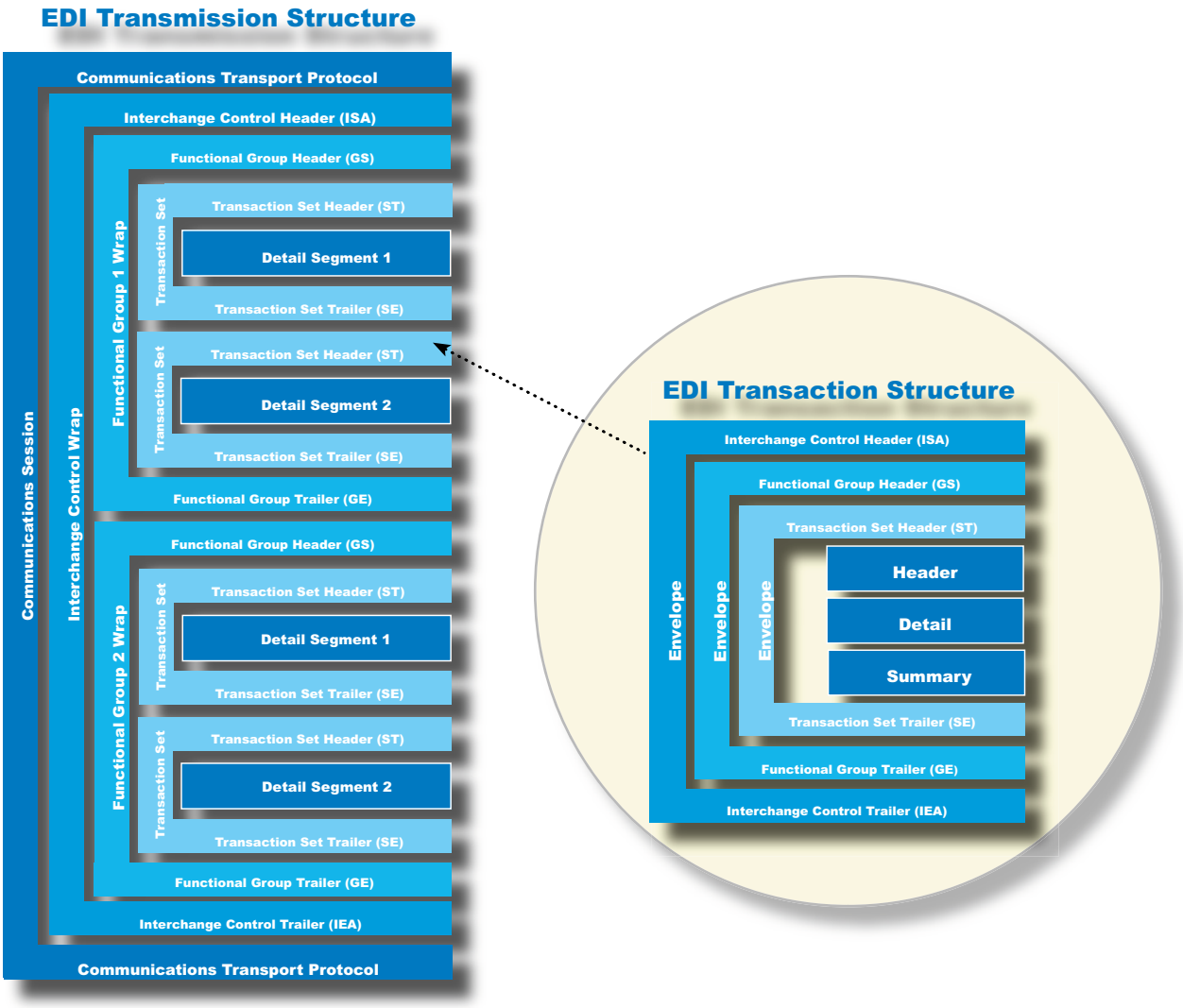
Section
2B

837I Institutional Health Care Claim

Basic Instructions

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

Use this companion document in conjunction with both the Transaction Set Implementation Guide "Health Care Claim: Institutional, 837, ASC X12N 837 (004010X096)", May 2000, and the subsequent Addenda (004010X096A1), October 2002, published by the Washington Publishing Co.



