

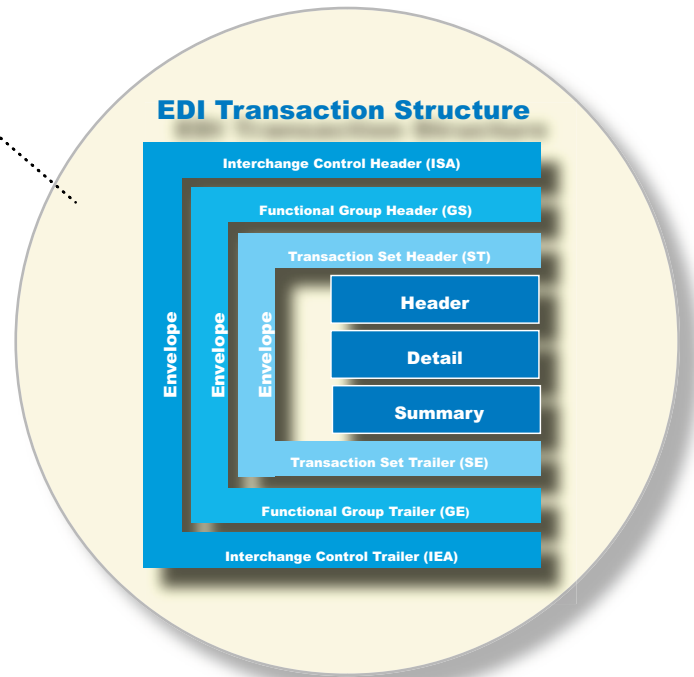
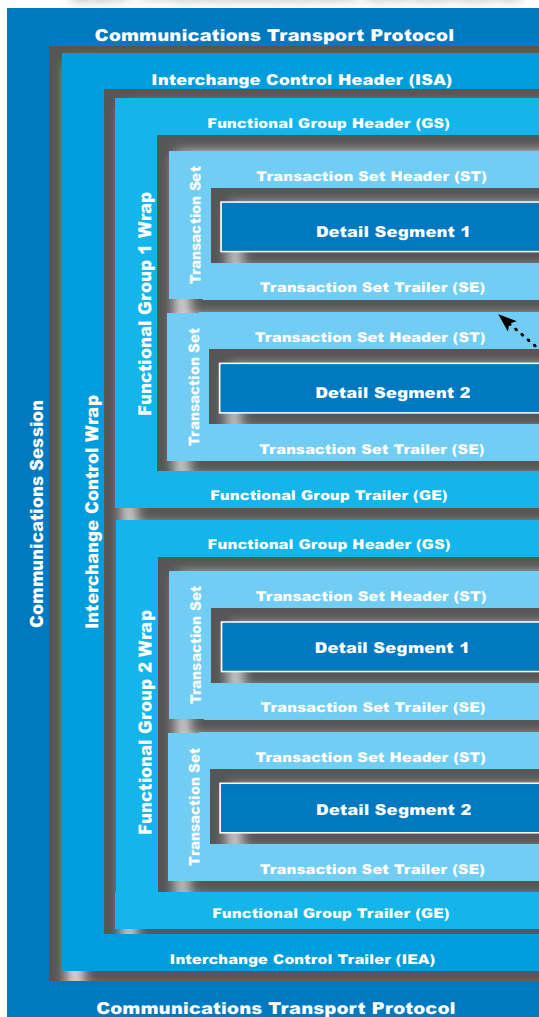
837 Professional Health Care Claim

Basic Instructions

This section provides information to help you prepare for the ANSI ASC X12N 837 Health Care transaction for professional claims. The tables in this document provide information about 837 Claim segments and data elements that require specific instructions to efficiently process through BlueChoice HealthPlan Medicaid systems.

Use this companion document in conjunction with both the Transaction Set Implementation Guide "Health Care Claim: Professional, 837, ASC X12N 837 (004010X098), May 2000, and the subsequent Addenda (004010X098A1), October 2002, published by the Washington Publishing Co.

EDI Transmission Structure



1 X12 and HIPAA Compliance Checking, and Business Edits

Level 1.

