



EDI Claims Companion Guide

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Acknowledgement

BMC HealthNet Plan (the Plan) acknowledges The New England HIPAA Workgroup (NEHW) subcommittee on EDI/TCS as the original source of this *EDI Companion Guide* provided by Blue Cross Blue Shield.

Introduction

In order to make claims submission easier for providers, and for required compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) Transaction and Code Set standards, we process electronic claims in the X12N 837 version 4010A1 format.

The Plan made significant investments in infrastructure, established relationships with five major clearinghouses (Emdeon, Gateway EDI, MedAvant, RelayHealth—a.k.a. McKesson and Per-Se—, and The SSI Group), joined the New England Healthcare EDI Network (NEHEN), and conducted extensive testing of telecom and information systems, tools, and processes to implement this capability.

As you know, HIPAA requires that the Plan and all other health insurance payers in the United States comply with electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The X12N 837 version 4010A1 (Addenda) implementation guides for Health Care Claims have been established as the standard for claims transactions compliance. The implementation guides for this format are available electronically at <http://www.wpc-edi.com/HIPAA>.

This document has been prepared as a BMC HealthNet Plan-specific companion document to that implementation guide and will clarify when conditional data elements and segments must be used for BMC HealthNet Plan reporting. It also will identify those situations and data elements that do not apply to BMC HealthNet Plan. This companion guide document supplements but does not supercede any requirements in the 837 version 4010A1 (Addenda) implementation guides.

The intended audiences for this document are the billing departments and the technical areas responsible for submitting electronic claims transactions to the Plan. In addition, this information should be communicated to and coordinated with the provider's billing office in order to ensure that the required billing information is provided to the billing agent/submitter.

Important Reminders

To ensure that your claims are processed through to adjudication:

1. In accordance with HIPAA rules, BMC HealthNet Plan accepts the National Provider Identifier (NPI); while we are not rejecting 837 files that contain legacy identifier, we do *not* use them for adjudication purposes. Please note that all NPIs must be registered with the Plan. In addition, the Plan reads NPIs in combination with tax IDs or Social Security numbers (tax IDs take precedence) to identify rendering providers, so we must have that combination on file for adjudication purposes (except in certain Behavioral Health or specialty situations, depending on providers' contracted situations). Visit our website to learn how to submit your NPI information:
http://www.bmchp.org/pages/providers/provider_hipaa_npi_information.aspx
2. *If your NPI and/or Tax ID is not provided or is not in the correct place the claim will be rejected.* Your NPI must be in the equivalent of UB-04 Form Locator 51 or CMS-1500 Box 24J or CMS-1500 Box 33. Please see Appendices B and C for valid locations for the BMCHP Provider ID on the 837 format.
3. A valid Plan-assigned member identification number (a.k.a. a B number; e.g., B12345678) must be provided. *If this number is not provided or is in the wrong place the claim will be rejected.* Please see Appendices B and C for valid locations for the member ID on the 837 format.
3. Modifiers must be appended to the CPT/HCPCS codes in the line items where they apply.
4. Claims requiring attachments (e.g., EOBs, invoices, etc.) cannot be submitted via EDI at this time.
5. Anesthesia claims must use ASA codes. Units must be in minutes—not in fractions of hours or days.
6. BMC HealthNet Plan can accept claim replacement (frequency code 7) and void (frequency code 8) transactions in the 837 formats, but adjustments or voids of any claims that have been split **MUST** be submitted on paper. See Pages 17 & 18 for details.
7. BMC HealthNet Plan accepts 837 Institutional and 837 Professional files written to the Addenda specifications (004010X096A1 for 837I, 004010X098A1 for 837P) only.
8. BMC HealthNet Plan can accept 25 total diagnosis codes for 837I (UB-04) claims and 8 total diagnosis codes for 837P (CMS-1500) claims.

9. The filenames of electronic claims files can be no longer than 50 characters, including the extension.

10. Claims with information in the 2320 (Other Subscriber Information) and 2330A-H (Other Subscriber Name – Other Payer Supervising Provider) loops will pend for COB investigation; thus, if your claims generation software populates those loops with information that matches the subscriber data (Loop 2010BA), the claim will be pended and delayed even though there is really no COB.

Example:

```
SBR*P*18*81720500151**MC****MC~  
DMG*D8*YYYYMMDD*M~  
OI***Y*B**Y~  
NM1*IL*1*LASTNAME*FIRSTNAME****MI*B12345678~  
N3*STREET ADDRESS~  
N4*CITY*MA*0000~  
REF*SY*123456789~  
NM1*PR*2*MEDICAID*****PI*MASSHEALTH~
```

Submitting Electronic Claims

BMC HealthNet Plan currently accepts and processes provider claims electronically for all providers and billing agencies who submit claims directly to us or who use Emdeon, MedAvant, RelayHealth, The SSI Group, NEHEN or a billing agency. If you or your billing agency uses one of these clearinghouses, contact the appropriate person below.

