Blue Cross & Blue Shield of Rhode Island

837 Health Care Claim: Institutional Companion Guide

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PREFACE

This Companion Guide supplements the ASC X12 837 (004010X096A1) Implementation Guide adopted under HIPAA. Its purpose is to clarify the rules and specify the data content when data is electronically transmitted to Blue Cross & Blue Shield of Rhode Island (hereinafter “BCBSRI”). The rules for transmitting data detailed herein are compliant with both X12 syntax and the Implementation Guides. This Companion Guide does not convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

DISCLAIMER

This Companion Guide is considered a living document, and as such, the information provided herein will be subject to change after October 16, 2003 in the event that BCBSRI revises its policies or HIPAA Transactions and Code Sets law is updated or amended.
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Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS).

The ANSI X12N Implementation Guides and Addenda adhere to the final HIPAA Transaction Regulations and have been established as the standards of compliance for electronic transactions. The Implementation Guides are available electronically at www.wpc-edi.com.

Scope

This 837 Institutional Health Care Claim Companion Guide is designed for use in conjunction with the ANSI ASC X12N 837 (004010X096A1) Institutional Health Care Claim Implementation Guide. The specifications contained within this Companion Guide define current functions and provide supplemental information specific to Blue Cross & Blue Shield of Rhode Island (BCBSRI). The information presented is for clarification and does not contradict any requirements in the ANSI X12N Implementation Guides.

The table in Section 7.0 details the additional information directly related to loops, segments, or data elements specific to BCBSRI transactions.

Trading Partners

A BCBSRI EDI trading partner is any business partner (provider, billing service, software vendor, employer group, financial institution, etc.) who transmits to or receives electronic data from BCBSRI.

In order to register as a BCBSRI Trading Partner and begin testing, it is necessary to complete the Trading Partner Registration (TPR) form. In addition, trading partners must print out and complete a copy of the Trading Partner Agreement (TPA) before partner testing can begin. Both documents are located on the BCBSRI Web site (https://www.bcbsri.com/BCBSRIWeb/providers/provider_network_system/companion_guides.jsp). Both original documents must be returned to:

Director, EDI & Electronic Information Exchange
ATTN: EDI Trading Partner Agreement & Registration
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903

Working with BCBSRI

BCBSRI will work closely with its trading partners to establish effective communication protocols and to resolve any connectivity issues that may arise regarding the exchange of HIPAA-related electronic transactions.
1.1 Contact Information

The following contact information is provided to assist in the process of implementing 837 transactions:

For Partner Testing:

**BCBSRI HIPAA EDI Testing Support**: 401-459-1970

HIPAA EDI Testing Support business hours are Monday through Friday, 8:00 AM to 4:30 PM.

**Email Address**: HIPAA.EDI.Support@bcbsri.org

For Production:

Call the Information Technology (IT) Service Desk, which supports BCBSRI, at 401-751-1673 or 1-800-343-5743.

Payer Connectivity/Communications

1.2 Transmission Administrative Procedures

BCBSRI Operations personnel will establish logons, passwords and a HIPAA transaction mailbox for each trading partner approved for testing.

1.3 Retransmission Procedures

In the event that issues arise requiring trading partners to resubmit transactions, BCBSRI support personnel will confirm that it is necessary to retransmit the file(s) in question and will forward specific information to the trading partner.

1.4 Communications Protocols

The initial communications will utilize Internet browser technology (IP Protocol) to the secure BCBSRI Web site. It is required that all trading partners have Internet access with an industry standard browser.

BCBSRI provides a Web-based application known as BCBSRI Connect Enterprise System that enables trading partners to:

- Submit (send) HIPAA transactions;
- Receive HIPAA transaction responses; and
- View history files (directory) of all transactions sent and received.

5.3.1 Passwords

Trading partner access will be verified by the logon and password whenever the BCBSRI Connect Enterprise system is accessed.Operation procedures will assure that logons and passwords are initiated, monitored and maintained in a secure manner.
5.3.2 Connecting to BCBSRI via EDI Gateway

Please go to [www.bcbsri.com](http://www.bcbsri.com) and select the Providers tab, HIPAA and Documentation to view or print BCBSRI EDI Gateway, a document that provides detailed instructions on how to connect to the BCBSRI Connect Enterprise System. If necessary, also reference the BCBSRI EDI Gateway Dialup Networking Guide for specific data communications set-up instructions.

