BOSTON MEDICAL CENTER
HEALTHNet PLAN

EDI Claims Companion Guide for 5010

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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 5010 Errata format.

Electronic claims can be submitted directly to the Plan, or via clearinghouses and billing agencies. (see the Contacts section for more information).

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 5010 Errata 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.

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 5010 Errata 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. The Plan can accept ICD-10 codes with upper-case characters only and without decimal points. Claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied. Please see our website for more info about submitting ICD-10 codes: http://www.bmchp.org/providers/claims/icd-10-info.

2. In accordance with HIPAA rules, BMC HealthNet Plan accepts the National Provider Identifier (NPI); 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

3. *If your NPI and/or Tax ID is not provided or is not in the correct place the claim will be rejected.* Your rendering/servicing provider NPI must be in the equivalent of UB-04 Form Locator 51 or CMS-1500 Box 24J or CMS-1500 Box 33. *Please note*: 5010 compliance rules state that if the rendering provider information is the same as the billing provider information, rendering provider information should *not* be sent in the 837. Please see Appendices B and C for valid locations for the BMCHP Provider ID on the 837 format.

4. A valid Plan-assigned member identification number (e.g., a B number, such as 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. Please note that claims for members of our Employer Choice/Commonwealth Choice plans should include the two-digit suffix (e.g., C1234567801).

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 Page 18 for details.

7. BMC HealthNet Plan accepts 837 Institutional and 837 Professional files written to the 5010 Errata specifications (005010X223A2 for 837I, 005010X222A1 for 837P) only.

8. BMC HealthNet Plan can accept 25 total diagnosis codes for 837I (UB-04) claims and 12 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 through 2330I (Other Subscriber Name – Other Payer Billing Provider) loops may pend for COB investigation; thus, if your claims generation software populates those loops with information that matches the subscriber data (Loop 2010BA), the claim might 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~

11. NDC codes required effective with 6/1/2012 date of service:

    To meet compliance standards outlined in the Deficit Reduction Act (DRA) of 2005 and the Commonwealth of Massachusetts regulations, **effective with date of service June 1, 2012**, BMC HealthNet Plan (the Plan) will require the 11 digit national Drug Code Number (NDC) to be reported on all qualifying claim forms when injectable physician-administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations.

    Providers will need to submit claims with both HCPCS and NDC codes to the Plan with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx), as well as the NDC units and descriptors. This coding requirement will apply only to all BMC HealthNet Plan MassHealth members. Failure to submit the exact applicable NDC number, units and descriptors administered to the MassHealth member will result in a front-end rejection and/or denial of the claim line that required NDC reporting.

    For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network-notifications).

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 Allscripts/PayerPath, Capario, Emdeon, Gateway EDI, , RelayHealth, the SSI Group, NEHEN (the New England Healthcare Exchange Network), 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
D I R E C T	N/A	Sheba Kelly, IT Ops Support BMC HealthNet Plan	617-478-3538	ITOpsSupport@ BMCHP- wellsense.org
Clearinghouse: **Allscripts** allscripts.com	13337	*Existing Allscripts clients:* Allscripts providers should contact their Allscripts support team		
		Non-clients: Sales	800-334-8534	
Clearinghouse: **Capario** capario.com	13337	*Existing Capario clients:* Capario Provider Services	800-792-5256 option 2	edi@ capario.com
		Non-clients: Capario Provider Sales Department	800-586-6870	providersales@ capario.com
Clearinghouse: **Emdeon** emdeon.com	13337	*Existing Emdeon clients:* Contact your vendor to have BMC HealthNet Plan added to your Payer Table		
		Non-clients: Emdeon Sales	866-369-8805	Physicianinfo @emdeon.com
Clearinghouse: **Gateway EDI** gatewayedi.com	13337	General info line	800-969-3666	salescontact@ gatewayedi.com
NEHEN/ **NEHEN*Net*:**		*Existing NEHEN clients:* Contact your site administrator	781-290-1290	nehennet@csc.com

nehen.org nehennet.org	N/A	*Non-clients:* Sales department	781-290-1290	neheninfo@ nehennet.org

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: **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: **ZirMed** zirmed.com	13337	David Meier	502-238-9231	david.meier@zirmed.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 under Contacts > Direct.