Contacts

Type of Connection	Payer ID	Contact Name	Telephone Number	Email Address
Direct	N/A	Sheba Kelly, BMC HealthNet Plan	617-478-3538	Sheba.Kelly@ bmchp.org
NEHEN/ NEHENNet: nehen.org nehennet.org	N/A	<i>Existing NEHEN clients:</i> Contact your site administrator	781-290-1290	neheninfo@ nehennet.org
		<i>Non-clients:</i> Sales department	781-290-1290	neheninfo@ nehennet.org
Clearinghouse: SSI Group thessigroup.com	0515	Sandy D. Hickman EDI Payer Development Coordinator	(251) 345-0000 ext. 1254	Sandy.Hickman @ssigroup.com
		Joan Kossow, Data Compliance Manager	(251) 345-0000 ext. 1218	joan.kossow @ssigroup.com
		Datacenter Group	800-880-3032	edi.operations @ssigroup.com
Clearinghouse: Emdeon emdeon.com	13337	<i>Existing Emdeon clients:</i> Contact your vendor to have BMC HealthNet Plan added to your Payer Table		
		<i>Non-clients:</i> Emdeon Sales	866-369-8805	Businessservicesale @emdeon.com <i>or</i> Physicianinfo @emdeon.com
Clearinghouse: Capario capario.com	13337	<i>Existing Capario clients:</i> Capario Provider Services	800-792-5256 option 2	edi@ capario.com
		<i>Non-clients:</i> Capario Provider Sales Department	800-586-6870	providersales@ capario.com

Type of Connection	Payer ID	Contact Name	Telephone Number	Email Address
Clearinghouse: RelayHealth relayhealth.com/ general/ contactUs/	 3818 (837P) 2921 (837I)	Most existing RelayHealth providers using RelayHealth Clearinghouse Services should contact their practice management system vendor for support. Providers working with RelayHealth directly on support or enrollment matters should contact 800-522-6562 or the ePREMIS support line. To add payer connectivity to BMC HealthNet Plan, providers can reference the payer list on Collaboration Compass and/or add a payer as they generally would based on their system set up.		
Clearinghouse: Gateway EDI gatewayedi.com	13337			salescontact@ gatewayedi.com

Establishing Direct Connectivity with BMC HealthNet Plan

This section addresses connectivity and the transmission of electronic transactions to BMC HealthNet Plan.

Setup

To establish EDI directly with the Plan, contact the Plan representative listed above.

Due to patient confidentiality and HIPAA regulations, all transmissions must be secure.

BMC HealthNet Plan's methods of transmission are:

1) Secure FTP via SSL (AUTH/TLS). A free, Open Source client that works is Filezilla (<http://filezilla-project.org/>).

or

2) Standard FTP using PGP file encryption. The free, Open Source version known as GnuPG (<http://www.gnupg.org/>) is also acceptable.

We will establish a secured, individual FTP directory at BMC HealthNet Plan for the submitter to transfer claim files and to retrieve acknowledgements and claims status reports. We can also periodically retrieve claim files from (and put acknowledgement and initial claims status reports on) an FTP server at the submitter's location.

All BMC HealthNet Plan FTP directories have the following sub-folders:

- ◇ **Archive:** previously submitted files are kept here
- ◇ **Inbox:** new **production** files should be submitted here
- ◇ **Reports:** new and old acknowledgement and claims acceptance reports can be downloaded here
- ◇ **Test:** all **test** files should be submitted here

Testing

This section details the testing procedures for anyone wishing to submit electronic claims directly to BMC HealthNet Plan.

Prior to implementing direct 837 EDI claims submission with the Plan, testing must be successfully completed. The following series of tests will be run.

Phase I: Connection testing

The first phase of testing ensures the ability to exchange files securely. Testing involves exchanging test files (dummy data) through the chosen connection mechanism (e.g., FTP) and encryption/decryption programs (e.g., PGP).

Requirements:

Submitter should have PGP or Secure FTP software installed prior to testing, and keys should be exchanged with BMCHP if necessary. Once an FTP directory is set up here at the Plan, the IP address, username, and password necessary for FTP transmissions will be given to the submitter. Submitter should also have FTP software installed and proper settings in place.

Test Goals:

- ◇ Successful encryption and decryption of files if using PGP
- ◇ Successful secure connection if using Secure FTP
- ◇ Successful transmission of 837 files and reception of reports

Phase II: Initial Content testing

The second phase of testing checks that the claim files are in acceptable form. The submitter is asked to send a file of 15-25 claims using real BMC HealthNet Plan claims/patient data; “comparison copies” on paper or in print-image format should also be sent to the Plan (if neither is possible we can do a system-to-system claims comparison) so that we can make sure everything you want to send is being translated correctly in the 837. A file-naming convention (including some form of incremental date stamp designation) that will work with submitter’s file production/automation processes will be discussed and tested.

Please note that test claims in both paper and electronic formats will NOT be processed for payment; if test claims are sent as a subset of your production batch you must make sure that those claims included in the test are also submitted on paper to BMC HealthNet Plan’s usual claims mailing address.

In addition to checking the 837 against the comparison claims, the Plan will run the submitted 837 against the Claredi HIPAA testing/certification service (<http://www.claredi.com>) to check for HIPAA compliance. Results of that compliance test will be communicated back to the submitter.

Standard Plan acknowledgement and initial claims status reports for test files in this stage will be produced and left on the FTP server for submitters to retrieve. Submitters should make sure they can successfully reconcile reported data and results to what was submitted. See the **Reporting** section below for more info.

If there are significant issues to resolve with 837 formatting, there may be several testing rounds in Phase II, though usually only one or two rounds are needed for successful completion.

If the submitter is a billing agency or software company that bills for multiple Plan providers, additional discussion of how each provider will be differentiated in the 837 will take place. In addition, distribution of acknowledgement and initial claims status reports from the Plan, through the submitter, and back to the individual providers must be successfully tested.

Requirements:

Submitter should produce the test claims in the electronic file and the comparison claims as close to simultaneously as possible. If comparison claims are cut too long after the electronic claims are put in 837 format, additional charges are often added to the patient account (e.g., drugs dispensed or procedures performed) that cause the comparison claims to differ significantly from the electronic claims.