Receiver/Sender Identifiers

1.5 ISA-IEA Control Segments/Envelopes

Sender ID interchange control segments: Use ID Qualifier code ZZ in ISA05. The Submitter ID provided by BCBSRI in the Trading Partner Agreement must be used in ISA06 and GS02. ID limited to 8 characters with a leading alpha prefix. Prefixes: P = Production, T = Test.

Receiver ID interchange control segments: Use ID Qualifier code ZZ in ISA07. The Receiver ID (610017) must be used in ISA08 and GS03.


6.1.1 ISA Delimiters

BCBSRI systems will accept the valid delimiters listed below and request that the use of delimiters be restricted to the following:

- * = Element Delimiter
- : = Composite Delimiter
- ~ = Terminator Delimiter

1.6 GS-GE Control Segments/Envelopes

Sender ID interchange control segments: Submitter = GS02.

Receiver ID interchange control segments: Receiver = GS03.

Sender IDs will be assigned.

GS Segments/Reference Codes:

<table>
<thead>
<tr>
<th>Functional Identifier Code</th>
<th>GS01</th>
<th>HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application’s Sender Code</td>
<td>GS02</td>
<td>T00XXXXXX</td>
</tr>
<tr>
<td>Application’s Receivers Code</td>
<td>GS03</td>
<td>610017</td>
</tr>
<tr>
<td>Date</td>
<td>GS04</td>
<td>Date</td>
</tr>
<tr>
<td>Time</td>
<td>GS05</td>
<td>Time</td>
</tr>
<tr>
<td>Group Control Number</td>
<td>GS06</td>
<td>Yes</td>
</tr>
<tr>
<td>Responsible Agency Code</td>
<td>GS07</td>
<td>X</td>
</tr>
<tr>
<td>Version/Release/Industry Identifier Code</td>
<td>GS08</td>
<td>004010X096A1</td>
</tr>
</tbody>
</table>
BCBSRI Specific Business Rules and Limitations

**Claim Models Supported:** BCBSRI will only support the Provider-to-Payer claim model with the exception of BCBSRI Blue on Blue coverage. Therefore, if a payer is secondary to BCBSRI, providers must submit their own secondary claims to the payer. BCBSRI will accept claims from Medicare for which BCBSRI is the secondary payer. Therefore, providers will not have to submit these to BCBSRI.

**Valid Submitters:** BCBSRI will only accept transactions from valid trading partners whose submitter IDs are on file. It will reject transmissions if the submitter ID cannot be validated.

**Enveloping Data:** BCBSRI will accept multiple GS-GE groupings of the same transaction type within the ISA-IEA. (Multiple providers are billed under one submitter.)

**Claim Editing:** In addition to the HIPAA Implementation Guide data requirements, BCBSRI will edit the claims based upon the requirements noted in this document. If any of these edits fail, the claim will be rejected on your Provider Control Report.

**Duplicate Batches:** Duplicate batches of claims should not be submitted for processing. BCBSRI will use GS02, GS04, GS05, and GS06 to determine batch numbers.

The following are specific BCBSRI rules applicable to institutional claims transactions:

<table>
<thead>
<tr>
<th>Item</th>
<th>Loop ID Segment Descriptions, and Element Names</th>
<th>Reference (REF) Designator</th>
<th>HIPAA IG Page Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1000A — SUBMITTER NAME Identification Code Qualifier</td>
<td>NM108, NM109</td>
<td>62, 63</td>
<td>Value 46. Must match the sender ID in the GS02. ID limited to eight characters.</td>
</tr>
<tr>
<td>2.</td>
<td>1000B — RECEIVER NAME Receiver Identifier</td>
<td>NM109</td>
<td>68</td>
<td>Value with 610017. (This is the same value in the GS03.)</td>
</tr>
<tr>
<td>3.</td>
<td>2010A — BILLING PROVIDER NAME Identification Code Qualifier</td>
<td>NM108, NM109</td>
<td>77, 78</td>
<td>Value XX. National Provider Identification (NPI) is required</td>
</tr>
<tr>
<td>4.</td>
<td>2010AA — BILLING PROVIDER NAME Reference Identification Qualifier Billing Provider Additional Identifier</td>
<td>REF01, REF02</td>
<td>83, 84</td>
<td>Value EI for Employer Identification Number or SY for Social Security Number. IDs must be valid and on file at BCBSRI. File Employers Identification number or Social Security number depending on the REF01.</td>
</tr>
<tr>
<td>5.</td>
<td>2010AB — PAY-TO PROVIDER NAME</td>
<td></td>
<td>91</td>
<td>Information sent in this loop will not be used. Payment will be made based upon the provider information in the BCBSRI system in correlation to the billing provider information sent in Loop 2010AA. File with NPI.</td>
</tr>
<tr>
<td>Item</td>
<td>Loop ID Segment Descriptions, and Element Names</td>
<td>Reference (REF) Designator</td>
<td>HIPAA IG Page Number</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------</td>
<td>----------</td>
</tr>
<tr>
<td>7.</td>
<td><strong>2000B — SUBSCRIBER INFORMATION</strong> Claim Filing Indicator Code</td>
<td>SBR09</td>
<td>104</td>
<td>BL indicator required for Blue Cross and Blue CHIP Coordinated Health Plan.</td>
</tr>
</tbody>
</table>
| 8.   | **2010BA — SUBSCRIBER NAME** Subscriber Primary Identifier | NM109                   | 110                 | BCBSRI does NOT issue individual ID numbers to dependents, the subscriber ID must always be sent.  
 **MUST** include the three alpha prefix with the nine numerics for FACETS member IDs (e.g. ZBF123456789). Use BCBSRI ID exactly as it appears on the member’s ID card. 
 **Note:** Dental-only contracts do not have three alpha prefix. |
| 10.  | **2300 — CLAIM INFORMATION** Total Claim Charge Amount Related Causes Information | CLM02 CLM11            | 159 161-162         | Total submitted charges must equal the sum of the line item charge amounts (SV203).  
 **Required** when the condition being reported is accident or employment related. If there is a value in CLM 11, the Occurrence Information segment must be filled in. |
| 11.  | **2300 — CLAIM INFORMATION** Attachment Transmission Code | PWK02                   | 174                 | At this time EL will not be accepted since BCBSRI does not accommodate the 275 transaction. BCBSRI will allow up to 30 days for providers to submit medical documentation when claim is submitted and indicates documentation is forthcoming (by surface mail, fax, or electronically).  
 **EM** – Will not be used for all other subscribers due to Privacy Regulation restrictions.  
 **BM** – Information should be mailed to the following address:  
 **Blue Cross & Blue Shield of Rhode Island**  
 **500 Exchange Street**  
 **Providence, RI 02903**  
 **Attn:** BCBSRI Claims Department |
<p>| 12.  | <strong>2300 — CLAIM INFORMATION</strong> Claim Original Reference Number | REF02                   | 192                 | The original BCBSRI claim number must be submitted with claims if the claim frequency type code (CLM05-3) is 7, 8, or J. |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>Loop ID Segment Descriptions, and Element Names</th>
<th>Reference (REF) Designator</th>
<th>HIPAA IG Page Number</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 13.  | **2300 – CLAIM INFORMATION Present on Admission** | K301                      | 204                  | **Effective March 15, 2010,** in compliance with ASC X12 HIR (HIPAA Implementation Guide Interpretation Requests) #511 Present on Admission Indicator (POA), BCBSRI will require providers to populate e-code information on POA submissions.  

**Note:** Since the original HIR did not accommodate a location for the reporting of the POA indicator for the submitted e-code, BCBSRI requires that e-code POA information MUST be placed in the first byte following the “Z” value. BCBSRI has no exception handling process.  

**POA Reporting Structure:**  
POA values will be reported in Loop 2300 K301 as follows:  

**Location / Value/Definition:**  
Positions 1-3 = POA  
Position 4 = Represents the POA indicator for the principal diagnosis code (HI01 with BK qualifier)  
Position 5 = Begins the reporting of POA indicators for all “other” diagnosis codes, if applicable (HI with BF qualifier)  

- A “Z” value must be reported to indicate the end of reporting of the POA indicators for the “other” diagnosis codes.  
- The byte following the “Z” value represents the POA indicator for a submitted e-code (HI03 with BN Qualifier). If the segment ends in a “Z” value, then the e-code was not submitted.  

**POA Indicator Values**  
Y = Yes  
N = No  
U = Unknown  
W = Clinically undetermined  
1 = Diagnosis code is exempt from reporting of POA  

**Examples Showing Reporting Structure:**  
K3*POAYNUZ~ e-code submitted  
K3*POANZ~ no e-code submitted  
K3*POAYNU1Z1~ e-code submitted  
K3*POAYNU1Z~ no e-code submitted
<table>
<thead>
<tr>
<th>Item</th>
<th>Loop ID Segment Descriptions, and Element Names</th>
<th>Reference (REF) Designator</th>
<th>HIPAA IG Page Number</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 13.  | 2300 – CLAIM INFORMATION Present on Admission | K301                      | 204                 | POA Examples:  
- No e-code submitted in HI03-external cause of injury with BN qualifier:  
  - HI*BK:41091*BJ:486~ (Principle, and Admitting)  
  - HI*BF:4019*BF:2859*BF:72887*BF:7295~ (four other diagnosis codes)  
    - K3*POA1YNU1Z~  
- A single e-code submitted in HI03-external cause of injury with BN qualifier:  
  - HI*BK:41091*BJ:486*BN:E8120~ (Principle, Admitting and External cause of injury)  
  - HI*BF:4019*BF:2859*BF:72887*BF:7295~ (four other diagnosis codes)  
    - 3*POAYNUYZY~  
- An e-code submitted in the external cause of injury element HI03 with BN qualifier and additional e-codes submitted as other diagnoses in the HI segment with BF qualifier:  
  - HI*BK:41091*BJ:486*BN:E8120~ (Principle, Admitting and External cause of injury)  
  - HI*BF:4019*BF:2859*BF:E9470*BF:E9270~ (4 other diagnosis codes; 2 are e-codes)  
    - K3*POAYYNNNZY~ |
<p>| 14.  | 2300 — CLAIM INFORMATION Admitting Diagnosis/Reason for Visit | HI0n-2                    | 227                 | Required on all institutional claims and encounters as well as all unscheduled Outpatient Visits. Must submit definitive diagnosis codes, otherwise claim will be returned. Maximum five characters. Do not send decimals—they are assumed. In addition to the primary and admitting diagnoses, HIPAA allows up to 24 additional diagnosis codes. Only nine of these are directly entered into the claim adjudication system. Up to 12 are saved as informational data. |
| 15.  | 2300 – PRINCIPLE PROCEDURE CODE | HI                         | 243                 | If HI BR segment is used, procedure and date are mandatory. |
| 16.  | 2300 — CLAIM INFORMATION Secondary Procedures Codes | HI0n-2                    | 244                 | In addition to the primary procedure code, HIPAA allows up to 24 additional procedure codes and dates. Only six of these are directly entered into the claim adjudication system. Up to 12 are saved as informational data. |
| 17.  | 2300 — CLAIM INFORMATION Occurrence Span Codes | HI0n-2                    | 257                 | HIPAA allows up to 24 occurrence span codes and dates. Only one of these is directly entered into the claim adjudication system. Up to 12 are saved as informational data. |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>Loop ID Segment Descriptions, and Element Names</th>
<th>Reference (REF) Designator</th>
<th>HIPAA IG Page Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td><strong>2300 — CLAIM INFORMATION</strong>&lt;br&gt;Occurrence Information</td>
<td>HI0n-2</td>
<td>267</td>
<td>HIPAA allows up to 24 occurrence codes and dates. None of these is directly entered into the claim adjudication system. Up to 12 are saved as informational data. Date of Occurrence: Use Occurrence Code BH. Workers Compensation: Use Work Related Occurrence Code 04 Use local codes. Contact Facility Representative, if necessary.</td>
</tr>
<tr>
<td>19.</td>
<td><strong>2300 — CLAIM INFORMATION</strong>&lt;br&gt;Value Codes</td>
<td>HI0n-2</td>
<td>281</td>
<td>HIPAA allows up to 24 value codes and amounts. Only two of these are directly entered into the claim adjudication system. Up to 12 are saved as informational data.</td>
</tr>
<tr>
<td>20.</td>
<td><strong>2300 — CLAIM INFORMATION</strong>&lt;br&gt;Condition Codes</td>
<td>HI0n-2</td>
<td>291</td>
<td>HIPAA allows up to 24 condition codes. Only one of these is directly entered into the claim adjudication system. Up to 12 are saved as informational data. Workers Compensation: Use Work-related Condition Code 02.</td>