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 Institutional 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 and 2310A 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

Blue Choice 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 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:

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.

BlueChoice HealthPlan of South Carolina

BlueChoice HealthPlan Medicaid
Attachment Face Sheet
(Claim Supplemental Information)

The paper documentation included in this mailing supports the electronically submitted claim.

Date Transmitted	
Line of Business	☐ Professional ☐ Institutional
Member's Contract Number	
Name of Patient	
Date of Service	
Name of Provider	
Identification Code (Attachment Control #):	

Mail or Fax Completed Form to:
EDI Solutions
13550 Triton Park Blvd.
Louisville, KY 40223
(866) 480-4916 (Fax)

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

EDI Solutions
13550 Triton Park Blvd
Louisville, KY 40223

(866) 480-4916 (Fax)

8 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 three data elements in Loop 2400, SV2 Institutional Service Line (See 837 Institutional IG, P.439):

SV203 Monetary Amount – Line Item Charge Amount

SV205 Quantity – Service Unit Count

SV207 Monetary Amount – Line Item Denied Charge or Non-Covered Charge Amount

9 Provider Identification Number

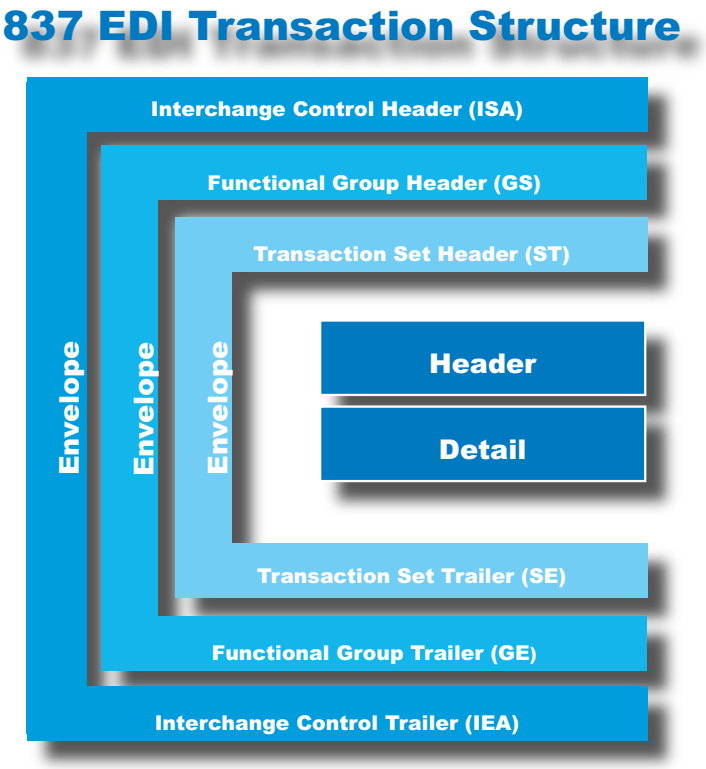
In order to accurately identify the provider when submitting claims, BlueChoice HealthPlan Medicaid requires a secondary identifier to accurately identify the provider. The REF01 & REF02 data elements are required to efficiently process through when including the following Loops / Segments:

Loop 2010AA	Billing Provider	1D - Medicare Provider Number
Loop 2310A	Attending Physician	1D - Medicare Provider Number
		1G - UPIN Number

Enveloping

EDI 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)



837 Envelope Control Segments – Inbound

1 837 Health Care Claim Interchange Control Header (ISA)

The ISA segment is the beginning, outermost envelope of the interchange control structure. Containing authorization and security information, it also clearly identifies the sender, receiver, date, time, and interchange control number. All data entered in the ISA-IEA segment must be in UPPERCASE. Use the following table to supplement the 837 Implementation Guides. The table provides information that is specific to BlueChoice HealthPlan Medicaid, and does not modify the 837 Implementation Guides.