X12 Compliance: A 997 Functional Acknowledgment is returned to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If it successfully passes X12 syntax edits, a 997 Functional Acknowledgement is returned indicating acceptance of the transaction. If the transaction fails X12 syntax compliance, the 997 Functional Acknowledgement will also report the Level 1 errors in the AK segments and, depending on where the error occurred, will indicate that the entire interchange, functional group or transaction set has been rejected.

Level 2.

HIPAA IG Compliance - Code Sets: HIPAA Implementation Guide edits are strictly enforced. A Level 2 Status Report is returned to the submitter indicating if a transaction set has been accepted or rejected. If the transaction set has been rejected, this report will indicate the Level 2 HIPAA compliance error(s) that occurred.

Business Edits: In addition to checking for X12 and HIPAA Compliance, business edits are performed to each 837 transaction. A Level 2 Status Report is returned to the submitter indicating if a particular claim has been accepted or denied.

2 HIPAA Compliant Codes

Follow the 837 Professional IG precisely. Use HIPAA-Compliant codes from current versions of the sources listed in the 837 Institutional IG, Appendix C: External Code Sources.

Acceptance of HIPAA standard codes or modifiers will not alter the BlueChoice HealthPlan Medicaid covered benefits or current payment policies, guidelines or processes.

3 Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are alphanumeric and are 10 positions in length. These codes are not "assigned" to health care providers; rather, health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

It is strongly recommended that the taxonomy be populated in Loops 2000A, 2310A, 2310B, 2420A, 2420F PRV segment for all applicable claims that you are filing. Refer to the CMS website for a listing of codes, www.wpc-edi.com/taxonomy.

4 Uppercase Letters

All alpha characters must be submitted in UPPERCASE letters only.

5 Delimiters

BlueChoice HealthPlan Medicaid accepts any of the standard delimiters as defined by the ANSI standards. The more commonly used delimiters include the following:

- Data Element Separator, Asterisk, (*)
- Sub-Element Separator, Vertical Bar, (|)
- Segment Terminator, Tilde, (~)

These delimiters are for illustration purposes only and are not specific recommendations or requirements.

6 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between the BlueChoice HealthPlan Medicaid and Medicare or other carriers. The tables in the section that follow (Loop 2320), identify the data elements that pertain to coordination of benefits with Medicare (Provider-to-Payer-to-Payer COB model) and with other carriers (Payer-to-Provider-to-Payer COB model).

BlueChoice HealthPlan Medicaid recognizes submission of an 837 to a sequential payer populated with data from the previous payer's 835 (Health Care Claim Payment/Advice). Based on the information provided and the type of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, payer sequencing is as follows:

- If a secondary payer is indicated, then all the data elements from the primary payer must also be present.
- If a tertiary payer is involved, then all the data elements from the primary and secondary payer must also be present.

If these data elements are omitted, the claim will fail.

7 Numeric Values, Monetary Amounts and Unit Amounts

- BlueChoice HealthPlan Medicaid pays all claims in US dollars and, therefore, accepts monetary amounts only in US dollars. If codes related to foreign currencies are used, then the claim will be denied.
- BlueChoice HealthPlan Medicaid recognizes unit amounts in whole numbers only.
- The claim will also be denied for negative values submitted in any of the two data elements in Loop 2400, SV1 Professional Service (See 837P IG, P.383):

SV102 Monetary Amount – Line Item Charge Amount

SV104 Quantity – Service Unit Count


8 Sending Attachments to Support a Claim

Loop 2300, PWK segment is required when paper documentation (attachments) supports a claim.

To expedite processing of a claim:

- Mail the attachment the same day the claim is submitted.
- Do not send a copy of the claim with the attachment.
- Send the completed PWK Attachment Face Sheet with the attachment.

