is submitted, the original claim reference number ICN/DCN must be reported in Loop 2300, REF segment (Qualifier F8).

### Reporting Commercial Payer ID's and Claim Office Numbers

- See the Commercial Payer Table for a list of Payer Numbers and Claim Office Numbers.
- The BCBSM Commercial Payer Table Listing is available from the BCBSM web site at: [http://www.bcbsm.com/pdf/commercial\\_payer\\_list.pdf](http://www.bcbsm.com/pdf/commercial_payer_list.pdf)
- If the Claim Office Number is blank or "0000" for a payer listed on the Commercial Payer List, then you should not report a Claim Office Number for that payer (REF segment with qualifier of FY should not be present).
- If there is a numeric claim office number for a payer on the Commercial Payer List, then the numeric claim office number shown should be reported on the claim.
- If "NOCD" is the claim office number shown for a payer on the Commercial Payer List, then "NOCD" should be reported as the claim office number on the claim.

There is also a column on the payer list labeled "TY". An "X" in this column indicates that although electronically submitted, claims are printed and mailed to the payer. An "E" in this column indicates that the claims submitted for that payer are processed electronically. A "D" in this column indicates that the claim is submitted directly to the payer by BCBSM. Some payers are shown numerous times on the list as "All Claim Offices" and also with a different numeric payer ID. In these instances, any valid Claim Office Number can be reported.

### 837 Institutional Health Care Claim Information

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 institutional health care claims. The BCBSM Clearinghouse accepts ANSI ASC X12N 837 addenda version Institutional transactions for Blue Cross Blue Shield of Michigan, Blue Care Network, the Federal Employee Program, Medicare Advantage, Medicare A and MDCH (Medicaid) carriers. Acceptance of 837 and return of 835 transactions will occur in batch mode and will not be accommodated in the real-time environment.

For detailed technical/reporting information, see the associated Companion Document. The companion document is located at the following URL:

[http://www.bcbsm.com/pdf/837\\_835\\_institutional\\_companion.pdf](http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf)

### Institutional 837 Electronic Claim Exclusions

Although BCBSM is currently working toward eliminating the need for any type of hardcopy claim submissions, additional system renovation is required to eliminate all of the electronic exclusions that exist today.

The exclusion list below will be updated as the exclusions listed are removed. Please note that items on the list cannot be submitted electronically until further notice:

- Medicare A bill types 33X (Home Health), 81X (Inpatient Hospice, Non Hospital based) and 82X (Inpatient Hospice Hospital based) for Medicare
- Medicare Advantage/Medicare Plus Blue bill types 81X (Inpatient Hospice, Non Hospital based) and 82X (Inpatient Hospice Hospital based)
- BCN and FEP when billing Tertiary payer COB claims
- FEP Bill types XX7 and XX8
- Out-of-State hospitals (Non-par) for Blue Cross, BCN and FEP
- BCN Secondary payer when billing Type of Bill XX7 and XX8
- BCN ESRD claims

### 837 Dental Health Care Claim Transaction Information

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 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.

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For detailed technical/reporting information, see the associated Companion Document. The companion document is located at the following URL: [http://www.bcbsm.com/pdf/dental\\_edi\\_837den.pdf](http://www.bcbsm.com/pdf/dental_edi_837den.pdf)

### Dental Electronic Claim Exclusions

- Other-payer dental claims (only electronic BCBSM and FEP dental claims are accepted by BCBSM).
- Secondary and tertiary claims

### 835 Health Care Claim Remittance Advice Transaction

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. The 835 may or may not contain responses for all services submitted within an individual claim and depends on how the claim is split by the adjudication system. This document refers only to 835s for BCBSM, BCN, Medicare Advantage/Medicare Plus Blue and NASCO, and does not reflect what Medicare, MDCH (Medicaid) or Commercial Payers will return.

The 835 remittance advice contains information on the final disposition of a claim that is processed by the payer. The output file will also include some claims that were previously pended and subsequently paid or rejected.

For detailed technical/reporting information, see the associated 837/835 Companion Document: [www.bcbsm.com](http://www.bcbsm.com)

### The following positions of the Document Control Number identify a claim as electronic:

- BCBSM professional, positions 5 and 6 will contain "87", "88" or "89"
- BCBSM institutional, positions 5 and 6 will contain "44"
- BCBSM dental claims, positions 5 and 6 will be "66"
- Blue Care Network, professional position will be 1 and will contain "E"
- Blue Care Network, institutional position will be 1 and will contain "E"

### 276/277 Claim Status Inquiry Request and Response Transaction Information

The 276/277 is designed to request the status of a health care claim(s) and respond with the information regarding the specified claim(s). BCBSM accepts and responds to ANSI ASC X12N 276/277 transactions for Blue Cross Blue Shield of Michigan, Blue Care Network and the Federal Employee Program.

For detailed technical/reporting information, see the associated Companion Document. The companion document is located at the following URL: [http://www.bcbsm.com/pdf/systems\\_resources\\_edi\\_276.pdf](http://www.bcbsm.com/pdf/systems_resources_edi_276.pdf)

### 270/271 Health Care Eligibility Benefit Inquiry and Response Transaction Information

The addenda version of the ANSI ASC X12 270/271 transaction sets were selected as the HIPAA-mandated format for electronic eligibility inquiries and responses. This transaction is available to Blue Cross Blue Shield of Michigan, Blue Care Network, BCN Advantage, Federal Employee Program, Medicare Advantage/Medicare Plus Blue and Blue Card Claims. These transactions were designed so that inquiry submitters (information receiver) can determine:

- Whether an information source organization (e.g. payer) has a particular subscriber or dependent on file.
- The healthcare eligibility and/or benefit information about that subscriber and/or dependent(s).