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), FTPS, or SFTP.

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

Some submitters may see an additional directory:

- <> **835**: ERAs can be retrieved 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.

Testing *(continued)*

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 host 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, 999s, TA1s, 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.20120229.89898.ack, where:

- *ABCDE* is trading partner name agreed upon beforehand
- *20120229* 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/yyyy

         Status: Successful
           File: abcde20120229.asc
      Submitter: ABCDE
   Total Claims: 358
  Total Charges: $52,839.29
    EDI Version: 5010
```

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.

999/TA1 Functional Acknowledgements

A 999 is the Functional Acknowledgment Transaction Set commonly exchanged with 837s, but is not easily readable. 999s are typically used to indicate whether a payer was unable to process particular claims in the file. Claims shown as rejected in a 999 should be fixed per the rejection reason in the 999 and resubmitted (as new claims). A TA1 that shows a rejection (a.k.a., a negative TA1) indicates that there was a problem in the header levels of the 837, meaning that none of the claims in the 837 were processed. Receipt of a negative TA1 can be most easily resolved by contacting the Plan representative listed in the Contacts > Direct section above.

A typical Plan 999 is named similarly to our Claims Transmission Acknowledgement report: 999_##_#_ABCDE.20120102.999999.edi, where:

- ##_# is a system-generated incremental identifier
- *ABCDE* is BMCHP's internal trading partner mnemonic
- *20120102* is the date of receipt by the Plan, and
- *999999* is an automatically incremented number used to create unique filenames

Sample BMC HealthNet Plan 999:

```
ISA*00*          *00*          *30*043373331      *30*#########
*120103*1133*^*00501*000000001*0*P*:~
GS*FA*043373331*##########*20120103*11330043*1*X*005010X231A1~
ST*999*1001*005010X231A1~
AK1*HC*118922*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK2*837*0002*005010X222A1~
IK5*A~
AK2*837*0003*005010X222A1~
IK3*NM1*27*2310*I9~
CTX*SITUATIONAL TRIGGER*NM1*11*2310*9~
CTX*CLM01:ABC123~
IK5*R*I5~
AK9*P*3*3*2~
SE*13*1001~
GE*1*1~
IEA*1*000000001~
```

If you need help interpreting a 999, please contact the Plan representative listed in the Contacts > Direct section above.

A typical Plan TA1 is named similarly to our Claims Transmission Acknowledgement report: TA1_#_ABCDE.20120102.999999.edi, where:

- # is a system-generated incremental identifier
- *ABCDE* is BMCHP's internal trading partner mnemonic
- *20120102* is the date of receipt by the Plan, and
- *999999* is an automatically incremented number used to create unique filenames

Sample BMC HealthNet Plan TA1:

```
ISA*00*          *00*          *30*043373331      *30*#########
*120102*1215*^*00501*000000002*0*P*:~
TA1*000118922*120102*0415*A*000~
IEA*0*000000002~
```

If you need help interpreting a TA1, please contact the Plan representative listed in the Contacts > Direct section above.

BMC HealthNet Plan Initial Claims Status report

BMC HealthNet Plan processes claims starting at 9:00 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 before noon the following business day. The Plan cannot produce a 277CA file at this time.

The filename of the Initial Claims Status report is the same as the submitted filename, but with a date/timestamp and the characters ‒.err‖ appended. Thus, if you submit a file named **20120229104.asc**, the Initial Claims Status report for that file will be named **20120229104.asc_20122295611.err**, where the 20122295611 is the yyyymdhmss date format of when the file was produced

BMC HealthNet Plan's Initial Claims Status reports are in a proprietary yet simple to understand format; the data elements are separated by commas, meaning you can open it in spreadsheet programs like Microsoft Excel. 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). Please note that any claims reported as rejected in a 999 report will *not* be included in the Initial Claims Status report once 5010 Compliance checking is turned on for a trading partner.

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 18), 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
Provider ID	If the claim was rejected for processing because the submitted NPI/Tax ID combination was not recognized, this field will be empty. Otherwise, the Plan's IDfor the servicing provider is displayed here.
Error Number	**0**.....Claim accepted and processing) **51303**.....Member ID not on File **51303**.....Subscriber/Member ID Invalid **51303**.....Patient Last Name Invalid **51303**.....Patient First Name Invalid **51303**.....Patient DOB Invalid **51303**.....Member Name Invalid **51303**.....Member Name and DOB Invalid **51304**.....Provider ID not on File The following errors only apply to replacement (frequency code 7) and void (frequency code 8) requests (see Page 18): **10010**.....Original Claim ID not supplied **10020**.....Submitted Original Claim ID is not valid **10030**.....Submitted Original Claim ID has already been adjusted; resubmit request on paper **10040**.....Provider ID on replacement/void must match provider ID of original claim **10050**.....Subscriber ID on replacement/void must match subscriber ID of original claim **10060**.....Submitted Original Claim ID has not been finalized; wait for remittance then resubmit
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.

Effective January 1, 2016, we extended our member verification process so that the following member demographic elements must match on all claims sent to the Plan for reimbursement:

- Member ID
- Member first and last name
- Member date of birth

If the above data elements do not match, the claim will reject and require resubmission with the correct information. The new rejection reasons are listed in the table above (under the 51303 error number); please note ‑Member ID not on File‖ is the Plan's existing error reason for when the supplied Member ID is not in our system, and that error reason ‑Subscriber/Member ID Invalid‖ indicates that the Member ID including the suffix supplied on the claim refers to a member name that does not match the member name supplied on the claim.

‑Provider not on File‖ rejections are usually caused by the NPI/Tax ID combination not being on file with the Plan, or the NPI being in the wrong place. If 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 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, or if you're billing for an entity that has a different Tax ID than you've billed for before, please 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	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 2 hours of receipt.
999 Functional Acknowledgement/ TA1	999_##_#_ABCDE.2012 0102.999999.edi, where ##_# is a system-generated incremental identifier, ABCDE shows the Plan's internal trading partner mnemonicand 999999 is an incremental filename identifier. The date the file is received	Standard acknowledgement files showing successful processing of claims file or problems that stopped the file from processing	Available no later than 36 hours after receipt of a claims file.

	by the Plan is included. TA1_#_ABCDE.20120102.999999.edi, where # is a system-generated incremental identifier, ABCDE shows the Plan's internal trading partner mnemonic, and 999999 is an incremental filename identifier.		
BMC HealthNet Plan Initial Claims Status report	Default = xxxx_ yyyymdhmss.err, where xxxx is the original submission filename and yyymdhmss is the date/timestampe of when the report was produced	List of accepted claims, and claims that cannot be processed due to missing or invalid elements or segments.	Available no later than 36 48 hours after receipt of file

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 (Plan-assigned numbers are preferred) and properly located NPI/tax ID combination that has been registered with the Plan to be accepted into our system. Claims must also pass HIPAA 5010 compliance rules.*