Refer to www.BlueChoiceSCMedicaid.com under Section 3: Appendices for the Attachment Face Sheet. This form includes the following fields:

 <p style="text-align: center;">BlueChoice HealthPlan Medicaid Attachment Face Sheet (Claim Supplemental Information)</p> <p style="text-align: center;">The paper documentation included in this mailing supports the electronically submitted claim.</p>	
Date Transmitted	
Line of Business	<input type="checkbox"/> Professional <input type="checkbox"/> Institutional
Member's Contract Number	
Name of Patient	
Date of Service	
Name of Provider	
Identification Code (Attachment Control #):	
<p>Mail or Fax Completed Form to: EDI Solutions 13550 Triton Park Blvd. Louisville, KY 40223 (866) 480-4916 (Fax)</p>	
<small>BlueChoice HealthPlan is a wholly owned subsidiary of BlueCross BlueShield of South Carolina. Both are independent licensees of the Blue Cross and Blue Shield Association. © BlueChoice, BlueCross, BlueShield, and the Cross and Shield symbols are registered marks of the Blue Cross and Blue Shield Association. © MedCall is a registered mark of WellPoint, Inc.</small>	
<small>Medicaid managed care administered by WellPoint Partnership Plan, LLC. © Copyright 2007 WellPoint, Inc.</small>	

- 1) Date Claim Transmitted
- 2) Line of Business (Professional, Institutional)
- 3) Member's Contract (Subscriber) Number
- 4) Patient Name
- 5) Date of Service
- 6) Provider Name
- 7) Identification Code. This is the Attachment Control Number, an alphanumeric code created by the provider for his records.

Mail or Fax the attachment cover sheet and supporting documentation to:

EDI Solutions
 13550 Triton Park Blvd.
 Louisville, KY 40223
 (866) 480-4916 (Fax)

9 Provider Identification Number

Beginning May 23, 2007 through May 23, 2008, providers can submit either their legacy provider identifiers or their valid & registered NPI on 837 Health Care Claim submissions. Invalid or unregistered NPIs will result in claim rejections. Effective May 24, 2008, all NPI non-exempt providers are required to use NPI as their primary ID (replaces the legacy provider identifier). The NPI will be populated in its 10-position, all numeric format on the returning 835 electronic remittance.

DUAL RECEIPT (end date 5/23/08)						
Loop		Primary Identification			Secondary Identification	
		NM101	NM108	NM109	REF01	REF02
2010AA - Billing Provider	NPI	85	XX	NPI	EI	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.
2010AB - Pay-to Provider	NPI	87	XX	NPI	EI	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.
2310A - Referring Provider	NPI	DN	XX	NPI	EI	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.
2310B - Rendering Provider	NPI	82	XX	NPI	EI	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.
2420A - Rendering Provider	NPI	82	XX	NPI	TJ	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.
2420F - Referring Provider	NPI	DN	XX	NPI	EI	Tax ID
	No NPI		24	Tax ID	1D	Medicaid Provider No.

***Note to Non-Exempt NPI Providers**
Effective 5/24/08 - NPI must be submitted as primary ID (NM1 segment), and legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 (REF segment) will not be accepted.

As previously indicated, our contingency period will formally end on May 24, 2008, unless further guidance is provided by CMS to allow for an extended contingency period. We are currently processing NPI Only claims and encourage all providers to move to NPI-only submission on transactions by the deadline. If you are currently submitting with dual identifiers, we encourage you to submit a sampling of claims to us with NPI-only identifiers prior to the deadline. After the end of the formal contingency period, we will work with you and your contracted vendors to maintain current business operations, while supporting your efforts to comply with the requirements of HIPAA's NPI Rule.

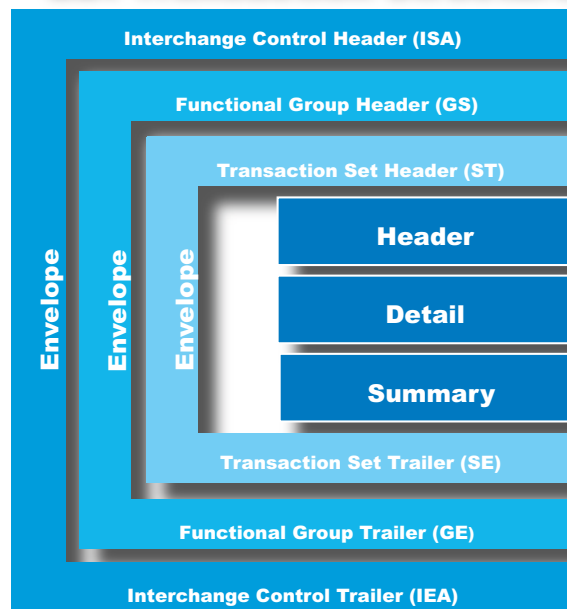
Enveloping

Electronic envelopes control and track communications between you and BlueChoice HealthPlan Medicaid. One envelope may contain many transaction sets grouped into functional groups.