Billing agencies and software companies should be able to separate different providers' claims in the 837s, and should have a way to parse and transmit the Plan reports so that each different provider receives only the reports that pertain to its submitted claims.

Test Goals:

- ◇ Mapping of test 837 claims
- ◇ Content checking to ensure BMCHP-required information is provided properly
- ◇ Establishment of file-naming/incrementing convention
- ◇ Verification of multiple provider submission segment terminators and formatting

Phase III: Final Process testing

The third phase of testing checks that the claims submission process will function correctly from beginning to end (i.e., file submission through claims status report decryption), including BMC HealthNet Plan's automated processes and any automation on the submitter's side. This is primarily a repeat of Phase II but with automation turned on to make sure that hands-off processes still produce clean results.

Requirements:

If the submitter plans to have any processes automated for 837 file generation, transmission, retrieval, and encryption/decryption (if used), those processes should be in place, with appropriate personnel available for contact. Any additional processes internal to the submitter's business flow (e.g., comparing totals for submitted claims to totals reported on the Plan's acknowledgement file) should be worked out and ready to test in this phase.

Test Goals:

- ◇ Problem-free processing of a claims file from start to finish with no automation miscues. File name should be automatically generated and incremented if part of submitter's process.

As part of the testing project, a project plan will be developed that covers the test phase, detailing what type of information should be included in test files, the frequency of test series, the schedule for testing runs, and review of the test results.

When all three test phases are successfully completed, BMC HealthNet Plan and the submitter will agree on a mutually acceptable date to move from testing to production. Production status means that the submitter will no longer have to send “live” paper copies of claims used in testing to the Plan for payment.

Reporting

This section identifies and describes reports issued by BMC HealthNet Plan related to claims submitted electronically. The reports include confirmation that claim files have been received, and preliminary claim rejections (missing elements or segments) and acceptances.

BMC HealthNet Plan’s Claims Transmission Acknowledgement, 997s (if requested), and Initial Claims Status reports are put in the **reports** directory in the submitter’s FTP folder. Reports remain in that directory until the submitter removes them or until a regularly scheduled Plan archiving process takes place. Thus, submitters can remove reports from the directory whenever they are downloaded, or reports can be kept on the server for reference until some later time when the Plan may archive the folder. Even after the Plan’s archiving process has occurred, you can always request a previously available report.

BMC HealthNet Plan Claims Transmission Acknowledgement report

Upon receipt of an 837 from a submitter, the Plan generates a confirmation file, referred to as the “Claims Transmission Acknowledgement report.” The filename of the Claims Transmission Acknowledgement report is automatically assigned by the Plan’s processes, with the characters “.ack” appended. A typical Claims Acknowledgement report filename is ABCDE.20040329.89898.ack, where:

- *ABCDE* is trading partner name agreed upon beforehand
- *20090329* is the date of receipt by the Plan, and
- *89898* is an automatically incremented number used to create unique filenames

Sample BMC HealthNet Plan Claims Acknowledgement report:

```
*****
*                               EDI ACKNOWLEDGEMENT                               *
*****

Received By: Boston Medical Center HealthNet Plan
Received Date: mm/dd/2003

Status: Successful
File: abcde20090329.asc
Submitter: ABCDE
Total Claims: 358
Total Charges: $52,839.29
```

Please note that the Claims Transmission Acknowledgement report indicates only that the Plan successfully received the file. The Total Claims and Total Charges lines do *not* mean that all the claims were accepted into the system nor that all the charges were adjudicated to the listed dollar volume. The totals shown on the Claims Transmission Acknowledgement report are provided so that submitters can check to make sure BMC HealthNet Plan received the correct file.

997 Functional Acknowledgement

A 997 is the Functional Acknowledgment Transaction Set commonly exchanged with 837s, but is not easily readable. 997s are typically used to indicate whether a payer was unable to process a file, but BMCHP currently does process files that fail high-level HIPAA validations, so a 997 indicating failure does *not* mean that an 837 wasn't processed, so 997s do not carry much significance for Plan processing; however, if a submitter's system requires a 997, the Plan *can* supply one.

A typical Plan 997 is named similarly to our Claims Transmission Acknowledgement report: EDI_997ACK_ABCDE.20090329.68686.edi_1_1, where:

- *ABCDE* is trading partner name agreed upon beforehand
- *20090329* is the date of receipt by the Plan, and
- *68686* is an automatically incremented number used to create unique filenames

Sample BMC HealthNet Plan 997:

```
ISA*00*                *00*                *30*043373331          *30*04#####1
*090326*0833*U*00401*287751153*0*P*:
GS*FA*NEAAAA##*NEAAAA##*20090326*08334926*083349*X*004010
ST*997*083349
AK1*HC*3093013
AK2*837*0001
AK5*A
AK2*837*0002
AK5*A
AK9*A*2*2*2
SE*8*083349
GE*1*083349
IEA*1*287751153
```

BMC HealthNet Plan Initial Claims Status report

BMC HealthNet Plan processes claims after 7:00 P.M. EST Monday through Friday. Once a submitter's claims file has been processed, an Initial Claims Status report is generated and made available in the **reports** folder of the submitter's FTP directory by 10 A.M. the following business day. The filename of the Initial Claims Status report is the same as the submitted filename, but with the characters ".err" appended. Thus, if you submit a file named **20040329104.asc**, the Initial Claims Status report for that file will be named **20030701104.asc.err**.

BMC HealthNet Plan's Initial Claims Status reports are in a proprietary yet simple to understand format. Any changes in format will be communicated to and tested with submitters well before changes affect production.

The Plan's Initial Claims Status report lets a submitter know if each of the submitted claims was accepted into the Plan's system for processing, or if it was rejected. If a claim was rejected, the reason will be given (i.e., the NPI and/or the patient's ID was not recognized by our system).

Each claim is listed on the report with the following information:

FIELD NAME	NOTE
Status	"ACCEPTED" or "REJECTED" If you are submitting replacement (frequency code 7) and/or void (frequency code 8) requests (see Page 17), the words "REPLACE" or "VOID" will precede the two status words above, separated by a colon. For example, "VOID:ACCEPTED" or "REPLACE:REJECTED"
Ext Claim No	The ID # for the claim supplied by the submitter or the submitter's clearinghouse or billing agency
Patient Account Number	
Receive Date	The date BMC HealthNet Plan received the claim
Service From Date	
Service To Date	
Member ID	The Member ID supplied by the submitter; if the claim was rejected for Member ID not on File, submitters can check to see what number was actually submitted for the claim
Member First Name	As supplied by the submitter
Member Last Name	As supplied by the submitter
Member Mid Initial	If supplied
Member Date of Birth	As supplied by the submitter
NPI/Tax ID combination	The NPI supplied by the submitter; if the claim was rejected for Provider Not Found, submitters can check to see what number was actually submitted for the claim. Please note that the Plan checks against NPI / Tax ID combinations, so the NPI might be valid but not in combination with the submitted Tax ID.

continued on next page

FIELD NAME	NOTE
Error Number	<p>0..... Claim accepted and processing (including Member Suspension claims)</p> <p>51303..... Member ID not on File</p> <p>51304..... Provider ID not on File</p> <p>The following errors only apply to replacement (frequency code 7) and void (frequency code 8) requests (see Page 17):</p> <p>10010..... Original Claim ID not supplied</p> <p>10020..... Submitted Original Claim ID is not valid</p> <p>10030..... Submitted Original Claim ID has already been adjusted; resubmit request on paper</p> <p>10040..... Provider ID on replacement/void must match provider ID of original claim</p> <p>10050..... Subscriber ID on replacement/void must match subscriber ID of original claim</p> <p>10060..... Submitted Original Claim ID has not been finalized; wait for remittance then resubmit</p>
Error Description	text explanations as above
Charge Amt	The submitted total charge amount for the claim

Rejected claims can be fixed and resubmitted electronically (as new claims, not as corrections), or dropped to paper and sent by regular mail.

“Provider not on File” rejections are usually caused by the NPI/Tax ID combination note being on file with the Plan, or the NPI being in the wrong place. If you have an NPI and you submit Professional (i.e., CMS-1500) claims, please see the sections *Professional Claims (837P) Data Requirements* and *Appendix B* for specific placement information; if you have an NPI and you submit Institutional (i.e., UB-04) claims, please see the sections *Institutional Claims (837I) Data Requirements* and *Appendix C* for specific placement information. If you have an NPI but haven’t registered it with BMC HealthNet Plan, please visit our website (http://www.bmchp.org/pages/providers/provider_hipaa_npi_information.aspx), call your Plan Provider Relations Representative, or call our provider line at 888-566-0008.

Reporting Summary

Report	File Name	Purpose	Turnaround from time of Submission
BMC HealthNet Plan Claims Transmission Acknowledgement report	Default = xxxx.ack, where xxxx shows trading partner initials, date received by the Plan, and a unique numeric	Acknowledgement of file receipt, showing date, filename, total claim volume, total claim dollars.	Available within 8 hours of receipt.

Report	File Name	Purpose	Turnaround from time of Submission
997 Functional Acknowledgement	Default = EDI_997ACK_XXXX.e di_1_1, where XXXX shows trading partner initials, datereceived by the Plan, and a unique numeric	Acknowledgement of file receipt, showing the number of transaction sets in the 837 and the accepted/rejected status of each.	Usually available by end of day when received, sometimes the next business day
BMC HealthNet Plan Initial Claims Status report	Default = XXXX.err, where XXXX is the original submission filename	List of accepted claims, and claims that cannot be processed due to missing or invalid elements or segments.	Available 10:00 A.M. EST the next business day if the Plan receives the file by 7:00 P.M. EST.

Operational Requirements Summary

Submitters must be able to produce 837 files, encrypt them with PGP if they transmit the files to the Plan via regular FTP, or use secure FTP to send the files to the Plan. Testing will validate each of these capabilities, as well as the accuracy of the claims information in the 837 files and the format of the 837 files. *Please note that claims must have a valid member ID and properly located NPI/tax ID combination that has been registered with the Plan to be accepted into our system.*

During the testing stages described above, files should be submitted into the **test** directory in the FTP area assigned to the submitter. In addition, when submitters use live claims data for testing, paper copies of those live claims *must* be submitted to the Plan in the normal manner for payment; *test claims will NOT be processed for payment by BMC HealthNet Plan.* Once a submitter moves out of the testing stage and into “live” production, claims files should be submitted into the **inbox** directory in the FTP area assigned to the submitter.

In both testing and production phases, the Plan will produce a Claims Transmission Acknowledgement report upon receipt of a file (a 997 can be produced if the submitter requests one). In production, electronic claims are processed each business night along with paper claims. The morning after each run, Initial Claims Status reports will be generated and made available. During testing, both reports will be in the **test** directory; when a submitter goes live the reports are made available in the **reports** directory. It is the submitters’ responsibility to periodically archive and remove files from the **reports** directory, though the Plan will clean those directories from time to time.

Claims that cannot be processed are reported in the Initial Claims Status report. These claims are not correctable by BMC HealthNet Plan; if you can resolve the problem yourself, the claims can be resubmitted electronically.

Any questions or problems submitters encounter during the testing/implementation phase should be directed to Sam Evans at 617-748-6175 (sam.evans@bmchp.org) or Sheba Kelly at 617-478-3538 (sheba.kelly@bmchp.org).

Electronic Replacement and Void requests

BMC HealthNet Plan can accept electronic claims with Claim Frequency Codes of 7 (replacement) or 8 (void) in a specific location in the 837:

Loop 2300
Segment CLM
Position 05-3

Example: **CLM*A37YH556*500***11::7*Y*A*Y*Y*C~**

the 7 indicates the claim is a replacement

We *cannot* accept frequency codes of 6 (correction). Late charges should use a frequency code of 5, not 7.

Please note:

- ◇ The 7 frequency code is for replacements only, NOT for late charges.
- ◇ The 837 format allows providers to submit frequency codes in 837 Professional claims (analogous to CMS-1500 claims) as well as 837 Institutional claims (analogous to UB-04 claims).

Void requests and replacement requests **MUST** include the Plan's original claim # in a specific location in the 837:

Loop 2300
Segment REF--Original Reference Number (ICN/DCN)
"F8" must be in Position 01 (the Reference Identification Qualifier)
the BMC claim number must be in Position 02

Example: **REF*F8*E00999999900~**

Void/replace claims without that information will be rejected.

Void and replacements will only be accepted for claims that are in a finalized status. Replacements for claims that have been split **MUST** be sent in on paper—we cannot process those electronically. Void/replace claims for non-finalized claims will be rejected.

Replacement claims can only be processed for the same provider and member IDs that were on the original claim. If a claim needs to have a different member or provider number, a void request must be submitted with the original claim number first, followed by a *new* claim (frequency code 1) with the new member/provider information.

Replacement claims must be complete, with ALL header and line item information that the submitter wants to see on the new claim. For instance, if the submitter wants

to replace an original claim that had seven lines with a claim that has 10 lines, all 10 lines must be submitted on the replacement claim, NOT just the three new lines.

Summary

Electronic replacement (frequency code 7) and void (frequency code 8) requests MUST meet the following requirements for processing:

- ◇ Replacement/Void claims must include the original BMC HealthNet Plan claim number in Loop 2300's Original Reference Number (ICN/DCN) REF segment, with an "F8" in Position 01.
- ◇ The original BMC HealthNet Plan claim referenced by that ID number MUST be in a finalized status.
- ◇ The Member ID and BMC HealthNet Plan provider ID on the replacement/void claims must be the same as what was submitted in the original claim.
- ◇ Electronic replacement claims for original claims that the Plan has split cannot be accepted.

Any replacement/void claims that do not meet ALL of these requirements will be rejected and reported accordingly in the Plan's initial claims status reports.

BMC HealthNet Plan Specific Conditional Data Requirements

Professional Claims (837P) Data Requirements

While electronic submission of claims means that your claims will get to BMC HealthNet Plan faster, supplying the necessary data elements in clean fashion also will help get those claims through the adjudication process quicker. The following guidelines will show you the minimal information that BMC HealthNet Plan needs to quickly process your professional (CMS-1500) claims.

If you use a clearinghouse, third-party billing agency, or software that converts your claims into ASC X12N 837 (004010X098A1) 837P format, please see *Technical Appendix B: Professional (CMS-1500) Claims Mapping to 837P format* for specific file placement requirements.

Please note that BMC HealthNet Plan accepts 837s in the HIPAA-required Addenda format (004010X098A1).

Below is the information required to process your professional claims:

DATA ELEMENT	CMS-1500 BOX NUMBER
National Provider Identifier (NPI)	24J or 33 <i>see Note 1</i>
BMC HealthNet Plan Member ID	1a
Diagnosis Codes	21 <i>see Note 2</i>
Total Charge	28
From/To Service Dates	24A
POS	24B
Charges	24F
Units	24G
Procedure	24D
Procedure Modifier(s)	24D

Notes:

1. The Servicing Provider NPI must be provided in either Box #24J or #33 (or their equivalents on your software). BMC HealthNet Plan always takes the NPI in Box 24J first, so if a submitter wants us to read the NPI in Box 33 there should *not* be an NPI in Box 24J. If a submitter is contracted with BMC HealthNet Plan so that individual practitioners' or clinicians' NPIs are not on file at the Plan, submitting those

individual NPIs in 24J will prevent the Plan from reading the group NPI in Box 33. The Plan also reads NPI/Tax ID combinations, so if we have the correct NPI on file but not with the Tax ID in Box 25, the claim will still reject. If an NPI/Tax ID combination is not found on file, the electronic claim *will reject*.

2. ICD9 diagnosis codes require a fourth and/or fifth digit to be valid and to provide the appropriate specificity for the condition. An example of the diagnosis code is 780.3; it refers to convulsions. In addition, we request that you submit secondary diagnosis data. Please note: When translating provider submissions to 837 formats, diagnosis codes cannot contain decimal points, so 780.3 should be mapped to appear as 7803. BMC HealthNet Plan cannot accept more than eight diagnosis codes in the 837P.

Special Claims

Claim types outlined below will require additional data or specifications, as noted.