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 and a 999/TA1 upon receipt of a file. 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; processing delays sometimes occur, but 999/TA1 and Initial Claims Status reports will be generated no later than 48 hours after claims files are received. 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.

Individual 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 (as new claims, not replacement/corrections).

Any questions or problems submitters encounter during the testing/implementation phase should be directed to ITOpsSupport@BMCHP-wellsense.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-- Payer Claim Control Number
"F8" must be in Position 01 (the Reference Identification Qualifier), and the BMC claim number must be in Position 02

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

Void/replace claims without this information will be rejected.

Voids 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 member ID and provider NPI/Tax ID that were on the original claim. If a claim needs to have a different member or provider identifier, 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 Payer Claim Control Number 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 provider NPI/Tax 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 (005010X222A1) 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 only in the HIPAA-required Errata format (005010X222A1).

Below is the information required to process your professional claims:

DATA ELEMENT	**CMS-1500** BOX NUMBER
National Provider Identifier (NPI)	**24J or 33a** *see Note 1*
Provider Tax ID or SSN	**25**
BMC HealthNet Plan Member ID	**1a**
Diagnosis Codes	**21** *see Note 2*
Total Charge	**28**
From/To Service Dates	**24A**
Place of Service (POS)	**24B**
Charges	**24F**
Units	**24G**
Procedure	**24D**
Procedure Modifier(s)	**24D**

Notes:

1. The Rendering 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. 5010 compliance rules state that provider information in Loop 2310B (Rendering Provider Name – claim-level) is *required when the Rendering Provider information is different than that carried in Loop 2010AA (Billing Provider); if not required, do not send.* Additionally, provider information in Loop 2420A (Rendering Provider Name – line-level) is *required when the Rendering Provider NM1 information is different than that carried in Loop 2310B (Rendering Provider – claim-level) OR when Loop 2310B is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop 2010AA (Billing Provider); if not required, do not send.*

3. The Plan will only accept ICD-10 codes with upper case characters; claims submitted with any lower case characters will be denied. ICD-10 codes should not be submitted with decimal points.

   Claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied.

   Please see our website for more info about submitting ICD-10 codes:

   http://www.bmchp.org/providers/claims/icd-10-info

4. The Plan cannot accept more than 12 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 starting on Page 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.

<> Behavioral Health / Durable Medical Equipment Claims
- Behavioral Health providers should call Beacon Health Strategies at 866-444-5155 or send e-mail to edi.operations@beaconhs.com for information about submitting electronic claims. Please note that early intervention (EI) claims should be sent directly to BMC HealthNet Plan, *not* Beacon Health Strategies.
- Durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers should call Northwood, Inc. at 866-802-6471 or visit the company's website at www.northwoodinc.com for information about submitting electronic claims.
- *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

- To meet regulatory requirements, claims with a June 1, 2012 date of service and beyond must include NDC codes when injectable physician-administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations. For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network-notifications).
- BMC HealthNet Plan accepts NDC codes electronically, but we do not 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.

Institutional Claims (837I) Data Requirements

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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 (005010X223A2) 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 (005010X223A2).

Below is the information required to process your institutional claims.

DATA ELEMENT	**UB-04** FORM LOCATOR
National Provider Identifier (NPI)	**56**
Provider Tax ID	**5**
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** *see Note 1*
Total Charge	*last line of line items* **(47)**
From/To Service Dates	**6**
Charges	**47**
Units	**46**
Revenue Code	**42** *see Note 2*
HCPCS Code	**44**
Procedure Modifier(s)	**44**
DRG	**71** *see Note 3*

Notes:

1. The Plan will only accept ICD-10 codes with upper case characters; claims submitted with any lower case characters will be denied. ICD-10 codes should not be submitted with decimal points.

   Any claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied.

