

NEBLUE *connect*



**Institutional
Health Care Claim
ANSI ASC X12N 837I**

Companion Document
Health Insurance Portability and Accountability Act



**BlueCross BlueShield
of Nebraska**

A Not-For-Profit Mutual Insurance Company and an Independent Licensee
of the Blue Cross and Blue Shield Association.

ANSI ASC X12N 837I Institutional Health Care Claim

Companion Document
Version 4010A1
Revised 4/14/09

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). The ANSI X12N 837I implementation guide has been established as the standards of compliance for eligibility transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837I implementation guide. The use of this document is solely for the purpose of clarification. This companion document supplements, but does not contradict any requirements in the X12N 837I implementation guide.

This document is subject to change as new information is available. Please check the BCBSNE Provider Web Site at www.bcbsneprovider.com for updated documents. Just click on the NEBLUECONNECT link to find all of the BCBSNE Companion Guides.

BCBSNE Requirements – 837I

General Information

NEBLUECONNECT requires using delimiters from the following list: > * ~ ^ | :
Submitting delimiters not supported with this list may cause an interchange (transmission) to be rejected.

NEBLUECONNECT will generate a 997 Functional Acknowledgement transaction in reply to the 837 transaction. The 997 performs validation against the X12 Standard.

NEBLUECONNECT will also generate a Claims Confirmation Report, also known as Gen Response Report, if the 837 passes X12 Standard validation. This is a report of the validation against the HIPAA Implementation Guide.

BCBSNE applies Business Quality Edits to the claim after the claims have passed syntax and structure edits. Any claims that are rejected during the Quality Edit Process are reported on the Quality Edit Reject Report. The Quality Edit Reject Report is generated during the nightly batch cycle and sent back out to the trading partner mailbox.

BCBSNE will reject an interchange (transmission) submitted with more than 9999 loops.

BCBSNE will reject an interchange (transmission) submitted with more than 9999 segments per loop.

BCBSNE will reject an interchange (transmission) with more than 5000 CLM segments (claims) submitted per transaction set.

Credit/Debit card information will be ignored and will not be processed. Credit/Debit card information must not be used to bill payers.

Negative dollar amounts will not be processed and will result in the claim being rejected, unless the negative dollar amounts are in COB segments. The maximum size for dollar amount fields is 10 characters (8 digits and 2 decimals). Blue Cross claims submitted with dollar amounts in excess of 99999999.99 will be returned to the submitter.

Dollar amounts must be rounded to two decimal spaces..

BCBSNE requires that percentages and/or units must be rounded to the nearest whole number.

Negative dollar amounts will not be processed and will result in the claim being rejected, unless the negative dollar amounts are in COB segments. The maximum size for dollar amount fields is 10 characters (8 digits and 2 decimals). Blue Cross claims submitted with dollar amounts in excess of 99999999.99 will be returned to the submitter.

Dollar amounts must be rounded to two decimal spaces.

BCBSNE requires that percentages and/or units must be rounded to the nearest whole number.

Interchange Sender and Receiver ID Requirements

ISA and GS ISA05 = ZZ
 ISA06 = Seven digit BCBSNE Trading Partner Number
 ISA07 = ZZ
 ISA08 = NEBLUECONNECT

 GS02 = Seven digit BCBSNE Trading Partner Number
 GS03 = NEBLUECONNECT

NPI Information

BCBSNE requires the NPI number and Tax ID on the claim.

Loop, Segment, Element

Header Level

BHT Segment Beginning of Hierarchial Transaction

BHT02 For BCBSNE, the transaction set purpose code must equal 00 (original)

BHT06 BCBSNE requires the claim or encounter equal CH (chargeable)

Receiver Name 1000B Loop

NM1 Segment Receiver Name

NM103 Please use NEBLUECONNECT for the Organization name.

Billing Provider 2000A Loop

CUR Segment Currency Information

2000A, CUR02 Currency Code must equal USA for BCBSNE.

Billing Provider Name 2010AA Loop

NM1 Segment Billing Provider Name

NM108 For BCBSNE Institutional claims, the value of XX (NPI qualifier) is required.

NM109 The NPI number is required in this field.

REF Segment Secondary Identification

REF01 For BCBSNE Institutional claims, the value of EI (Employee Identification number) is required.

REF02 The tax ID is required in this field.

Subscriber Information 2000B Loop

SBR Secondary Subscriber Identification

SBR02 BCBSNE checks the Patient Relationship to Insured Code against the BCBSNE Membership System. Claims that do not pass these checks will be rejected by the Quality Edits.

SBR09 For the claim to route correctly to BCBSNE please use BL BCBSNE also accepts HM and 12.

Your claims will be rejected with "Unable to Determine Route" if one of these values is not sent.

Subscriber Information 2010BA Loop

NM1 Segment Subscriber Name

NM103 The Subscriber Last Name must match totally with what is on the BCBSNE Membership System for the Member ID sent in the NM109. Claims that don't match up will be rejected by the Quality Edits.

NM108 Submit MI for BCBSNE.

NM109 BCBSNE requires all Member ID information as follows:

1. Must include Member ID including Plan Prefix, ID# and Member suffix.
2. When submitting multiple parts of an ID, the data should be provided to BCBSNE as a string with no dashes, spaces, commas, slashes, etc. in between the elements of the ID.

Without the Plan Prefix, BCBSNE may not be able to match the member identification number correctly.

An example of Member suffix for a Member ID is:

ID Card is YES123 45 6789 with the following names below that ID#:

John Q Public 01
Jane A Public 02

The suffix for John is 01 and the suffix for Jane is 02. The entire Member ID for Jane would consist of YES12345678902 with no dashes, no spaces, no commas and no slashes specified.

Payer Name 2010BC Loop

NM1 Segment Payer Name

NM109 For your claims to route to BCBSNE correctly please use following:

77780 with qualifier NI (NAIC) in the NM108

00260 with qualifier PI (Payor Identification) in the NM108

Your claims will be rejected with "Unable to Determine Route" if one of these values is not sent.

Claim Name 2300 Loop

CLM Segment Claim Information

CLM01 Patient Control Number can not exceed the IG gray box edit of:

No more than 20 positions of the submitted number will be stored on the BCBSNE claims processing system

CLM02 For BCBSNE, claim total charges must be greater than zero.
Negative dollar amounts will not be processed and will result in the claim being rejected, unless the negative dollar amounts are in COB segments.

The maximum size for dollar amount fields is 10 characters (8 digits and 2 decimals). Blue Cross claims submitted with dollar amounts in excess of 99999999.99 will be returned to the submitter.

Dollar amounts must be rounded to two decimal spaces.

CLM05-1 Institutional claims having TOB code 5xx or 14x are required to also have the "patient reason for visit" code entered. Institutional claims with TOB 4xx must have the admit diagnosis code entered.

Hospital "Other" (14x bill type) claims that lack diagnosis information when required for BCBSNE Institutional claim adjudication (Loop 2300, HI (Principal, Admitting, E-code and Patient Reason for visit Diagnosis Information) will error and be returned to the billing Provider.

Institutional claims with TOB codes 11x, 18x or 21x need to have the Attending or Operating Physician's six digit UPIN # and Physician's name submitted.

CLM20 Data submitted in CLM20 will not be used for processing.

PWK Segment Paperwork

PWK You may submit the PWK related to the claim by the following Report Transmission codes:

BM - By Mail at the following address:

PWK837
Blue Cross and Blue Shield of Nebraska
PO Box 247039
Omaha, NE 68124-7039

EM - Email to: PWK837@BCBSNE.com

FX - Fax to local #402-548-4684 or toll free to 1-888-233-8084

If the PWK segment is utilized, each page of PWK submitted MUST have the attachment control number clearly visible.

BCBSNE will not be able to process any PWK that is sent via fax, email, regular mail or electronically without the attachment control number.

ONLY information relating to Claim Supplemental Information (PWK) may be sent to these addresses.

REF Segment Medical Record Number

REF02 The Medical Record Number is required on Institutional claims for BCBSNE.

NTE Segment Claim Note

Data submitted in this segment will not be used for processing.

NTE Segment Billing Note

Data submitted in this segment will not be used for processing.

HI Segment BCBSNE claim system does not process decimal points in the ICD9-CM diagnosis codes or ICD9-CM procedure codes. Diagnosis codes have a maximum of 5 characters.

Diagnosis codes may be sent as described in the Implementation Guide, however; only the primary/principal and first ten other diagnosis codes will be considered for adjudication and payment determination on institutional claims.

Institutional claims having TOB code 5xx or 14x are required to also have the "patient reason for visit" code entered. Institutional claims with TOB 4xx must have the admit diagnosis code entered.

Hospital "Other" (14x bill type) claims that lack diagnosis information when required for BCBSNE Institutional claim adjudication (Loop 2300, HI (Principal, Admitting, E-code and Patient Reason for visit Diagnosis Information) will error and be returned to the billing Provider.

Other Subscriber 2320 Loop

BCBSNE is using the business model referenced in the Implementation Guide as the "Provider-to-Payer-to-Provider Model 1" for COB processing.

Institutional Service Line 2400 Loop

SV2 Segment Service Line

SV201 When entering a three digit revenue code, you must preface the code with a 0 (zero). Revenue codes must be a length of four positions to pass HIPAA syntax and structure edits. i.e. for revenue code 120, you enter 0120.

PWK Segment Paperwork

You may submit the PWK related to the claim by the following Report Transmission codes:

BM - By Mail at the following address:

PWK837
Blue Cross and Blue Shield of Nebraska
PO Box 247039
Omaha, NE 68124-7039

EM - Email to: PWK837@BCBSNE.com

FX - Fax to local #402-548-4684 or toll free to 1-888-233-8084

If the PWK segment is utilized, each page of PWK submitted MUST have the attachment control number clearly visible.

BCBSNE will not be able to process any PWK that is sent via fax, email, regular mail or electronically without the attachment control number.

ONLY information relating to Claim Supplemental Information (PWK) may be sent to these addresses.

Attending Physician Name 2420A Loop

Institutional claims with TOB codes 11x, 18x or 21x need to have the Attending or Operating Physician's NPI number and Physician's name submitted.

Operating Physician Name 2420B Loop

Institutional claims with TOB codes 11x, 18x or 21x need to have the Attending or Operating Physician's NPI number and Physician's name submitted.