837 Institutional Health Care Claim Interchange Control Header (ISA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
ISA Interchange Control Header	**ISA01** Authorization Information Qualifier	***00***	00 - No Authorization Information Present
	ISA02 Authorization Information	***(10 Spaces)***	Enter 10 positions.
	ISA03 Security Information Qualifier	***00***	00 - No Security Information Present
	ISA04 Security Information	***(10 Spaces)***	Enter 10 positions.
	ISA05 Interchange ID Qualifier	***ZZ***	ZZ - Mutually Defined
	ISA06 Interchange Sender ID	***(Sender ID) UPPERCASE***	▪ EDI Sender ID ▪ ISA06 = GS02 = Loop 1000A, NM109 ▪ 8-alphanumeric, left justified followed by trailing spaces
	ISA07 Interchange ID Qualifier	***ZZ***	ZZ - Mutually Defined
	ISA08 Interchange Receiver ID	***BCBSCAID***	BCBSCAID - BlueChoice HealthPlan Medicaid
	ISA09 Interchange Date	***(YYMMDD)***	Value must be a valid date in YYMMDD format.
	ISA10 Interchange Time	***(HHMM)***	Value must be a valid time in HHMM format.
	ISA11 Interchange Control Standards Identifier	***U***	U - U.S. EDI Community of ASC X12, TDCC, and UCS
	ISA12 Interchange Control Version Number	***00401***	00401 - Draft Standards for Trial Used Approved for Publication by ASC X12 Procedures Review Board through October 1997
	ISA13 Interchange Control Number	***(Assigned by Sender)***	▪ 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 right-justified, filled with leading zeroes ▪ ISA13 = IEA02
	ISA14 Acknowledgment Requested	***0, 1***	997 Functional Acknowledgment returned when a valid, enveloped X12 transaction is processed.
	ISA15 Usage Indicator	***P, T***	Sender ID must be approved to submit production data. P - Production Data | T - Test Data
	ISA16 Component Element Separator	|	▪ BlueChoice HealthPlan Medicaid recommends a vertical bar (|) for Component Element Separator ▪ Value must not equal A-Z, a-z, 0-9, "space", and special characters which may appear in text data (i.e., hyphen, comma, period, apostrophe).

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.

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

837 Institutional 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	***HC***	HC - Health Care Claim (837)
	GS02 Application Sender's Code	***(SENDER ID)***	▪ 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	***Left justified with no leading or trailing spaces***	
		BCBSCAIDSC	▪ Represents BlueChoice HealthPlan Medicaid
	GS04 Date	***(CCYYMMDD)***	Value must be a valid date in CCYYMMDD format.
	GS05 Time	***(HHMM)***	Value must be a valid time in HHMM format.
	GS06 Group Control Number	***(Assigned by Sender)***	▪ 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	***X***	X - Accredited Standards Committee X12
	GS08 Version / Release / Industry Identifier Code	***004010X096A1***	Operationally used to identify the 837 Institutional Health Care Claim transaction

NOTE. Critical Batching and Editing Information.
****Transactions must be batched 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 to supplement the 837 Implementation Guides. The table provides information that is specific to BlueChoice HealthPlan Medicaid. This information does not modify the 837 Implementation Guide.

837 Institutional 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	***(n)***	Format - 1-6 positions, numeric Value is left justified with no leading zeroes
	GE02 Group Control Number	***(Identical to GS06)***	Format - 1-9 positions, numeric ▪ 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, outmost level of the interchange control structure. It indicates and verifies the number of functional groups included with 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 does not modify the 837 Implementation Guide.