- ◇ Adjustments, voids, replacements, etc.
 - Any replacement or void requests for previously submitted claims (e.g., claims frequency codes of 7 and 8) must satisfy the requirements outlined on Pages 17 & 18. Changes to split claims must be submitted on paper.
- ◇ Anesthesia:
 - Units must be in minutes, not fractions of hours or days.
 - Use ASA codes, not surgical codes.
- ◇ COB:
 - Please include as much COB-related information (e.g., accident indicators, accident locations) as you can. BMC HealthNet Plan cannot accept attachments such as other EOBs electronically at this time.
- ◇ DME:
 - **Nonspecific, unlisted and invoice priced codes require attachments;** therefore, BMC HealthNet Plan cannot accept these claims electronically at this time since there is an attachment.
- ◇ Immunizations:
 - Claims seeking additional reimbursement for immunizations normally supplied by the State require an invoice and should not be submitted electronically at this time since there is an attachment.
- ◇ Invoices:
 - Any claim requiring an invoice attachment must be sent on paper at this time.

- ◇ Modifiers:
 - Modifiers must be included in the appropriate location (CMS-1500 Box 24D MODIFIER) next to the CPT/HCPCS code on the line items where they apply.
 - If you use multiple modifiers, pricing modifiers should be in the first modifier position (i.e., statistical modifiers should be placed after a pricing modifier). Please make sure that multiple modifiers are separated by accepted HIPAA delimiting characters (e.g., ;, ^, or >).

- ◇ Newborn Claims:
 - Claims for newborns should be submitted separately from the mother's claims, and with the unique subscriber/member number instead of the mother's.

- ◇ NDC Codes:
 - BMC HealthNet Plan can accept NDC codes electronically, but we cannot use them for adjudication purposes.

- ◇ Year-spanning Claims:
 - Claims with service dates that span a calendar year should be split into two separate claims. For example, a hospital stay beginning on December 27 and ending January 6 should be billed on two separate claims, one covering December 27-31, the other covering January 1-6.

BMC HealthNet Plan Specific Conditional Data Requirements

Institutional Claims (837I) Data Requirements

While electronic submission of claims means that your claims will get to BMC HealthNet Plan faster, supplying the necessary data elements in clean fashion will help get those claims through the adjudication process quicker. The following guidelines will show you the minimal information BMC HealthNet Plan needs to quickly process your institutional (UB-04) claims.

If you use a clearinghouse, third-party billing agency or software that converts your claims into ASC X12N 837 (004010X096A1) 837I format, please see *Technical Appendix C: Institutional (UB-04 Claims Mapping to 837I format)* for specific file placement requirements for this information.

Please note that BMC HealthNet Plan accepts 837s in the HIPAA-required Addenda format (004010X096A1).

Below is the information required to process your institutional claims.

DATA ELEMENT	UB-04 FORM LOCATOR
National Provider Identifier (NPI)	56
BMC HealthNet Plan Member ID	60
Type & Class	4 (0 in first digit) 4 (second digit) & 4 (third digit)
Frequency	4 (fourth digit)
Diagnosis Codes	66 <i>see Note 1</i>
Total Charge	last line of line items (47)
From/To Service Dates	6
Charges	47
Units	46
Revenue Code	42 <i>see Note 2</i>
HCPCS Code	44
Procedure Modifier(s)	44
DRG	71 <i>see Note 3</i>

Notes:

1. ICD9 diagnosis codes require a fourth and/or fifth digit to be valid and to provide the appropriate specificity for the condition. An example of the diagnosis code is 780.3; it refers to convulsions. In addition, we urge you to submit secondary diagnosis data. Please note: When translating provider submissions to 837 formats, diagnosis codes *cannot* contain decimal points, so 780.3 should be mapped to appear as 7803. *BMC HealthNet Plan cannot accept more than 25 diagnosis codes in the 837I.*
2. Procedure Codes should be supplied in addition to Revenue Codes for behavioral health claims to avoid delays in processing.
3. DRG information is required for inpatient claims for MassHealth compliance.

Special Claims

Claim types outlined below will require additional data or specifications, as noted.

- ◇ Adjustments, voids, replacements, etc.
 - Any replacement or void requests for previously submitted claims (e.g., claims frequency codes of 7 and 8) must satisfy the requirements outlined on Pages 17 and 18. Changes to split claims must be submitted on paper.
- ◇ Anesthesia:
 - Units must be in minutes, not fractions of hours or days.
 - Use ASA codes, not surgical codes.
- ◇ COB:
 - Please include as much COB-related information (e.g., accident indicators, accident locations) as you can. BMC HealthNet Plan cannot accept attachments such as other EOBs electronically at this time.
- ◇ DME:
 - Codes ending with 99 require an invoice; therefore, BMC HealthNet Plan cannot accept these claims electronically at this time since there is an attachment.
- ◇ Immunizations:
 - Provider claims seeking additional reimbursement for immunizations normally supplied by the State require an invoice and should not be submitted electronically at this time because of the attachment.
- ◇ Invoices:
 - Any claim requiring an invoice attachment must be sent on paper at this time.

- ◇ Modifiers:
 - Modifiers must be appended to the HCPCS code (UB-04 Form Locator 44) on the line items where they apply. Modifiers *cannot* be appended to the BMC HealthNet Plan Provider ID number.
 - If you use multiple modifiers, pricing modifiers should be in the first modifier position (i.e., statistical modifiers should be placed after a pricing modifier). Please make sure that multiple modifiers are separated by accepted HIPAA delimiting characters (e.g., : or >).
- ◇ NDC Codes:
 - BMC HealthNet Plan can accept NDC codes electronically, but we cannot use them for adjudication purposes.
- ◇ Newborn Claims:
 - Whenever possible, claims for newborns should be submitted separately from the mother's claims, and with the unique subscriber/member number instead of the mother's.
- ◇ Year-spanning Claims:
 - Claims with service dates that span a calendar year should be split into two separate claims. For example, a hospital stay beginning on December 27 and ending January 6 should be billed on two separate claims, one covering December 27-31, the other covering January 1-6.