The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use based on inquiry submitted.

For detailed technical/reporting information, see the associated Companion Document. The companion document is located at the following URL: [http://www.bcbsm.com/pdf/systems\\_elig\\_benefit\\_inq\\_and\\_response\\_270\\_271.pdf](http://www.bcbsm.com/pdf/systems_elig_benefit_inq_and_response_270_271.pdf)

### 278 Health Care Services Review and Response Transaction Information

The addenda version of the ANSI ASC X12 278 - 13/11 transaction sets were selected as the HIPAA-mandated format for electronic referrals, pre-certification and case management requests and responses. The 278 – 13/11 transactions were designed to submit the request and respond with the information regarding the specified electronic referrals, pre-certification and case management.

BCBSM accepts and responds to transactions for Blue Cross Blue Shield of Michigan, Blue Care Network, BCBN Advantage, Federal Employee Program, Medicare Advantage/Medicare Plus Blue and Blue Card claims. See below for applicable specific functionality. BCBSM has chosen to implement exchange of the addenda 278 – 13/11 transactions in batch mode. Health Care Services Review request transactions can also be submitted for members from other Blue Cross and/or Blue Shield plans. These transactions will be routed to the members' home plan through a Blue Cross Blue Shield Association process referred to as BlueExchange.

For detailed technical/reporting information, see the associated Companion Document. The companion document is located at the following URL: [http://www.bcbsm.com/pdf/edi\\_278.pdf](http://www.bcbsm.com/pdf/edi_278.pdf)

### Unsolicited 277 Transaction/Report File and Med A & B Prepass Edit Reports

BCBSM EDI selected the ANSI ASC X12 Unsolicited 277 transaction as the format to return the notification of claim statuses for claims that did not reach the processing system; specifically, claims that have front end edited. Claims that receive an Unsolicited 277 edit must be corrected and resubmitted.

1. Medicare A and B also performs front end editing. Their rejections are provided in an edit report, detailed at the end of this section. The front end edits that BCBSM EDI performs are contained in Section 2 of this guide.

The Medicare A and B edit lists are also provided by the Medicare carriers on their web sites:

Medicare A NGS: <http://www.ngsmedicare.com/>

Medicare B WPS: [http://www.wpsic.com/edi/pdf/hipaa\\_mcs837.pdf](http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf)

### Maximums/Limitations

- Status responses will be returned at the claim and service levels.
- When a service is rejected on a claim, all services within the claim must be resubmitted.
- A maximum of three edit rejects will be returned per claim/service at this time.

This transaction set is used to return edit information for professional, institutional, vision, hearing and dental claims. The information contained in the Unsolicited 277 transaction will also be available in report form.

- BCBSM may not be able to return U277 transactions/reports for rejected claims that do not follow the Implementation Guide and BCBSM Companion Document requirements.
- Claim responses will be returned to the submitter of the claim data.

### What is an Edit?

A claim that has edited has been dropped from the claim processing system due to missing or invalid data. Claims that receive edits must be corrected and resubmitted. These claims will not appear on your check vouchers. They will only be returned on the Unsolicited 277 edit response file or report.

### Claim Editing

All claims are validated based on HIPAA medical code set and payer specific requirements. Payer specific requirements have been identified in the comment area of the data clarification section of the applicable EDI companion documents. All EDI companion documents are available for download from [www.bcbsm.com](http://www.bcbsm.com)

The following types of codes will be validated:

- ICD-9-CM (Volume 1 & 2) – diagnosis codes
- ICD-9-CM (Volume 3) – procedure codes

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- HCPCS (Level 1 – CPT-4) – procedure codes
- HCPCS (Level 2) – procedure codes
- Modifiers (CPT)
- Modifiers (HCPCS)
- Revenue Codes
- CDT-4

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 to the destination payer for processing.

### **Unsolicited 277 Response File**

The unsolicited 277 electronic claim status response file is a file electronic billers can receive via their computer system, explaining which claims have edited and have been prevented from further processing.

### **Unsolicited 277 Response Report**

In addition to (or in place of) the 277 transaction is an unsolicited 277 edit report which provides information about claims that have received edits. The report is in an 80-character wrap format.

### **Printing U277 Report from EOS (eligible facilities only)**

Follow instructions from your EOS manual for viewing and printing forms. The following forms are available (as applicable):

- MYBC Professional – all claims
- MSAF HIPAA Professional Front-end Compliance Rejections
- MSAG Dental Front-end Compliance Rejections
- MSAH Institutional Front-end Compliance Rejections
- MSAI Commercial Front-end Compliance Rejections
- MSAJ BCN Facets
- MSAV P & A Legacy Professional
- MCAW Institutional - all claims

### **Control logs**

- CFAA Blue Cross Control Log (Institutional claims)
- CFGA Blue Care Network/Medicare Advantage Control Log (Institutional claims)
- MCAA FEP Control Log (Institutional claims)

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### Reading the Unsolicited 277 report

Below is an example of an Unsolicited BLUE CROSS 277 Report:

PROGRAM : MPS8913-R01	BLUE CROSS BLUE SHIELD OF MICHIGAN	
RUN DATE : 08-21-2007 20:04:36	277 UNSOLICITED REPORT - PROFESSIONAL	
	PAGE 20	
PAYER ID: 00123	CNTL NBR:000001091	
SUBMITTER ID: C0XXX	OFI: ANSI	
NAME: ANY PROVIDER	SUB ETIN/TIN:C0XXX	
NPI: 1234567890	SOP: MB	
NAME: SUBMITTER NAME	TAX EIN: 123456789	
*SUBSCRIBER NBR:	LAST NAME	FIRST NAME
PATIENT ACCOUNT NBR:	LAST NAME	FIRST NAME
SERV LN SERV DATE	PROC CODE	ORIG CHG
REA ST CD DESCRIPTION		
*MQA123456789	DOE	JOHN
123456	DOE	JOHN
DATA DATE: 08-21-2007		
CLAIM TOTAL CHARGES		2,375.00
A3 164 P341 CONTRACT NUMBER NOT FOUND		
PROGRAM : MPS8913-R01	BLUE CROSS BLUE SHIELD OF MICHIGAN	
RUN DATE : 08-21-2007 20:04:36	277 UNSOLICITED REPORT - PROFESSIONAL	
	PAGE 21	
PAYER ID: 00123	CNTL NBR:000001091	
SUBMITTER ID: C0XXX	OFI: ANSI	
NAME: ANY PROVIDER	SUB ETIN/TIN:C0XXX	
NPI: 1234567890	SOP: MB	
NAME: SUBMITTER NAME	TAX EIN: 123456789	
*SUBSCRIBER NBR:	LAST NAME	FIRST NAME
PATIENT ACCOUNT NBR:	LAST NAME	FIRST NAME
SERV LN SERV DATE	PROC CODE	ORIG CHG
REA ST CD DESCRIPTION		
021 04-20-2007	27245	2,375.00
A3 247 LINE INFORMATION		
*MQA123456789	DOE	JOHN
137750	DOE	JOHN
DATA DATE: 08-21-2007		
CLAIM TOTAL CHARGES		110.00
A3 164 P341 CONTRACT NUMBER NOT FOUND		
021 05-30-2007 73510		55.00
A3 247 LINE INFORMATION		
021 05-30-2007 73550		55.00
A3 247 LINE INFORMATION		
*MQA123456789	DOE	JOHN
140572	DOE	JOHN
DATA DATE: 08-21-2007		
CLAIM TOTAL CHARGES		55.00
A3 164 P341 CONTRACT NUMBER NOT FOUND		
021 07-11-2007 73510		55.00
A3 247 LINE INFORMATION		

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Report Fields	Description
PROGRAM : MPS8903-R01	Program name for the Unsolicited 277 Report
BLUE CROSS BLUE SHIELD OF MICHIGAN 277 UNSOLICITED REPORT	Report name. Will also include one of the following to further describe the report, as applicable: Dental P & A Professional (Professional 837) Commercial Institutional Medav Prof Medav Inst Facets/BCN
RUN DATE :	Date the report was generated
DATA DATE:	Date that the data was submitted that generated the report
PAGE:	Page number of the report
PAYER ID:	This field will contain one of the following, depending on the entity that has issued the front end edit rejection: 00710: Professional, P&A, Medav & Facets/BCN THIN-EDI: Professional Commercial from THIN 00210: Institutional Blue Cross, Medav & Facets/BCN 382069753: Dental D00111: Professional (Medicaid) D00111: Institutional (Medicaid) 00953: Professional (Medicare) 00452: Institutional (Medicare) Commercial insurance payer ID: See payer ID list
<b>The following information is returned from the originating inbound transaction BCBSM received from the trading partner.</b>	
CNTL NBR	Control number reported in ISA13 of submitted file
SUBMITTER ID	Submitter ID
OFI	Original Format Indicator ANSI=ANSI ASC X12N format only
NAME	Submitter Name
SUB ETIN/TIN	Submitter tax ID
PROVIDER NBR/NPI	Billing provider ID
SOP BL	Source of payment BL=BCBSM _ HM=BCN and BCN Advantage CI=Commercial MA=Medicare A and Medicare Advantage MB=Medicare B and Medicare Advantage MC=Medicaid OF=FEP (Professional and Institutional) FI=FEP (Dental)
NAME	Provider name
TAX EIN	Provider tax ID
SUBSCRIBER NBR	Subscriber contract number
LAST NAME	Subscriber last name
FIRST NAME	Subscriber first name
PATIENT ACCOUNT NBR	Trading partner assigned patient account number
LAST NAME	Patient last name
FIRST NAME	Patient first name
PATIENT CONTRACT NBR	Patient contract number
SERV LN	Service line number
DATE	Date of service
PROC	Procedure code
<b>The following information is copied from the submitter summary and grand total sections of the report.</b>	
SUBMITTER SUMMARY	Portion of the report for submitter summary information.
SUBMITTER ID:	Submitter ID
NAME:	Submitter Name
SOP:	Source of payment
STATUS CD	Status code that the summary is for.
TOTAL	Total number of times submitter received this status code.

Submitters should contact their software developers and inquire about whether they will receive their edit information via file or report form. Software developers must let us know this information via the EDI Information Sheet for each of their submitters.

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If electronic claims are submitted and your unsolicited 277 file (or report), is not downloaded and reviewed, you will not be aware that your claims have edited. Therefore, it is very important that providers have the ability to download the Unsolicited U277 edit report or file. 277's are only created when there are edited claims.