   Please see our website for more info about submitting ICD-10 codes:

   http://www.bmchp.org/providers/claims/icd-10-info

2. The Plan cannot accept more than 25 diagnosis codes in the 837I.

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 starting on Page 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.

<> Behavioral Health / Durable Medical Equipment Claims

- Behavioral Health providers should call Beacon Health Strategies at 866-444-5155 or send e-mail to edi.operations@beaconhs.com for information about submitting electronic claims. Please note that early intervention (EI) claims should be sent directly to BMC HealthNet Plan, *not* Beacon Health Strategies.
- Durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers should call Northwood, Inc. at 866-802-6471 or visit the company's website at www.northwoodinc.com for information about submitting electronic claims.
- 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

- To meet regulatory requirements, claims with a June 1, 2012 date of service and beyond must include NDC codes when injectable physician-administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations. For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network-notifications).
- BMC HealthNet Plan accepts NDC codes electronically, but we do not 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 TR3s
	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 if confirmed with the Plan before sending
	ISA06	Interchange Sender ID	*Submitter's* tax ID #	no dash
	ISA07	Interchange ID Qualifier	30 = U.S. federal tax identification number	***Must*** be a 30; we *cannot* process files that have ZZ here
	ISA08	Interchange Receiver ID	043373331	*BMCHP's* Tax ID #
	ISA11		^ or |	As advised by TR3s
	ISA12		00501	As advised by TR3s

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	*Submitter's* tax ID #	no dash
	GS03	Application Receiver's Code	043373331	*BMC HealthNet Plan*'s Tax ID #
	GS08		005010X222 A1 (for 837P) 005010X223 A2 (for 837I)	

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	*Submitter's* 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 **Plan-assigned Member ID** 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 (005010X222A1).

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	**NMI**	SUBSCRIBER NAME		
2010BA	**NM108**	Identification Code Qualifier	MI = Member ID #	
	NM109	Subscriber Primary Identifier	Nine-digit member identifier or 11-digit member identifier (9 + 2-digit suffix) for Employer Choice/Commonwealth Choice plan members	Required. See Note 1 above. The Plan prefers the IDs we assign to members. Member IDs for Employer Choice/Commonwealth Choice members should include the 2-digit suffix
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 12 diagnosis codes in total
	HI01-2	Diagnosis Code		No decimal points.

837P Implementation Guide Data

Position	Segment ID/ Data Element Number	Description	837 Requirements	BMC HealthNet Plan Specific Data/Comments
Loop	**REF**	CLAIM IDENTIFICATION NUMBER		
2300	**REF01**	Reference Identification Qualifier	D9 = Claim number	*Optional*
	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 18above
	REF01	Original Reference Number (ICN/DCN)	F8 = Original reference #	
	REF02	Claim Original Reference Number		The original BMC HealthNet Plan Claim ID number
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.
Loop	**LIN**	DRUG - IDENTIFICATION		
2410	**LIN02**	Product/Service ID Qualifier	N4	Must be used if the claim qualifies for NDC code reporting
2410	**LIN03**	Product/Service ID		The NDC code
Loop	**CTP**	DRUG QUANTITY		
2410	**CTP04**	Quantity		Quantity for the NDC billed
2410	**CTP05-1**	Unit or Basis for Measurement Code		F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit

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 Plan-assigned Member ID** 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 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 (005010X223A2).

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 identifier or 11-digit member identifier (9 + 2-digit suffix) for Employer Choice/Commonwealth Choice plan members	Required. See Note 1 above. The Plan prefers the IDs we assign to members. Member IDs for Employer Choice/Commonwealth Choice members should include the 2-digit suffix
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		

837I Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirements**	**BMC HealthNet Plan Specific Data/Comments**
Loop	**REF**	CLAIM IDENTIFICATION NUMBER		
2300	**REF01**	Reference Identification Qualifier	D9 = Claim Number	*Optional*
	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.
Loop	CLAIM INFORMATION for REPLACEMENT/VOID REQUESTS			
2300	**CLM05-3**	Claim Frequency Code	7 = replacement 8 = void	See Page 18 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.
Loop	**LIN**	DRUG - IDENTIFICATION		
2410	**LIN02**	Product/Service ID Qualifier	N4	Must be used if the claim qualifies for NDC code reporting
2410	**LIN03**	Product/Service ID		The NDC code
Loop	**CTP**	DRUG QUANTITY		
2410	**CTP04**	Quantity		Quantity for the NDC billed
2410	**CTP05-1**	Unit or Basis for Measurement Code		F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit