

Administrative Services of Kansas

ANSI X12N 837P V4010A1 Health Care Claim Companion Guide - Professional All Payers

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The Health Insurance Portability and Accountability Act (HIPAA) requires all health insurance payers in the United States to 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 837 implementation guide has been established as the standards of compliance for health care claims 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 guide to the HIPAA ANSI X12N 837 Implementation Guide for the submission of professional claims. It should be used only as a supplement to the ANSI Implementation Guides for clarification purposes – not as a replacement.

This Companion Guide is subject to change as new information is available. Please check the ASK Web Site at www.ask-edi.com for updated documents.

Documentation of ASK common payer and Payer Specific edits will provide additional help in submitting your transactions. These are located on the ASK Web Site at www.ask-edi.com.

General Statements

1. All transmissions submitted without a valid Trading Partner number will be rejected. A Trading Partner number can be obtained by completing the EDI Enrollment Form found on the website.
2. Only loops, segments, and data elements valid for the HIPAA Implementation Guide will be translated. Submitting data, not valid based on the Implementation Guide, will cause files to be rejected.
3. The incoming 837 transactions utilize delimiters from the following list: '>', '*', '~', '^', '|', and ':'. Submitting other delimiters may cause an interchange (transmission) to be rejected. These characters should not be used within the data if used as a delimiter.
4. Claim data submitted in the incoming 837 must use the basic character set as defined in Appendix A of the Implementation Guide. In addition to the basic character set, you may submit lower case characters and the '@' symbol from the extended character set. Any other characters from the extended character set may cause the interchange (transmission) to be rejected at the translator or in some Health Plans payment systems. Please see edit lists for further documentation. **Exception:** The apostrophe (') should not be used in any name or city field and any character used as a delimiter should not be used within the data.
5. All lower case characters submitted on an inbound 837 file will be converted to upper case when sending data to the payers processing system including Coordination of Benefits data subsequently sent to Medicare.
6. All calendar dates on an incoming 837 claim transaction must be in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the entire file.
7. Information submitted in a 'Not Used' element will not be forwarded to any payer.
8. Taxonomy codes are not required in order to process claims, but will be accepted if submitted. Taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes. Claims submitted with invalid taxonomy codes will be rejected. BCBSKS and BCBSKC do not use taxonomy codes for claims adjudication.

9. Data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) will be edited beyond the requirements defined in the Implementation Guide. Please see edit lists for further documentation.
10. Employer Identification Numbers (EIN) may be submitted with or without a dash ("-"). When using a dash ("-") it must be in the 3rd position.
11. Social Security Numbers (SSN) may be submitted with or without dashes ("-"). When using dashes ("-") they must be in the 4th and 7th positions.
12. Compression of files is supported between the submitter and receiver.
13. File names should not contain any of the following characters: Dollar ("\$"), Ampersand("&"), Plus ("+"), Comma (","), Forward slash/Virgule ("/"), Colon (":"), Semi-colon (";"), Equals ("="), Question mark ("?"), or 'At' symbol ("@").
14. For Internet File Transmissions Only: File names must contain only alphabetical ("A-Z, a-z"), Numeric (0-9), hyphen ("-"), or underscore ("_") as characters, with hyphen and underscore not acceptable as starting and ending characters.
15. The max length for any input file name should not exceed 28 characters.
16. All trading partners are required to submit NPI unless specifically identified by the payer or ASK as atypical.
17. [HealthNow processes rendering provider information at the claim level only \(Loop 2310B or 2010AA\). Line level rendering provider information submitted in loop 2420A will be ignored and not considered in the adjudication process.](#)

Companion Information

The following information is intended to serve as a guide to the HIPAA ANSI X12N 837 Implementation Guide for the submission for professional claims. Information contained within this document applies to all payers unless otherwise stated.

Page	Loop	Seg.	Data Element	Comments
INTERCHANGE CONTROL HEADER/ISA				
B.4	N/A	ISA05	Interchange ID Qualifier	'ZZ'
B.4	N/A	ISA06	Interchange Sender ID	Trading Partner Number Assigned by ASK.
B.4	N/A	ISA07	Interchange ID Qualifier	'ZZ'
B.5	N/A	ISA08	Interchange Receiver ID	ASK INC (A space should be entered between ASK and INC)
FUNCTIONAL GROUP HEADER/GS				
B.8	N/A	GS02	Application Sender's Code	Trading Partner Number Assigned by ASK.
B.8	N/A	GS03	Application Receiver's Code	ASK INC (A space should be entered between ASK and INC)
TRANSACTION SET/ST				
62	N/A	ST02	Transaction Set Control Number	Transmissions may be rejected that are not submitted with unique values in the ST02.
66	N/A	REF02	Transmission Type Code	The 837P transaction will not be piloted. Claims files submitted with a Transmission Type Code value of 004010X098DA1 in the REF02 will cause the file to be rejected.
LOOP 1000A - SUBMITTER NAME				
69	1000A	NM109	Submitter Identifier	Trading Partner Number Assigned by ASK.