### Blue Cross Automated Input Control Log

The Blue Cross Automated Input Control Log is used to show accountability and disposition of all Blue Cross claims submitted in an electronic claim file.

A separate log is created for each facility code and data date within the same Blue Cross run. If two files for the same facility are submitted within the same data date, the information on the Control Log will be combined as one report.

Heading	Definition
CPF4073-R01	BCBSM report name.
RUNDATE/TIME	The date and time the file was processed through production at BCBSM.
BLUE CROSS AUTOMATED INPUT CONTROL LOG	The report name.
JULIAN DATE	The Julian date the file was processed.
EDP	The BCBSM page number (for BCBSM use only).
FACILITY NUMBER & NAME	The provider number and name of the facility submitting the claims.
TAPE VERSION	<b>004</b> will always be on report.
TAPE SERIAL	This field is not used
DATADATE	The date reported as the prepare date in the file.
PAGE	The page number of the log.
PATIENT CONTROL NUMBER	The number assigned to the claim by the facility.
PATIENT LAST NAME	The last name of the patient
EDIT RESULT OF CLAIMS PROCESSING	The disposition of each claim. <b>TO BE PAID</b> - The claim passed all edits and will be paid on this date. <b>CLAIM PENDED</b> - The claim is being reviewed by BCBSM. <b>CLAIM REJECTED</b> - An error code followed by a brief description of the error condition which caused the claim to reject. <b>IXXXX</b> - Whenever a code beginning with an 'I' is listed the claim is rejected and must be corrected and resubmitted. <b>TRANSFERRED TO NASCO</b> - The claim has been verified as a BCBSM subscriber and is being transferred to the NASCO claims system for further processing.
CONTRACT NO.	The BCBSM contract number.
FIRST NAME	The first name of the patient
CHARGES	Total charges reported on the claim. This amount may be reduced by non-payable charges by BCBSM.
DOCUMENT CONTROL NUMBER	The document control number assigned by BCBSM for use in the claims area.

**Sample Blue Cross Automated Input Control Log**

TIME 225923		BLUE CROSS AUTOMATED INPUT CONTROL LOG			XXXXXX JULIAN DATE 07-222 EDP 00422		
12345 Any Hospital		TAPE VERSION 004 TAPE SERIAL			DATADATE 08/09/07 PAGE 00001		
PATIENT CONTROL NUMBER	PATIENT LAST NAME	EDIT RESULT OF CLAIM PROCESSING	CONTRACT NUMBER	FIRST NAME	CHARGES	DOC CONTROL NUMBER	
123xxxxxxx	Doe	CLAIM PENDED	123xxxxxxx	Jane	294.84	123xxxxxxx	
123xxxxxxx	Doe	TO BE PAID 08-21-07	123xxxxxxx	John	299.77	123xxxxxxx	
123xxxxxxx	Doe	* CLAIM REJECTED	123xxxxxxx	Jane	238.82	123xxxxxxx	
>> 822	CLAIM WAS SUBMITTED AS ORIGINAL BILL						
123xxxxxxx	Doe	* CLAIM REJECTED	123xxxxxxx	John	54.13	123xxxxxxx	
>> 822	CLAIM WAS SUBMITTED AS ORIGINAL BILL						
123xxxxxxx	Doe	TO BE REJECTED 08-21-07	123xxxxxxx	Jane	54.13	123xxxxxxx	
>> R1	NOT A BENEFIT OF GROUP						
123xxxxxxx	Doe	TO BE PAID 08-21-07	123xxxxxxx	John	4.32	123xxxxxxx	
123xxxxxxx	Doe	CLAIM TRANSFERRED TO NASCO	123xxxxxxx	Jane	138.18	123xxxxxxx	
123xxxxxxx	Doe	TO BE PAID 08-21-07	123xxxxxxx	John	131.46	123xxxxxxx	
123xxxxxxx	Doe	TO BE PAID 08-21-07	123xxxxxxx	Jane	22.75	123xxxxxxx	

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The last page of the log (below) is a summary listing of total claims submitted and the total estimated responsibility. The following categories are listed:

- Inpatient
- SNF
- Home Health
- Outpatient
- Unknown

In all dollar fields for total claims submitted, both paid and pended, the amount could be reduced by non-covered charges.

Each billing category will show:

- Number of claims paid
- Total dollars for the paid claims
- Number of claims pended
- Total dollars for the pended claims
- Number of claims rejected
- Total dollars for the rejected claims
- Number of claims transferred to NASCO for processing
- Total dollars for the transferred claims

**Sample Blue Cross Automated Input Control Log (last page)**

CPF4073-R01	RUNDATE 08/10/07	TIME 225923	BLUE CROSS AUTOMATED INPUT CONTROL LOG	XXXXXX JULIAN DATE 07-222	EDP 00423
12345	Any Hospital		TAPE VERSION 004	TAPE SERIAL	DATADATE 08/09/07
					PAGE 00002
PROVIDER CONTROL TOTALS					
TOTAL CLAIMS SUBMITTED	9		\$1,238.40		
INPATIENT	0		\$0.00		
S.N.F.	0		\$0.00		
HOME HEALTH	0		\$0.00		
OUTPATIENT	9		\$1,238.40		
UNKNOWN	0		\$0.00		
INPATIENT -PAID	0		\$0.00		
-PENDED	0		\$0.00		
-REJECTED	0		\$0.00		
-TRANSFERED	0		\$0.00		
S.N.F. -PAID	0		\$0.00		
-PENDED	0		\$0.00		
-REJECTED	0		\$0.00		
-TRANSFERED	0		\$0.00		
HOME HEALTH -PAID	0		\$0.00		
-PENDED	0		\$0.00		
-REJECTED	0		\$0.00		
-TRANSFERED	0		\$0.00		
OUTPATIENT -PAID	4		\$458.30		
-PENDED	1		\$294.84		
-REJECTED	3		\$347.08		
-TRANSFERED	1		\$138.18		
UNKNOWN -PAID	0		\$0.00		
-PENDED	0		\$0.00		
-REJECTED	0		\$0.00		