The envelope consists of:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

EDI Transaction Structure



2 837 Health Care Claim Functional Group Header (GS)

The GS segment identifies the collection of transaction sets that are included within the functional group. More specifically, the GS segment identifies the functional control group, sender, receiver, date, time, group control number and version/release/industry code for the transaction sets. All data in the GS-GE segment must be entered in UPPERCASE.

Use the following table in conjunction with the 837 Implementation Guides. The table provides information that is specific to BlueChoice HealthPlan Medicaid. This information is supplemental and does not modify the 837 Implementation Guides.

837 Professional Health Care Claim Functional Group Header (GS)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
GS Functional Group Header	GS01 Functional Identifier Code	<i>HC</i>	HC - Health Care Claim (837)
	GS02 Application Sender's Code	<i>(SENDER ID)</i>	<ul style="list-style-type: none"> Enter the EDI Sender ID GS02 = ISA06 = Loop 1000A, NM109 8-alphanumeric, left justified with no leading or trailing spaces
	GS03 Application Receiver's Code	<i>Left justified with no leading or trailing spaces</i> <i>BCBSCAIDSC</i>	<ul style="list-style-type: none"> Represents BlueChoice HealthPlan Medicaid
	GS04 Date	<i>(CCYYMMDD)</i>	Value must be a valid date in CCYYMMDD format.
	GS05 Time	<i>(HHMM)</i>	Value must be a valid time in HHMM format.
	GS06 Group Control Number	<i>(Assigned by Sender)</i>	<ul style="list-style-type: none"> Format - 9 position numeric Value must be unique (not have been used in previous HIPAA transaction in last 365 calendar days) Value must be greater than zero Value is left justified with no leading or trailing zeroes GS06 = GE02
	GS07 Responsible Agency Code	<i>X</i>	X - Accredited Standards Committee X12
	GS08 Version / Release / Industry Identifier Code	<i>004010X098A1</i>	Operationally used to identify the 837 Professional Health Care Claim transaction

NOTE. Critical Batching and Editing Information.

****Transactions must be batched in separate functional group by Application Receiver's Code (GS03).**

*****Group Control Number (GS06) may not be duplicated by submitter. Files containing duplicate or previously received group control numbers will be rejected.**

3 837 Health Care Claim Functional Group Trailer (GE)

The GE segment indicates the end of the functional group and provides control information.

Use the following table in conjunction with the 837 Implementation Guides. The table provides information that is specific to BlueChoice HealthPlan Medicaid. This information is supplemental and does not modify the 837 Implementation Guides.

837 Professional Health Care Claim Functional Group Trailer (GE)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
GE Functional Group Trailer	GE01 Number of Transaction Sets Included	<i>(n)</i>	Format - 1-6 positions, numeric Value is left justified with no leading zeroes
	GE02 Group Control Number	<i>(Identical to GS06)</i>	Format - 1-9 positions, numeric <ul style="list-style-type: none"> Unique value greater than zero. Value is left justified with no leading or trailing zeroes Value must be identical to the associated Functional Group Header GS06

4 837 Health Care Claim Interchange Control Trailer (IEA)

The IEA segment is the ending, outermost level of the interchange control structure. It indicates and verifies the number of functional groups included within the interchange and the interchange control number (the same number indicated in the ISA segment).

Use the following table to supplement the 837 Implementation Guides. The table provides information that is specific to BlueChoice HealthPlan Medicaid. This information is supplemental and does not modify the 837 Implementation Guides.

837 Professional Health Care Claim Interchange Control Trailer (IEA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
IEA Interchange Control Trailer	IEA01 Number of Included Functional Groups	<i>(n)</i>	Format - 1-5 positions, numeric <ul style="list-style-type: none"> Value is left justified with no leading or trailing zeroes Value equal to the number of functional groups (GS/GE pairs) included in the interchange.
	IEA02 Interchange Control Number	<i>(Identical to ISA13)</i>	Format - 9 positions, numeric <ul style="list-style-type: none"> Unique value greater than zero. Value must be identical to the associated Interchange Control Header ISA13

837 Professional Claim Header

The 837 Claim Header identifies the start of a transaction, the specific transaction set, and its business purpose. Also, when a transaction set uses a hierarchical data structure, a data element in the header, BHT01 (Hierarchical Structure Code) relates the type of business data expected within each level. The following table indicates the specific values of the required header segments and data elements for processing.