Appendices

The following appendices are meant to be supplemental material to the official Implementation Guides for the 837 transactions and codesets required by HIPAA.

Appendix A – Control and Identifier Segments for the 837P and 837I files

ISA: Interchange Control Header Segment

837 Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	ISA	INTERCHANGE CONTROL HEADER		
Header	ISA01	Authorization Information Qualifier	00	As advised by Implementation Guides
	ISA02	Authorization Information	null	
	ISA03	Security Information Qualifier	00	As advised by Implementation Guides
	ISA04	Security Information	null	
	ISA05	Interchange ID Qualifier	30 = U.S. federal tax identification number	ZZ is also acceptable
	ISA06	Interchange Sender ID	<i>Submitter's</i> tax ID #	no dash
	ISA07	Interchange ID Qualifier	30 = U.S. federal tax identification number	ZZ is also acceptable
	ISA08	Interchange Receiver ID	043373331	<i>BMCHP's</i> Tax ID #

GS: Functional Group Header Segment

837 Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	GS	FUNCTIONAL GROUP HEADER		
Header	GS02	Application Sender's Code	<i>Submitter's</i> tax ID #	no dash
	GS03	Application Receiver's Code	043373331	<i>BMC HealthNet Plan's</i> Tax ID #

Submitter & Receiver Name Loops

837 Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	NM1	SUBMITTER NAME		
1000A	NM103	Submitter Name	Name or abbreviation of submitter's name	This is used by BMC HealthNet Plan for manual verification of file's origin in case of processing difficulties.
	NM109	Submitter Identifier	<i>Submitter's</i> tax ID #	no dash
Loop	NM1	RECEIVER NAME		
1000B	NM103	Receiver Name	BMC HealthNet Plan	
	NM109	Receiver Primary Identifier	043373331	BMC HealthNet Plan's Tax ID #

Appendix B - Professional (CMS-1500) Claims Mapping to 837P format

Notes:

1. Claims submitted via EDI to BMC HealthNet Plan require a valid **NPI/Tax ID combination that is registered at BMC HealthNet Plan** *and* a valid **nine-digit Plan Member B#** for acceptance.
2. BMC HealthNet Plan looks for the NPI in the following loop order: 2420A (rendering provider—service line), 2310B (rendering provider), 2010AA (billing provider). Once an NPI is found, other NPIs are not used for adjudication purposes.
3. In addition to the NPI, BMC HealthNet Plan uses the rendering provider’s tax ID to identify the correct provider for adjudication. The Plan looks for the rendering provider’s tax ID in the following loop order: 2420A, 2310B, 2010AA (the same loop order as we look for the NPI). Once a tax ID is found, other tax IDs are not used for adjudication purposes.
4. We accept 837Ps only in the HIPAA-required Addenda format (004010X098A1).

837P Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	NM1	RENDERING PROVIDER NAME		
2310B or 2420A	NM108	Identification Code Qualifier	XX = Healthcare Financing Administration National Provider Identifier	If you supply an NPI in the 2420A loop, that info will override any NPI you supply in the 2310B or 2010AA loops. Thus, if the NPI you have registered with BMC HealthNet Plan is in the 2010AA loop, please make sure that there is no NPI in the 2420A or 2310B loops, since we will read the NPI in those “lower level” loops first and ignore the NPI in 2010AA for adjudication purposes. See Note 1 above.
	NM109	Identification Code	10-digit NPI	See Notes 1 & 2 above

837P Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop REF RENDERING PROVIDER SECONDARY ID				
2310B or 2420A	REF01	Reference Identification Qualifier	EI = Employer's identification number	This is necessary because BMC HealthNet Plan uses the NPI and Tax ID in combination for adjudication purposes. See Note 3 above.
	REF02	Reference Identification	Rendering provider's tax ID	Or Social Security number if that is what was registered with BMC HealthNet Plan; the REF01 qualifier for Social Security number is "SY"
Loop NM1 BILLING PROVIDER NAME				
2010AA	NM108	Identification Code Qualifier	XX = Healthcare Financing Administration National Provider Identifier	This NPI is usually the group NPI (Type 2), which isn't always necessary for our adjudication; but if the rendering provider's NPI is provided in Loop 2420A or 2310B the NPI in 2010AA will not be used for adjudication, so its inclusion in the claim is encouraged.
	NM109	Billing Provider Identifier	10-digit NPI	See Note 2 above
Loop REF BILLING PROVIDER SECONDARY ID				
2010AA	REF01	Reference Identification Qualifier	EI = Employer's identification number	This is necessary because BMC HealthNet Plan uses the NPI and tax ID in combination for adjudication purposes. See Note 3 above.
	REF02	Reference Identification	Billing provider's tax ID	Or Social Security number if that is what was registered with BMC HealthNet Plan; the REF01 qualifier for SSN is "SY"

837P Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop NM1 PAYER NAME				
2010AA	NM103	Payer Name	BMC HealthNet Plan	
	NM108	Identification Code Qualifier	PI = Payer identification	
	NM109	Identification Code	043373331	BMC HealthNet Plan's Tax ID #
Loop NMI SUBSCRIBER NAME				
2010BA	NM108	Identification Code Qualifier	MI = Member ID #	
	NM109	Subscriber Primary Identifier	Nine-digit member identifier	Required. See Note 1 above. The Plan prefers the B# we assign to members.
Loop CLM CLAIM INFORMATION				
2300	CLM01	Patient Account Number		Necessary for Remittances.
	CLM02	Total Claim Charge Amount		
Loop HI CLAIM INFORMATION				
2300	HI01-1	Diagnosis Type Code	BK = Principal diagnosis	BMC HealthNet Plan can only accept eight diagnosis codes
	HI01-2	Diagnosis Code		No decimal points.
Loop REF CLAIM IDENTIFICATION NUMBER				
2300	REF01	Reference Identification Qualifier	D9 = Claim number	<i>Optional</i>
	REF02	Clearinghouse Trace Number		Usually used by Clearinghouses: any unique internal reference number the Submitter can use to identify a claim that errors.
Loop CLAIM INFORMATION for REPLACEMENT/VOID REQUESTS				
2300	CLM05-3	Claim Frequency Code	7 = replacement 8 = void	See Page 17 above
	REF01	Original Reference Number (ICN/DCN)	F8 = Original reference #	
	REF02	Claim Original Reference Number		The original BMC HealthNet Plan Claim ID number

837P Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	REF	RENDERING PROVIDER SECONDARY ID		
Loop	SV1	PROFESSIONAL SERVICE – SERVICE LINE		
2400	SV101-2	Procedure Code		
	SV101-3 SV101-4	Procedure Code Modifier(s)		
	SV102	Line Item Charge Amount		
	SV103	Unit or Basis for Measurement Code		For Anesthesia, use MJ (= minutes).
	SV104	Service Unit Count		For Anesthesia, use # of minutes; no fractions.
	SV105	Place Of Service Code		
Loop	DTP	DATE – SERVICE DATE		
2400	DTP03	Service Date		Single date or From/To Service Dates.

Appendix C - Institutional (UB-04) Claims Mapping to 837I format

Notes:

1. Claims submitted via EDI to BMC HealthNet Plan require a valid **NPI/tax ID combination that is registered at BMC HealthNet Plan** *and* a valid **nine-digit member B#** for acceptance.
2. BMC HealthNet Plan looks for the NPI in the following loop order: 2010AA (billing provider), 2010AB (pay-to provider), 2310E (service facility), 2310A (attending physician). Once an NPI is found other NPIs are not used for adjudication purposes.
3. In addition to the NPI, BMC HealthNet Plan uses the rendering provider's tax ID to identify the correct provider for adjudication. BMC HealthNet Plan looks for the rendering provider's tax ID in the following loop order: 2010AA, 2010AB, 2310E, 2310A (the same loop order as we look for the NPI). Once a tax ID is found other tax IDs are not used for adjudication purposes.
4. We accept 837Is only in the HIPAA-required Addenda format (004010X096A1).

837I Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	NM1	BILLING PROVIDER NAME		
2010AA	NM108	Identification Code Qualifier	XX = Healthcare Financing Administration National Provider Identifier	
	NM109	Identification Code	10-digit NPI	See Notes 1 & 2 above
Loop	REF	RENDERING PROVIDER SECONDARY ID		
2010AA	REF01	Reference Identification Qualifier	EI = Employer's identification number	This is necessary because BMC HealthNet Plan uses the NPI and tax ID in combination for adjudication purposes. See Note 3 above.
	REF02	Reference Identification	Rendering provider's tax ID	Or Social Security number if that is what was registered with BMC HealthNet Plan; the REF01 qualifier for SSN is "SY"

837I Implementation Guide Data

Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop NMI SUBSCRIBER NAME				
2010BA	NM108	Identification Code Qualifier	MI = Member ID #	
	NM109	Subscriber Primary Identifier	Nine-digit member ID	Required. See Note 1 above. The Plan prefers the B# we assign to members.
Loop CLM CLAIM INFORMATION				
2300	CLM01	Patient Account Number		Necessary for Remittances.
	CLM02	Total Claim Charge Amount		
	CLM05-1	Facility Type Code		
	CLM05-3	Claim Frequency Code		
Loop DTP CLAIM INFORMATION – STATEMENT DATES				
2300	DTP03	Statement From or To Date		Statement dates loop.
Loop HI CLAIM INFORMATION – DIAGNOSIS INFORMATION				
2300	HI01-1	Code List Qualifier Code	BK = Principal Diagnosis	BMC HealthNet Plan can only accept 25 maximum
	HI01-2	Diagnosis Code		No decimal points.
Loop HI CLAIM INFORMATION – DRG INFORMATION				
2300	HI01-1	Code List Qualifier Code	DR = Diagnosis Related Group	
	HI01-2	DRG Code		
Loop REF CLAIM IDENTIFICATION NUMBER				
2300	REF01	Reference Identification Qualifier	D9 = Claim Number	<i>Optional</i>
	REF02	Value Added Network Trace Number		Usually used by Clearinghouses: any unique internal reference number the Submitter can use to identify a claim that errors.

837I Implementation Guide Data				
Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop CLAIM INFORMATION for REPLACEMENT/VOID REQUESTS				
2300	CLM05-3	Claim Frequency Code	7 = replacement 8 = void	See Page 17 above
	REF01	Original Reference Number (ICN/DCN)	F8 = Original Reference Number	
	REF02	Claim Original Reference Number		The original BMC HealthNet Plan Claim ID number
Loop SV2 INSTITUTIONAL SERVICE LINE – SERVICE LINE #				
2400	SV201	Service Line Revenue Code		Four digits (zero-filled at the beginning) if possible
	SV202-2	Procedure Code		
	SV202-3 SV202-4	Procedure Code Modifier(s)		
	SV203	Line Item Charge Amount		
	SV204	Unit or Basis for Measurement Code		For Anesthesia, use MJ (= minutes).
	SV205	Service Unit Count		For Anesthesia, # of minutes; no fractions.