Page	Loop	Seg.	Data Element	Comments
LOOP 1000B - RECEIVER NAME				
75	1000B	NM103	Receiver Name	ASK INC (A space should be entered between ASK and INC)
75	1000B	NM109	Receiver Primary Identifier	ASK INC (A space should be entered between ASK and INC)
LOOP 2000A – BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL				
78	2000A	HL	N/A	A separate batch is created for each 2000A HL submitted within a file. To keep the Claims Confirmation Report to a minimum, it is strongly recommended that only one 2000A HL segment be submitted for each Billing Provider and Payer.
82	2000A	CUR02	Currency Code	If submitted, must equal 'USA'.
LOOP 2010AA - BILLING PROVIDER NAME				
84	2010AA	N/A	N/A	BCBSKS does not accept claims from non-provider billing entities.
86	2010AA	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI.
86	2010AA	NM109	Billing Provider Identifier	Must be a valid 10-digit NPI number if submitting 'XX' in the 2010AA NM108.
92	2010AA	REF01	Reference Identification Qualifier	One occurrence of 'SY' (Social Security Number) or 'EI' (Employer's Identification Number) is required, if submitting 'XX' in the 2010AA NM108. EDI Midwest: One (1) occurrence must contain 'G5'.
92	2010AA	REF02	Billing Provider Additional Identifier	One (1) occurrence of 'SY' or 'EI' is required if the NPI is submitted in the 2010AA NM109. EDI Midwest: Must contain a Tax ID Number identified as the Provider Site Number in the 2010AA REF01 (G5).
97	2010AA	PER02	Billing Provider Contact Name	Submission of the PER segment is highly recommended. This information will be used to contact the provider in the event claims cannot be submitted to the payer.
LOOP 2000B – SUBSCRIBER HIERARCHICAL LEVEL				
108	2000B	N/A	N/A	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
110	2000B	SBR01	Payer Responsibility Sequence Number Code	Must be populated accurately on secondary and tertiary claims to insure accurate payment.
112	2000B	SBR09	Claim Filing Indicator Code	BCBSKS = 'BL' BCBSKC = 'BL' PHP = 'CI' EDI Midwest = 'CI'
LOOP 2010BA – SUBSCRIBER NAME				
118	2010BA	NM103	Name Last or Organization Name	BCBSKS: Last names should be submitted without special characters or spaces providing one continuous last name. (Example: OBrien, or SmithJones)
118	2010BA	NM104	Name First	BCBSKS: First names should be submitted without special characters or spaces providing one continuous first name. (Example: LouAnn or TMika)
119	2010BA	NM108	Identification Code Qualifier	Must be 'MI'.

Page	Loop	Seg.	Data Element	Comments
119	2010BA	NM109	Subscriber Primary Identifier	BCBSKS: Enter the BCBSKS Subscriber ID number. Alpha prefixes should be entered in capital letters. BCBSKC: Enter the BCBSKC Subscriber ID number. Alpha prefixes should be entered in capital letters. PHP: Enter the Subscriber Identification Number. EDI Midwest: Enter the Subscriber Identification Number.
LOOP 2010BB - PAYER NAME				
131	2010BB	NM108	Identification Code Qualifier	Must be 'PI'.
131	2010BB	NM109	Payer Identifier	BCBSKS = 47163 BCBSKC = 47171 PHP = 00023 or 31478 EDI Midwest = Appropriate payer number from EDI Midwest payer list.
LOOP 2010BD – CREDIT/DEBIT CARD HOLDER				
146	2010BD	N/A	N/A	Credit/Debit Card information cannot be used to bill payers.
LOOP 2010CA – PATIENT NAME				
158	2010CA	NM103	Name Last or Organization Name	BCBSKS: Last names should be submitted without special characters or spaces providing one continuous last name. (Example: OBrien, or SmithJones)
158	2010CA	NM104	Name First	BCBSKS: First names should be submitted without special characters or spaces providing one continuous first name. (Example: LouAnn or TMika)
LOOP 2300 – CLAIM INFORMATION				
172	2300	CLM02	Total Claim Charge Amount	Amount must be greater than '0'. Total Claims Charge Amount must equal the sum of the line item charge amounts (SV102).
174	2300	CLM07	Medicare Assignment Code	BCBSKC: For secondary or tertiary claims, if one of the prior payers is Medicare, this field must be populated accurately in order to ensure accurate payment.
220	2300	AMT02	Patient Amount Paid	A negative value will result in the claim being rejected.
221	2300	AMT02	Total Purchased Service Amount	A negative value will result in the claim being rejected.
247	2300	NTE02	Claim Note Text	Characters that can be used as delimiters cannot be used in narrative.
248	2300	CR102	Patient Weight	A negative value will result in claim rejection.
250	2300	CR106	Transport Distance	A negative value will result in claim rejection.
265	2300	HI01-2 HI02-2 HI03-2 HI04-2 HI05-2 HI06-2 HI07-2 HI08-2	Health Care Diagnosis Code	Must be submitted without decimal points. BCBSKC: A valid diagnosis code is required on all claims for adjudication.
LOOP 2310A – REFERRING PROVIDER NAME				
284	2310A	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI.