## EDI User Guide

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### F.E.P. Facility Automated Input Control Log

The FEP Facility Automated Input Control Log is used to show accountability and disposition of all FEP claims submitted on an electronic file.

A separate log is created for each facility code and data date within the same FEP run. If two files for the same facility are submitted with the same data date, the information on the control Log will be combined as one report.

Heading	Definition
MPC8883-R01	BCBSM Report Name (for BCBSM use only).
F.E.P. FACILITY AUTOMATED INPUT - CONTROL LOG	The report name.
L1-00000-001	The BCBSM page number (for BCBSM use only).
FACILITY NUMBER & NAME	The provider number and name of the facility submitting the claims.
DATA DATE	The date reported as the prepare date in the file.
PAGE	The page number of the log.
RUNDATE	The date the file was processed.
TIME	The time the file was processed.
PATIENT CONTROL NUMBER	The number assigned to the claim by the facility.
PATIENT NAME	The name of the patient.
CONTRACT NO.	The F.E.P. contract number.
CHARGES	Total charges reported on the claim.
MESSAGE	The disposition of each claim.

### Sample F.E.P Facility Automated Input Control Log

MPC8883-R01	F.E.P. FACILITY AUTOMATED INPUT - CONTROL LOG	L1-00000-001		
D1234 ANY DIALYSIS C	DATADATE 08/09/07	PAGE 0001		
RUNDATE 20070809		TIME 1648		
PATIENT CONTROL NUMBER	PATIENT NAME	CONTRACT NO	CHARGES	MESSAGE
123456789/1234567	TXINT	SECONDA	R23456789	26,369.90
				TRANSFERRED TO NASCO
123456789/1234567	TXINT	SECONDA	R23456789	33,994.50
				TRANSFERRED TO NASCO

The last page of the log (next page) is a summary listing of total claims and total charges submitted. The following categories are listed:

- Inpatient
- SNF
- Home Health
- Outpatient
- Unknown

### Each billing category will show:

1. Number of claims submitted
2. Total charges for submitted claims
3. Number of claims accepted
4. Total charges for accepted claims

**Sample F.E.P Facility Automated Input Control Log (last page)**

MPC8883-R01	F.E.P. FACILITY AUTOMATED INPUT - CONTROL LOG	L1-00000-002
D1234 ANY DIALYSIS C	DATADATE 08/09/07	PAGE 0002
RUNDATE 20070809		TIME 1648
PROVIDER CONTROL TOTALS		
TOTAL CLAIMS SUBMITTED	2	\$60,364.40
INPATIENT	2	\$60,364.40
HOME HEALTH	0	\$0.00
OUTPATIENT	0	\$0.00
UNKNOWN	0	\$0.00
INPATIENT -ACCEPTED	2	\$60,364.40
HOME HEALTH -ACCEPTED	0	\$0.00
OUTPATIENT -ACCEPTED	0	\$0.00

**BCBSM EDI Control Log**

The EDI Control Log is used to show accountability and disposition of all BCN and Medicare Advantage claims submitted in an electronic file. This report serves as an acknowledgement of receipt and forwarding of non-rejected claims to the appropriate payer.

Heading	Definition
CPX4067-R01	BCBSM Report name.
RUNDATE	The date the claims were submitted to the payer indicated in the report name.
TIME	The time the report was printed.
JULIAN DATE	The Julian date the claims were submitted to the payer indicated in the report name.
BCBSM EDI - BLUE CARE NETWORK/MEDICARE ADVANTAGE CONTROL LOG - ALL CLAIMS	The report name. The heading will be BLUE CARE NETWORK or MEDICARE ADVANTAGE.
SUBMITTER	The name of the provider, billing service or other organization that submitted the file.
EIN	The Employer Identification Number of the submitted as reported on the file. Also referred to as the Tax Identification Number.
DATA DATE	The date reported as the prepare date in the file.
VENDOR	This field is not used.
MODE	The manner of entry for this file. <b>COM</b> - Telecommunication
PAGE	The page number of the report.
PROVIDER	The name of the provider as reported in the file.
EIN	The Employer Identification Number (also referred to as the Tax Identification Number) reported in the file, including a leading zero.
PROV NO.	The provider number of the facility submitting the claims.
PATIENT ACCOUNT NO.	The number assigned to the claim by the facility.
PATIENT NAME	The first eight letters of the patient's last name and the first three letters of the patient's first name.
MSG#	This field is not used.

**EDI User Guide**

Heading	Definition
MESSAGE	For Blue Care Network the message displayed will be TRANSMITTED TO BCN FACETS. For Medicare Advantage the message displayed will be either ACCEPTED BY MEDICARE ADVANTAGE or TRANSFERRED TO TMG.
TOB	The type of bill.
HEALTH INS NO.	The Health Insurance Number. Blue Care Network - BCN Health Insurance number. Medicare Advantage - Medicare Advantage contract number.
FROM DATE	Statement Covers From Date.
TOTAL CHARGES	Total charges reported on the claim.
DOCUMENT NO	This field is not used.