837 Institutional 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	***(n)***	Format - 1-5 positions, numeric ▪ 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	***(Identical to ISA13)***	Format - 9 positions, numeric ▪ Unique value greater than zero. ▪ Value must be identical to the associated Interchange Control Header ISA13

837 Institutional 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 Institutional Health Care Claim—Header				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Beginning of Hierarchical Transaction				
P.57	**BHT** Beginning of Hierarchical Transaction	**BHT06** Transaction Type Code	***CH***	CH - Chargeable
P.60	**REF** Transmission Type Identification	**REF02** Transmission Type Code	***004010X096A1***	Will not be used to distinguish between test and production.
Loop ID 1000A—Submitter Name				
P.61	**NM1** Submitter Name	**NM109** Identification Code	***(Submitter Identifier) UPPERCASE***	▪ EDI Sender ID ▪ Equals the value entered in ISA06 and GS02
P.64	**PER** Administrative Communications Contact	**PER03** Communication Qualifier	***TE***	TE - Telephone For support purposes, recommend the telephone number of the submitter be identified
Loop ID 1000B—Receiver Name				
P.67	**NM1** Receiver Name	**NM103** Last Name or Organization	***BLUECHOICE HEALTHPLAN MEDICAID***	Receiver Name
		NM109 Identification Code	***00403***	00403 - represents BlueChoice HealthPlan Medicaid

837 Institutional Claim Detail

The 837 Claim Detail level has a hierarchical level (HL) structure based on the participants involved in the transaction. The three levels for the participant types 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 Health Care Claim Detail: Billing/Pay-to Provider Hierarchical Level

The first hierarchical level (HL) of the 837 detail is the Information Source HL, also known as the Health Care Claim Detail, Billing/Pay-to Provider.

837 Institutional 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.71	**PRV** Billing/Pay-to Provider Specialty Information	**PRV01** Provider Code	***BI***	BI - Billing
		PRV03 Reference Identification	***(Provider Taxonomy Code)***	Strongly recommended to include a taxonomony on all applicable claims that you are filing (**NOTE** to Clearinghouses - DO NOT DEFAULT)
P.73	**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.76	**NM1** Billing Provider Name	**NM108** Identification Code Qualifier	***24*** ***XX *****	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Billing Prov Primary Identification No.)***	• Tax ID (with '24'); for Exempt providers • NPI (with 'XX'); for Non-Exempt providers
P.82	**REF** Billing Provider Secondary Identification	**REF01** Reference Identification Qualifier	***1D***	1D - Medicaid Provider number
		REF02 Reference Identification	***(Billing Prov Secondary Identification No.)***	Billing Provider's BlueChoice HealthPlan Medicaid Provider No.
Loop ID 2010AB—Pay-to Provider Name				
P.91	**NM1** Pay-to Provider Name	**NM108** Identication Code Qualifier	***24*** ***XX *****	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Pay-to Prov Primary Identification No.)***	• Tax ID (with '24'); for Exempt providers • NPI (with 'XX'); for Non-Exempt 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.**

2 837 Health Care Claim Detail: Subscriber Hierarchical Level

The second hierarchical level (HL) of the 837 Health Care Claim Detail is the Subscriber HL. It is recommeded that each interchange (ISA-IEA envelope) be limited to 5000 claims for processing efficiency.

837 Institutional 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.101	**SBR** Subscriber Information	**SBR01** Payer Responsibility Sequence	***P, S, T***	Usage of 'S' and 'T' accompanies information populated in Loop 2320.	
Loop ID 2010BA—Subscriber Name					
P.106	**NM1** Subscriber Name	**NM109** Identification Code	***(Subscriber Primary Identifier)***	***Enter one of the following formats:***	Format Explanation
				ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.	
				Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.	
				(XXX9999999999) e.g. XYZ1234567899	3-character alpha prefix (uppercase) followed by 10-character alphanumeric subscriber ID code
Loop ID 2010BC—Payer Name					
P.126	**NM1** Payer Name	**NM108** Identification Code Qualifier	***PI***	PI - Payer Identification	
		NM109 Identification Code	***(Payer Primary Identifier)***	045 - represents BlueChoice HealthPlan Medicaid	

3 837 Health Care Claim Detail: Patient Hierarchical Level

The third hierarchical level (HL) of the 837 Health Care Claim Detail is the Patient HL. It is recommended that each interchange (ISA-IEA envelope) be limited to 5000 claims for processing efficiency.