Page	Loop	Seg.	Data Element	Comments
284	2310A	NM109	Identification Code	Must be a valid 10-digit NPI number if submitting 'XX' in the 2310A NM108.
LOOP 2310B – RENDERING PROVIDER NAME				
290	2310B	N/A	N/A	Do not submit rendering provider if it is the same as the billing provider in 2010AA.
290	2310B	N/A	N/A	Required for PHP and most commercial claims.
292	2310B	NM108	Identification Code Qualifier	Must be 'XX' if submitting NPI. Required if different than billing NPI.
292	2310B	NM109	Rendering Provider Identifier	Must be a valid 10-digit NPI number if submitting 'XX' in the 2310B NM108.
296	2310B	REF01	Reference Identification Qualifier	Some commercial payers may require 'SY' or 'EI' at this level.
297	2310B	REF02	Rendering Provider Secondary Identifier	Some commercial payers may require a Tax ID Number at this level.
LOOP 2320 – OTHER SUBSCRIBER INFORMATION				
318	2320	N/A	N/A	BCBSKC: Blue Cross and Blue Shield of Kansas City requires that 837P claims with COB information contain all COB information at the line level (Loop 2430). You may send COB information at the claim level (Loop 2320), but 837P COB claims without line level (Loop 2430) data will be denied for incorrect or inadequate COB information.
332	2320	AMT02	Payer Paid Amount	All Payers: A negative value will result in claim rejection.
334	2320	AMT02	Allowed Amount	All Payers: A negative value will result in claim rejection.
LOOP 2400 – SERVICE LINE				
402	2400	SV102	Line Item Charge Amount	Negative value will result in claim being rejected.
403	2400	SV104	Units or Minutes	Negative value will result in claim being rejected.
413	2400	CR102	Patient Weight	Negative value will result in claim being rejected.
414	2400	CR106	Transport Distance	Negative value will result in claim being rejected.
473	2400	REF02	Line Item Control Number	EDI Midwest: Only the first 20 characters will be passed on to the payer.
479	2400	REF02	Ambulatory Patient Group Number	EDI Midwest: Only the first 3 characters will be passed on to the payer.
483	2400	REF02	Universal Product Number	EDI Midwest: Only the first 14 characters will be passed on to the payer.
490	2400	PS102	Purchased Service Charge Amount	Negative value will result in claim being rejected.
497	2400	HCP06	Approved APG Code, Pricing	EDI Midwest: Only the first 3 characters will be passed on to the payer.
LOOP 2420A – RENDERING PROVIDER NAME				
501	2420A	N/A	N/A	HNNY: HealthNow processes rendering provider information at the claim level only (Loop 2310B or 2010AA). Line level rendering provider information submitted in loop 2420A will be ignored and not considered in the adjudication process.

Page	Loop	Seg.	Data Element	Comments
LOOP 2430 – LINE ADJUDICATION INFORMATION				
554	2430	N/A	N/A	BCBSKC: Blue Cross and Blue Shield of Kansas City requires that 837P claims with COB information contain all COB information at the line level (Loop 2430). You may send COB information at the claim level (Loop 2320), but 837P COB claims without line level (Loop 2430) data will be denied for incorrect or inadequate COB information.

997 – Functional Acknowledgement

1. We suggest retrieval of the TA1 & ANSI 997 functional acknowledgement files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.
2. The version of the 837 inbound transactions will be returned in the GS08 (Version/Release/Industry/Identifier Code) of the 997.
3. Separate response files and/or reports are created for each ISA-IEA Interchange within a physical file.

Claims Confirmation Report

1. The Claims Confirmation Report can only return the value in the first occurrence of the 2010AA-REF02. If a TP wants the billing provider number to be returned on the Claims Confirmation Report it must be submitted in the first occurrence of the 2010AA-REF02.
2. Separate response files and/or reports are created for each ISA-IEA Interchange within a physical file.
3. A separate batch is created for each 2000A HL submitted within a file. To keep the Claims Confirmation Report to a minimum, it is strongly recommended that only one 2000A HL segment be submitted for each Billing Provider and Payer.

Suggestions for Generating Data Interchanges

1. From the aspect of the ASC X12 and the Implementation Guides, more than one ST/SE segment set *may* be used with one functional group (GS/GE segment set).
2. We recommend, though, that a single ST/SE segment set be generated per GS/GE segment set and that a single GS/GE segment set be generated per ISA/IEA segment set. This will eliminate the chances of multiple billing providers' transactions being rejected on a 997 if there is a problem within only one ST/SE segment set.
3. If claims are being submitted for a single Billing Provider number, we recommend a single 2000A-HL Loop be generated within the single ST/SE segment set for that Billing Provider Number.
4. If claims are being submitted for multiple Billing Provider Numbers, we recommend that a separate data interchange (ISA/IEA segment set with a single GS/GE segment set with a single ST/SE segment set and a single 2000A-HL loop) be generated for each Billing Provider Number.