**Sample BCBSM EDI – Blue Care Network Control Log**

PATIENT ACCOUNT NO	PATIENT NAME	MSG#	MESSAGE	DOCUMENT NO
TOB HEALTH INS NO	FROM DATE		TOTAL CHARGES	
CPX4067-R01 RUNDATE 08/09/07 TIME 15:20 JULIAN DATE 07-221 EDP 36				
BCBSM EDI - BLUE CARE NETWORK CONTROL LOG - ALL CLAIMS				
SUBMITTER: Submitter Name EIN: 123456789 DATA DATE: 08/09/07				
VENDOR: MODE: COM PAGE 1				
PROVIDER: Any Hospital EIN: 1234567890 PROV NO: 12345				
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	06/28/07		2,672.30	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
137 XYH123456789	03/26/07		8,429.55	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	07/09/07		4,884.00	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
111 XYH123456789	08/01/07		17,064.70	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
137 XYH123456789	05/15/07		4,598.40	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	07/23/07		3,624.30	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	07/30/07		8,171.20	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	07/10/07		161.00	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	07/25/07		1,757.00	
12345678	DOE JOHN		TRANSMITTED TO BCN FACETS	
131 XYH123456789	06/22/07		335.05	



## EDI User Guide

### BCBSM EDI Provider Summary (Payer and All Claims)

The Provider Summary Control Log (Payer and All Sources of Payment) are the total pages for claims submitted under the same Provider Tax Identification Number. The Payer report provides a summary by payer. The All Sources of Payment provides a summary by payer and a grand total for all sources of payment. The first four lines of this report are identical to all other EDI Control Log reports.

Heading	Definition
PROVIDER SUMMARY FOR XXXX	The report name (XXXX will be replaced by the payer name).
BILL TYPE	The bill types reported for the associated payer and provider number.
REJECTED	This field is not used.
- CLAIMS	This field is not used.
- CHARGES	This field is not used.
ACCEPTED	The three columns reported under this heading summarize information for accepted claims.
- CLAIMS	The total claims accepted for this bill type.
- PCT	The percent of accepted claims for this bill type.
- CHARGES	The total claims accepted for this bill type.
TOTAL	The two columns reported under this heading summarize totals.
- CLAIMS	The total claims for this bill type.
- CHARGES	The total charges for this bill type.
TOTAL	The grand total for all claims on the file.

### Sample BCBSM EDI – Blue Care Network Control Log

CPX4067-R01	RUNDATE 08/09/07	TIME 15:20	JULIAN DATE 07-221	EDP	37
BCBSM EDI - BLUE CARE NETWORK CONTROL LOG - ALL CLAIMS					
SUBMITTER: Submitter Name	EIN: 123456789	DATA DATE: 08/09/07			
VENDOR:		MODE: COM	PAGE	2	
PROVIDER: Any Hospital	EIN: 1234567890	PROV NO: 12345			
PROVIDER SUMMARY FOR BLUE CARE					
BILL	----- REJECTED -----	----- ACCEPTED -----	-----	TOTAL	-----
TYPE	CLAIMS	CHARGES	CLAIMS	PCT	CHARGES CLAIMS CHARGES
-----	-----	-----	-----	-----	-----
111			1	100.0%	17,064.70 1 17,064.70
131			7	100.0%	21,604.85 7 21,604.85
137			2	100.0%	13,027.95 2 13,027.95
-----	-----	-----	-----	-----	-----
TOTAL			10	100.0%	51,697.50 10 51,697.50

### Sample BCBSM EDI – Medicare Advantage Control Log

BCBSM EDI - MEDICARE ADVANTAGE CONTROL LOG - ALL CLAIMS					
SUBMITTER: Submitter Name	EIN: 123456789	DATA DATE: 08/09/07			
VENDOR:		MODE: COM	PAGE	2	
PROVIDER: Any Hospital	EIN: 1234567890	PROV NO: 123456			
PROVIDER SUMMARY FOR MED ADVANTAGE					
BILL	----- REJECTED -----	----- ACCEPTED -----	-----	TOTAL	-----
TYPE	CLAIMS	CHARGES	CLAIMS	PCT	CHARGES CLAIMS CHARGES
-----	-----	-----	-----	-----	-----
111			1	100.0%	17,396.95 1 17,396.95
131			13	100.0%	3,362.00 13 3,362.00
-----	-----	-----	-----	-----	-----
TOTAL			14	100.0%	20,758.95 14 20,758.95

**EDI User Guide**

**Sample BCBSM EDI – Provider Summary Control Log**

```

CPX4067-R01   RUNDATE 08/09/07   TIME 15:20   JULIAN DATE 07-221   EDP   40
              BCBSM EDI - PROVIDER SUMMARY CONTROL LOG - ALL CLAIMS

SUBMITTER: Submitter Name      EIN: 123456789   DATA DATE: 08/09/07
VENDOR:                               MODE:      COM       PAGE   3
PROVIDER: Any Hospital          EIN: 1234567890

              PROVIDER SUMMARY FOR ALL SOURCES OF PAYMENT

PZR          BILL REJ  ----- ACCEPTED ----- TOTAL -----
PROVIDER NO TYPE CLMS  CLMS  PCT          CHARGES CLAIMS          CHARGES
-----
BCN    12345    111      1 100.0%    17,064.70    1    17,064.70
              131      7 100.0%    21,604.85    7    21,604.85
              137      2 100.0%    13,027.95    2    13,027.95
MEDADV 123456    111      1 100.0%    17,396.95    1    17,396.95
              131     13 100.0%     3,362.00   13     3,362.00
=====
PROVIDER TOTAL          24 100.0%    72,456.45    24    72,456.45
    
```