837 Institutional 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.157	**CLM** Claim Information	**CLM01** Claim Submitter's Identifier	***(Patient Control Number)***	▪ Max. of 20 characters ▪ Returned on outbound 835 and other transactions
		CLM02 Monetary Amount	***(Total Claim Charge***	Must equal the total amount of submitted charges for service lines in Loop 2400, SV203.
		CLM05-3 Claim Frequency Type Code	***(3rd Position of Uniform Billing Claim Form Bill Type)***	If '7' (replacement) or '8' (void/cancel) then the Original Reference No. (ICN/DCN) data segment (Loop 2300, REF02) is required and must contain the originally assigned claim no.
		CLM18 Explanation of Benefits (EOB) Indicator	***N or Y***	N - No; Y - Yes Paper EOBs will be distibuted regardless of value
P.167	**DTP** Statement Dates	**DTP03** Date Time Period	***(Statement From or To Date)***	Valid medical codes based on the "Statement From Date"
P.173	**PWK** Claim Supplemental Information	**PWK02** Report Transmission	***BM FX***	Supporting documentation accepted by mail (BM) and fax (FX) only. Illegible information will delay processing.
		PWK06 Identification Code	***(Attachment Control Number)***	Field reserved for self-assigned attachment control number on the Attachment Face Sheet.
P.182	**AMT** Patient Paid Amount	**AMT01** Amount Qualifier Code	***F5***	F5 - Patient Amount Paid
		AMT02 Monetary Amount	***(Patient Amount Paid)***	Represents the Patient Amount Paid.
P.185	**REF** Original Reference Number (ICN/DCN)	**REF01** Reference Identification	***F8***	F8 - Original Reference Number
		REF02 Reference Identification	***(Claim Original Reference Number)***	Represents the claim no. 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.193	**REF** Prior Authorization or Referral Number	**REF02** Reference Identification	***(Prior Authorization Number)***	For PEP recipients, use the Gate Keeper's Medicaid provider number.
P.195	**REF** Medical Record Number	**REF02** Reference Identification	***(Medical Record Number)***	Represents the Medical Record No. indicated on the 835. Asterisks (ex. EDI*2004) in this field prevent smooth return of the 835, and therefore are strongly discouraged from using.

837 Institutional 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 (cont'd)				
P.200	**NTE** Claim Note	**NTE01** Note Reference Code	***UPI***	UPI - Updated Information (for regular nursing homes)
		NTE02 Claim Note Text	***(Claim Note Text)***	Enter SNFxx or ICFxx where 'xx' = no. days, do not enter a space between values. If no days apply, 'xx' = 00.
P.203	**NTE** Billing Note	**NTE01** Note Reference Code	***ADD***	ADD - Additional Information (for all nursing homes)
		NTE02 Description	***(Billing Note Text)***	• Enter EXT, REG, or OSS • Enter RCFxxIPCxx where 'xx' = no. days, do not enter a space between values. If no days apply, 'xx' = 00.
P.234	**HI** Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information	**HI01-2 -- HI03-2** Diagnosis Code	***See Code Source 131: ICD-9-CM***	▪ Include diagnosis information to promote more efficient adjudication/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.
P.237	**HI** Diagnosis Group (DRG) Information	**HI01-1** Code List Qualifier	***DR***	DR - Diagnosis Related Group (DRG)
		HI01-2 Industry Code	***(Diagnosis Related Group (DRG) Code)***	All DRG claim submissions require the DRG code for processing
P.311	**QTY** Claim Quantity	**QTY01** Quantity Qualifier	***CA LA CD NA***	CA - Covered-Actual; LA - Life-time Reserve-Actual; CD - Co-insured-Actual; NA - Number of Non-covered Days
		QTY02 Quantity	***(Claim Days Count)***	Represents the numeric value of quantity.