837 Professional Health Care Claim—Header			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Beginning of Hierarchical Transaction			
BHT Beginning of Hierarchical Transaction	BHT06 Transaction Type Code	<i>CH</i>	CH - chargeable
REF Transmission Type Identification	REF02 Transmission Type Code	<i>004010X098A1</i>	Will not be used to distinguish between test and production.
Loop ID 1000A—Submitter Name			
NM1 Submitter Name	NM109 Identification Code	<i>(Submitter Identifier) UPPERCASE</i>	<ul style="list-style-type: none"> ▪ EDI Sender ID ▪ Equals the value entered in ISA06 and GS02
PER Administrative Communications Contact	PER03 Communication Qualifier	<i>TE</i>	TE - Telephone For support purposes, recommend the telephone number of the submitter be identified
Loop ID 1000B—Receiver Name			
NM1 Receiver Name	NM103 Last Name or Organization Name	<i>BLUECHOICE HEALTHPLAN MEDICAID</i>	Receiver Name
	NM109 Identification Code	<i>00403</i>	00403 - represents BlueChoice HealthPlan Medicaid

837 Professional Claim Detail

The 837 Detail level has a hierarchical level (HL) structure based on the participants involved in the transaction. The three levels for the participant levels include:

- 1) **Information Source** (Billing/Pay-to Provider)
- 2) **Subscriber** (Can be the Patient when the Patient is the Subscriber)
- 3) **Dependent** (Patient when the Patient is not the Subscriber)

1 837 Claim Detail: Billing/Pay-to Provider Hierarchical Level

The first hierarchical level (HL) of the 837 Claim Detail, Billing/Pay-to Provider HL, identifies the original entity who submitted the electronic claim/encounter to the destination payer.

837 Professional Health Care Claim—Detail Billing/Pay-to Provider Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2000A—Billing/Pay-to Provider Hierarchical Level				
P.76	PRV Billing/Pay-to Provider Specialty Information	PRV01 Provider Code	BI	BI - Billing
		PRV03 Reference Identification	(Provider Taxonomy Code)	Strongly recommended to include a taxonomy on all applicable claims that you are filing (NOTE to Clearinghouses - DO NOT DEFAULT)
P.78	CUR Foreign Currency Information	CUR02 Currency Code	USD	USD - US dollars Monetary amounts in US dollars recognized only.
Loop ID 2010AA—Billing Provider Name				
P.81	NM1 Billing Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Billing Provider Primary Identification No.)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers
P.87	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	1D	1D - Medicaid Provider number
		REF02 Reference Identification	(Billing Provider Secondary Identification No.)	Billing Provider's BlueChoice HealthPlan Medicaid Provider No.
Loop ID 2010AB—Pay-to Provider Name				
P.95	NM1 Pay-to Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Pay-to Provider Primary Identification No.)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers

NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.

**Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers OB, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.

2 837 Claim Detail Subscriber Hierarchical Level

The second hierarchical level (HL) of the 837 Detail is the Subscriber HL. It is recommended that each interchange (ISA-IEA envelope) be limited to 3000 claims for processing efficiency.