**Medicare A Prepass Report**

Below is an example of Medicare A (NGS) front end edit prepass report. For detailed edit codes, their descriptions and additional information about how to read the report please go to the NGS web site at: <http://www.ngsmedicare.com/>

```

              MED A GENRESPONSE REPORT (PREPASS REPORT)

              Batch Totals

Batch Number:      1                      Batch Type: 000
Processing date:   2007-08-02             Time:      11:08:27
Batch Status:     GOOD                    Batch No:  000000000001
Number of Batch Errors: 0                 Provider ID: 123456
                                              NPI:      16xxxxxxxxx

+-----+
|          Claims          Other          Total          Total
|          with Errors +   Rejected   = Rejected   +   Accepted   =   Claims
|-----+-----+-----+-----+-----+
| Count          1          0          1          734          735
| Charges    1,545.00      0.00    1,545.00  3,322,637.34  3,324,182.34
+-----+-----+-----+-----+-----+

Start of Claims With Errors list for Batch:  1
-----
SUBSCRIBER level:
ERROR:  Loop: 2010BA_LOOP   Segment: N4           Field: 03::0116   Seq: 23047
        Code: A051         Value:  N0H 2T0
        Desc: Subscriber postal zip code is invalid
-----
Patient Acct: 81xxxxxxxxl           Patient Name: Doe, Jane
Date: 20070724  Amt: $           1,545.00  Cert/HIC No.: 386xxxxx6A
Claim No: 381xxxx62 0708           Payer ID: 12345           Source of Pay: MA

Start of Claims With Warnings list for Batch:  1
No claims with warnings.
    
```

## EDI User Guide

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<b>Report Fields</b>	<b>Description</b>
MED A GENRESPONSE REPORT (PREPASS REPORT)	Report name.
Processing date	Date file was processed.
Time	Time file was processed.
Batch Type	Type of batch. Will always contain 000.
Batch Status	Status of batch. Values are: GOOD, WARNING and REJECT. Batches with status of good and warning are accepted. Batches containing a value of rejected must be corrected and resubmitted.
Batch Number	Number of batch.
Number of batch errors	Number of errors at the batch level.
Provider ID	Medicare A provider ID for the claim with errors.
NPI	National Provider Identifier.
Claims with Errors	Number of claims in the batch receiving errors.
Other Rejected	Number of claims in the batch receiving other rejections.
Total Rejected	Total number of claims being rejected.
Accepted	Number of claims in the batch that were accepted.
Total Claims	Total number of claims received in the batch.
Charges	Applicable charges for each of the above categories.
Start of claims with errors list for Batch	Claim within file where errors begin.
Patient Acct	Patient Account Number reported on the claim receiving an error.
Patient Name	Patient Name reported on the claim receiving an error.
Date	Service Date reported on the claim receiving an error.
Cert/HIC No.	Medicare HIC Number reported on the claim receiving an error.
Claim No	Claim Number reported on the claim receiving an error.
Payer ID	Payer ID reported on the claim receiving an error.
Source of Pay	Source of Payment reported on the claim receiving an error.
Loop	Loop where error occurred.
Segment	Segment where error occurred.
Field	The first two characters are the number of the element within the segment. The next set of numbers is the data element numbers.
Seq	N/A – For internal payer use.
Code	Edit rejection code the claim received.
Value	Value reported in the element that received the rejection.
Desc	Description of edit rejection code.

**Medicare B Prepass Report**

Below is an example of Medicare B (WPS) front end edit prepass report. For detailed edit codes, their descriptions and additional information about how to read the report; please go to the WPS web site at: [http://www.wpsic.com/edi/hipaa\\_main.shtml](http://www.wpsic.com/edi/hipaa_main.shtml)

H99RAR04		WISCONSIN PHYSICIANS SERVICE- MICHIGAN				PAGE 429	
PRODUCTION		PROFESSIONAL EMC PROGRAM					
		MEDICARE-B EMC INPUT					
		BATCH DETAIL CONTROL LISTING					
		A SUBMITTER ID: 67000		SUBMITTER NAME: BCBSMI			
				B ADDRESS: 53200 GRAND RIVER			
				CITY: NEW HUDSON			
				STATE/ZIP: MI 48165			
				PROCESS DATE: 08/17/2007			
D EMC PROVIDER : NPI: 1234567890		E PIN: 0X12345		J BATCH NUMBER : 1		K	
F PROV NPI#		G PROV PIN#		H REFERENCE NUMBER		M	
				I REC TYPE DTL		L	
				FIELD IN FIELD		K	
				ERROR CONTENTS		L	
				ERR NUM		M	
				MESSAGE		M	
				ERROR SEVERITY			
				-----			
		EMC PROVIDER : NPI: 1234567890		PIN: 0X12345		BATCH STATUS : ACCEPTED	
		TOTAL CLAIMS RECEIVED :		33			
		TOTAL CLAIMS ACCEPTED :		33			
		TOTAL CLAIMS DELETED :		0			
		TOTAL CLAIMS WITH ERRORS :		0			
		TOTAL CHARGES ACCEPTED :		\$ 4,123.00			