837 Institutional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2310A—Attending Physician Name				
P.326	**NM1** Attending Physician Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Attend Phys Primary ID)***	• Tax ID (with '24') For Exempt providers • NPI (with 'XX') For Non-Exempt providers
P.329	**PRV** Attend Phys Specialty Info	**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.331	**REF** Attending Physician Secondary Identification	**REF01** Reference Identification Qualifier	***1D*** ***1G***	1D - Medicaid Provider number 1G - Provider UPIN number
		REF02 Reference Identification	***(Attending Physician Secondary ID)***	• Attending Physician's BlueChoice HealthPlan Medicaid Provider No. (with '1D') • Attending Physician's UPIN No. (with '1G')
Loop ID 2310B—Operating Physician Name				
P.333	**NM1** Operating Physician Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Operating Physician Primary ID)***	• Tax ID (with '24') For Exempt providers • NPI (with 'XX') For Non-Exempt providers
Loop ID 2310C—Other Provider Name				
P.340	**NM1** Other Provider Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Other Provider Primary ID)***	NPI (with 'XX' qualifier)
Loop ID 2310E—Service Facility Name				
P.347	**NM1** Service Facility Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Laboratory / Facility Primary ID)***	• Tax ID (with '24') For Exempt providers • NPI (with 'XX') For Non-Exempt providers
Loop ID 2320—Other Subscriber Information				
P.357	**SBR** Other Subscriber Information	**SBR01** Payer Responsibility Sequence Number Code	***P*** ***S*** ***T***	P - Primary; S - Secondary; T - Tertiary Represents the other payer(s) level of responsibility for payment of this claim

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 Institutional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to BlueChoice HealthPlan Medicaid
Loop ID 2400—Service Line				
P.438	**SV2** Institutional Service Line	**SV201** Product/Service ID	***(Service Line Rev Code)***	If value ends in "9", then enter Loop 2300/2400 PWK or Loop 2300 NTE (Claim Note). Report NDC# in Loop 2410 LIN03.
		SV202-2 HCPCS Procedure Code	***(HCPCS Procedure Code)***	▪ When billing unlisted HCPCS (NOC codes), include procedure description in Loop 2300 NTE02, or Loop 2300/2400 PWK with supporting documentation. Report NDC# in Loop 2410 LIN03. ▪ For OHAS (Outpatient Hospital Allowance Schedule), HCPCS coding is required.
		SV202-3 -- 6 HCPCS Modifier 1-	***(HCPCS Modifiers)***	Use the modifiers listed in the UB92 manual
		SV203 Monetary Amount	***(Line Item Charge Amount)***	▪ Accept values greater than or equal to zero ▪ Sum of Line Item Charges must equal Total Claim Charge Amount in Loop 2300, CLM02.
		SV205 Quantity	***(Service Unit Count)***	Value cannot exceed 999 units
		SVC206 Unit Rate	***(Service Line Rate)***	Accept values greater than or equal to zero
		SV207 Monetary Amount	***(Line Item Denied Charge of Non-Covered Charge Amount)***	Accept values greater than or equal to zero
Loop ID 2410—Drug Identification				
P.459	**LIN** Drug Identification	**LIN03** Product/Service ID	***(National Drug Code)***	When billing for unlisted HCPCS (NOC codes) in Loop 2400, SV201 and SV202-2, identify the drug & dosage in Loop 2400 NTE02.
Loop ID 2420A—Attending Physician Name				
P.467	**NM1** Attending Physician Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Attending Physician Primary Identifier)***	NPI (with 'XX' qualifier)
Loop ID 2420B—Operating Physician Name				
P.474	**NM1** Operating Physician Name	**NM108** Identification Code Qualifier	***24*** ***XX*** **	24 - Employer's Identification Number XX - HCFA National Provider Identifier
		NM109 Identification Code	***(Operating Physician Primary Identifier)***	NPI (with 'XX' qualifier)
Loop ID 2430—Service Line Adjudication Information				
P.488	**SVD** Service Line Adjud Info	**SVD02** Payer Resp Seq Code No.	***(Service Line Paid Amount)***	When BlueChoice HealthPlan Medicaid is secondary, enter the amount paid by Medicare or the other payer.
P.500	**DTP** Service Adjud Date	**DTP03** Date Time Period	***(Service Adjud or Paymt Date)***	Represents when the primary payer made payment and is recognized for processing Coordination of Benefits.

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.**