837 Professional Health Care Claim—Detail Subscriber Hierarchical Level												
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid								
Loop ID 2000B—Subscriber Hierarchical Level												
P.105	SBR Subscriber Information	SBR01 Payer Responsibility Sequence	<i>P, S, T</i>	usage of 'S' or 'T' accompanies information populated in Loop 2320.								
Loop ID 2010BA—Subscriber Name												
P.112	NM1 Subscriber Name	NM109 Identification Code	<i>(Subscriber Primary Identifier)</i>	<table border="1"> <tr> <td><i>Enter one of the following formats:</i></td> <td>Format Explanation</td> </tr> <tr> <td colspan="2">ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.</td> </tr> <tr> <td colspan="2"><i>Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.</i></td> </tr> <tr> <td><i>(XXX999999999)</i> e.g. XYZ1234567899</td> <td>3-character alpha prefix (uppercase) followed by 10-character alphanumeric subscriber ID code</td> </tr> </table>	<i>Enter one of the following formats:</i>	Format Explanation	ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.		<i>Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.</i>		<i>(XXX999999999)</i> e.g. XYZ1234567899	3-character alpha prefix (uppercase) followed by 10-character alphanumeric subscriber ID code
<i>Enter one of the following formats:</i>	Format Explanation											
ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.												
<i>Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.</i>												
<i>(XXX999999999)</i> e.g. XYZ1234567899	3-character alpha prefix (uppercase) followed by 10-character alphanumeric subscriber ID code											
Loop ID 2010BB—Payer Name												
P.124	NM1 Payer Name	NM108 Identification Code Qualifier	<i>PI</i>	PI - Payer Identification								
		NM109 Identification Code	<i>(Payer Primary Identifier)</i>	045 - represents BlueChoice HealthPlan Medicaid								

3 837 Claim Detail Patient Hierarchical Level

The third hierarchical level (HL) of the 837 Claim Detail is the Patient HL. It is recommended that each interchange (ISA-IEA envelope) be limited to 3000 claims for processing efficiency.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2300—Claim Information				
P.160	CLM Claim Information	CLM01 Claim Submitter's Identifier	<i>(Patient Account Number)</i>	<ul style="list-style-type: none"> Max. of 20 characters Value is returned on outbound 835 and other transactions
		CLM02 Monetary Amount	<i>(Total Claim Charge Amount)</i>	This field must equal the total amount of submitted charges for service lines in Loop 2400, SV102.
		CLM05-3 Claim Frequency Type Code	<i>7, 8</i>	If '7' (replacement) or '8' (void/cancel) then the Original Reference Number (ICN/DCN) data segment (Loop 2300, REF02) is required and must contain originally assigned claim no.
P.199	PWK Claim Supplemental Information	PWK02 Report Transmission Code	<i>BM, FX</i>	Supporting documentation accepted by mail (BM) or fax (FX) only. Illegible information will delay processing.
		PWK06 Identification Code	<i>(Attachment Control Number)</i>	Field reserved for self-assigned attachment control number on the Attachment Face Sheet.
P.216	REF Original Reference Number (ICN/DCN)	REF01 Reference Identification Qualifier	<i>F8</i>	F8 - Original Reference Number
		REF02 Reference Identification	<i>(Claim Original Reference Number)</i>	Represents the claim number assigned by BlueChoice HealthPlan Medicaid. Providers should submit the original claim number indicated on the 835 when Loop 2300, CLM05-3 Claim Frequency Type Code is populated with values of '7' or '8'.
P.254	HI Health Care Diagnosis Code	HI01-2 -- HI08-2 Industry Code	<i>(Diagnosis Code)</i>	<ul style="list-style-type: none"> Include diagnosis information to promote more efficient adjudication and processing of bill type 4XX, 5XX, and 14 transactions. ICD-9-CM Guide requires diagnosis codes to the highest level of specificity. A 3-digit code cannot be used if a 4-digit exists, no 4-digit if a 5-digit code exists, etc. A code is invalid if it has not been coded to the full number of digits required for that code.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2310A—Referring Provider Name				
P.271	NM1 Rendering Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Referring Provider Primary Identifier)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers
P.274	PRV Referring Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	Strongly recommended to include a taxonomy on all applicable claims that you are filing (NOTE to Clearinghouses - DO NOT DEFAULT)
Loop ID 2310B—Rendering Provider Name				
P.278	NM1 Rendering Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Rendering Primary Identifier)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers
P.281	PRV Rendering Provider Specialty	PRV03 Reference Identification	(Provider Taxonomy Code)	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing (NOTE to Clearinghouses - DO NOT DEFAULT)
P.283	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	1D	1D - Medicaid Provider number
		REF02 Reference Identification	(Rendering Prov Secondary Identifier)	Rendering Provider's BlueChoice HealthPlan Medicaid Provider No.
Loop ID 2310C—Purchased Service Provider Name				
P.285	NM1 Purchased Service Provider	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Purchased Service Prov Primary Identifier)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers
Loop ID 2310D—Service Facility Location				
P.290	NM1 Service Facility Location Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Service Facility Location Primary Identifier)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers

NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.

**Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2310E—Supervising Provider Name				
P.312	NM1 Supervising Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Supervising Prov Primary Identifier)	• Tax ID (with '24') For <u>Exempt</u> providers • NPI (with 'XX') For <u>Non-Exempt</u> providers
Loop ID 2320—Other Subscriber Information				
P.318	SBR Other Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	P S T	• Use of 'S' requires that primary payer information be present in Loop 2320 • Use of 'T' requires that both primary and secondary payer information be present in Loop 2320
Loop ID 2400—Service Line				
P.398	LX Service Line	LX01 Assigned Number		Service lines are limited to 50 per claim. If more than 50 lines are submitted, potential for claim to be returned or delayed in processing.
P.400	SV1 Professional Service	SV101-2 Procedure Code	(Procedure Code)	When necessary to bill for unlisted HCPCS (NOC codes), include a the drug and dosage at the service line in Loop 2400, NTE02 (Description). Report the corresponding NDC# in the Loop 2410 LIN03.
		SV101-3—6 Procedure Modifier	(Procedure Modifier 1-4)	• Only modifiers listed in the CPT and HCPCS manuals considered compliant. • Additional information - contact your provider representative for billing guidelines.
		SV102 Monetary Amount	(Line Item Charge Amount)	Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.
		SV103 Unit or Measurement Code	MJ	MJ - Minutes • Report total anesthesia time in minutes.
		SV104 Quantity	(Service Unit Count)	• Accept values greater than or equal to zero • May return claim if units exceed 999 • When SV103 = MJ, value divided by 15 minutes to determine number of anesthesia units • When SV103 = UN, value rounded to the nearest whole integer during processing.
P.485	AMT Approved Amount	AMT02 Monetary Amount	(Approved Amount)	When BlueChoice HealthPlan Medicaid is secondary, enter the amount allowed by Medicare or primary carrier.
P.488	NTE Line Note	NTE02 Description	(Line Note Text)	When it is necessary to bill for unlisted HCPCS (NOC codes) in Loop 2400 SV101-2 (Procedure Code), include the drug and dosage.

NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.

** Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2420A—Rendering Provider Name				
P.501	NM1 Rendering Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Rendering Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')
P.504	PRV Rendering Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	Strongly recommended to include a taxonomy on all applicable claims that you are filing (NOTE to Clearinghouses - DO NOT DEFAULT)
Loop ID 2420B—Purchased Service Provider Name				
P.509	NM1 Purchased Service Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Purchased Service Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')
Loop ID 2420C—Service Facility Location				
P.514	NM1 Service Facility Location	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Service Facility Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')
Loop ID 2420D—Supervising Provider Name				
P.523	NM1 Supervising Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Supervising Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')
Loop ID 2420E—Ordering Provider Name				
P.523	NM1 Ordering Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Ordering Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')

NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.
 **Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2420F—Referring Provider Name				
P.541	NM1 Referring Provider Name	NM108 Identification Code Qualifier	24 XX **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	(Referring Provider Primary Identifier)	• Tax ID (with '24') • NPI (with 'XX')
P.544	PRV Referring Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	Strongly recommended to include a taxonomy on all applicable claims that you are filing (NOTE to Clearinghouses - DO NOT DEFAULT)
Loop ID 2430—Line Adjudication Information				
P.554	SVD Service Line Adjudication	SVD02 Monetary Amount	(Service Line Paid Amount)	When BlueChoice HealthPlan Medicaid is secondary, enter the amount paid by Medicare or the primary carrier.
P.566	DTP Line Adjudication Date	DTP03 Date Time Period	(Adjudication or Payment Date)	Represents when the primary payer made payment and is recognized for processing Coordination of Benefits (COB).

NOTE. National Provider Identifier (NPI) Information for Non-Exempt Providers.

**Under CMS guidance, BlueChoice HealthPlan Medicaid is allowing a contingency period for usage of the NPI. Either legacy provider identifiers or valid & registered NPI will be accepted through May 23, 2008. Effective May 24, 2008, NPI-only submissions accepted; Legacy identifiers 0B, 1A, 1B, 1C, 1D, 1G, 1H, E2, LU, N5, X5 will be rejected. If applicable, please alert your Billing Service, Software vendor, and/or Clearinghouse of this dual receipt time period.