Report H99RAR04 will provide specific information for each file and batch of EDI submitted claims. The following information will appear within this report:

- A. **SUBMITTER ID:** Will contain 67000.
- B. **SUBMITTER NAME, ADDRESS, CITY, STATE, ZIP:** Will contain BCBSM's name and address.
- C. **PROCESS DATE:** The date that your EDI claim file was entered onto the Medicare processing system.
- D. **EMC PROVIDER:** The Medicare provider number assigned by the Part B Carrier.
- E. **BATCH NUMBER:** The Batch Number provided to WPS by BCBSM.
- F. **PROV NPI PROV PIN#:** The NPI or the Medicare Provider number assigned by the Part B carrier (same as item D above).
- G. **REFERENCE NUMBER:** The reference number assigned by the provider to this patient. Only present on rejected claims.
- H. **REC TYP/DTL NUM:** The ANSI segment/element which indicates where an error occurred (for any claims that contain errors).
- I. **FIELD IN ERROR:** A written description of the ANSI element in error.
- J. **FIELD CONTENTS:** The actual data that appears within the erroneous element of your claim.
- K. **ERR NUM:** The error number that corresponds with a specific error message in the EDS pre-pass edit system.
- L. **MESSAGE:** The error message that corresponds with the error number in the EDS pre-pass edit system.

- M. **ERROR SEVERITY:** Information regarding the severity of the error – i.e. INFORMATIONAL, CLAIM DELETE, BATCH DELETE, FILE DELETE. Claims with informational errors are passed to the processing system to complete processing. All other error types must be re-submitted with the necessary corrections. NOTE: Fatal file errors (e.g. FILE, BATCH or CLAIM DELETED) do not have batch or claim counts.
- N. **FILE CONTROL NUMBER:** 14 digit control number assigned by BCBSM. The last five positions contain submitter's Billing Location Code.

The **BATCH STATUS** field (which appears immediately below the REC TYP columns) indicates whether the batch was accepted (and passed to the processing system) or rejected for any reason. The totals at the bottom of this report will provide specific information regarding the number of claims received, including claims and charges accepted, total claims deleted, and total claims with errors for the batch of claims submitted.

H99RAR04		WISCONSIN PHYSICIANS SERVICE- MICHIGAN						PAGE 657	
PRODUCTION		PROFESSIONAL EMC PROGRAM							
		MEDICARE-B EMC INPUT							
		BATCH DETAIL CONTROL LISTING							
		SUBMITTER ID: 67000			SUBMITTER NAME: BCBSMI				
					ADDRESS: 53200 GRAND RIVER				
					CITY: NEW HUDSON				
					STATE/ZIP: MI 48165				
		PROCESS DATE: 08/15/2007							
EMC PROVIDER : NPI: 1234567890		PIN: 0X12345		BATCH NUMBER : 1					
PROV	PROV	REFERENCE	REC TYPE	DTL	FIELD IN	FIELD	ERR	MESSAGE	ERROR
NPI#	PIN#	NUMBER		NUM	ERROR	CONTENTS	NUM		SEVERITY
-----									
EMC PROVIDER : NPI: 1234567890		PIN: 0X12345		BATCH STATUS : DELETED		ENTIRE BATCH MUST BE RESUBMITTED			
1234567890	0X12345	12345678	2430	CAS	01 2430 CAS	42		M385 INVALID VALUE	CLAIM DELETED
HIC FOR ABOVE CLAIM IN ERROR: 123456789A				ICN: 0000000000000					
TOTAL CLAIMS RECEIVED :				1					
TOTAL CLAIMS ACCEPTED :				0					
TOTAL CLAIMS DELETED :				1					
TOTAL CLAIMS WITH ERRORS :				1					
TOTAL CHARGES ACCEPTED : \$				0.00					

H99RAR04

WISCONSIN PHYSICIANS SERVICE- MICHIGAN

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PRODUCTION

PROFESSIONAL EMC PROGRAM

MEDICARE-B EMC INPUT

BATCH DETAIL CONTROL LISTING

SUBMITTER ID: 67000

SUBMITTER NAME: BCBSMI

ADDRESS: 53200 GRAND RIVER

CITY: NEW HUDSON

STATE/ZIP: MI 48165

PROCESS DATE: 08/15/2007

TOTALS FOR THIS FILE 000012345C0XXX N

TOTAL CLAIMS RECEIVED	:	644
TOTAL CLAIMS ACCEPTED	:	641
TOTAL CLAIMS DELETED	:	3
TOTAL CLAIMS WITH ERRORS	:	18
TOTAL BATCHES RECEIVED	:	58
TOTAL BATCHES ACCEPTED	:	57
TOTAL BATCHES DELETED	:	1
FILE TOTAL CHARGED	:	\$ 572,348.08

This report reflects a total submission of claim files sent and processed for the date indicated.

#### Medicare B AdminaStar DMERC Front End Error Report

BCBSM – EDI will return a text error report created by AdminaStar that provides an accepted or rejected status on all Medicare DMERC claims that have been forwarded to AdminaStar.

This report is identified on the BCBSM EDDI platform as DMERC. Claims that have been rejected need to be corrected and rebilled.

For detailed information on the edit codes, their description and additional information on how to read the reports please go to the AdminaStar web site at <http://www.adminastar.com>