</tr>
<tr>
<td>21.</td>
<td><strong>2305 — HOME HEALTH CARE PLAN INFORMATION</strong></td>
<td></td>
<td>314</td>
<td>Home Health services require pre-authorization. Any Home Health Plan of treatment information sent with the claim is saved as informational, but it is not directly entered into the adjudication system.</td>
</tr>
<tr>
<td>22.</td>
<td><strong>2310A — ATTENDING PHYSICIAN NAME</strong>&lt;br&gt;Identification Code Qualifier</td>
<td>NM108</td>
<td>323</td>
<td>Value XX.</td>
</tr>
<tr>
<td></td>
<td>ID Code</td>
<td>NM109</td>
<td>323</td>
<td>File NPI provider identification number</td>
</tr>
<tr>
<td></td>
<td>Reference Identification Qualifier</td>
<td>REF01</td>
<td>326</td>
<td>Required for Inpatient and Home Health. REF segment not used when filing NPI in NM108 &amp; NM109 of 2310A loop.</td>
</tr>
<tr>
<td></td>
<td>Referring Provider Secondary Identifier&lt;br&gt;INPATIENT</td>
<td>REF02</td>
<td>327</td>
<td>SLF000 no longer allowed. A blank Attending/Referring Identification is allowed, you may omit REF segment.</td>
</tr>
<tr>
<td></td>
<td>OUTPATIENT</td>
<td>REF01 REF02</td>
<td></td>
<td>Attending provider not required. When supplied, same rules as Inpatient apply.</td>
</tr>
<tr>
<td>23.</td>
<td><strong>2310C — PROVIDERS OTHER THAN ATTENDING PHYSICIAN</strong></td>
<td></td>
<td></td>
<td>Any information for other provider types reported on the 837 (claim or line level) will not be utilized.</td>
</tr>
<tr>
<td>24.</td>
<td><strong>2330B — OTHER PAYER NAME</strong>&lt;br&gt;Other Payer Primary Identifier</td>
<td>NM109</td>
<td>411</td>
<td>If the subscriber has BCBSRI as a secondary coverage value with 00370, otherwise value with the payer ID of the other payer. If reporting any other payer’s payments at the line, be sure this value matches the value in the SVD01.</td>
</tr>
<tr>
<td>Item</td>
<td>Loop ID Segment Descriptions, and Element Names</td>
<td>Reference (REF) Designator</td>
<td>HIPAA IG Page Number</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------</td>
<td>---------------------------</td>
<td>---------------------</td>
<td>----------</td>
</tr>
<tr>
<td>25.</td>
<td><strong>2400 — SERVICE LINE</strong>&lt;br&gt;Item</td>
<td></td>
<td>444</td>
<td>While HIPAA allows you to bill up to 999 service lines on a claim, please be advised that BCBSRI can process 98 service lines per claim. Any claims received with greater than 98 lines will be split prior to adjudication. NOTE: BCBSRI system will reject claims with a 0001 Revenue Code. Claims will be sent back via BCBSRI provider reporting system.</td>
</tr>
<tr>
<td>26.</td>
<td><strong>2400 — SERVICE LINE</strong>&lt;br&gt;Product or Service ID Qualifier Procedure Code</td>
<td>SV202-1 SV202-2</td>
<td>446 447</td>
<td>BCBSRI only accepts National Standard Procedure Codes except for Workers Compensation claims where local codes are accepted. You should use a procedure code that is appropriate for the services rendered. Please refer to your provider contract for more information regarding use of National Drug Codes. Value ZZ for Workers Compensation claims with local codes.</td>
</tr>
<tr>
<td>27.</td>
<td><strong>2400 — Drug ID Contingency</strong>&lt;br&gt;This does not pertain to UB04.</td>
<td></td>
<td></td>
<td>For NDC codes in ANSIX12 format, file valid J code with HC qualifier or ZZ qualifier with 8-digit NDC number, or use LIN segment with 11-digit NDC with N4 qualifier.</td>
</tr>
<tr>
<td>28.</td>
<td><strong>2410 — Drug Identification</strong>&lt;br&gt;Product or Service ID Qualifier</td>
<td>LIN02 LIN03</td>
<td>A1 – 56</td>
<td>Qualifier N4 – National Drug Code required in S-4-2-format.</td>
</tr>
</tbody>
</table>
### 1.7 Medicare Advantage Claim Filing Requirements

<table>
<thead>
<tr>
<th>Data Element</th>
<th>837 Institutional 004010A1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taxonomy Code</strong>&lt;br&gt;(If you represent an institution with more than one subpart to bill)</td>
<td>2000A Billing/Pay-To Provider Specialty Information Loop&lt;br&gt;PRV Segment; PRV03</td>
</tr>
<tr>
<td><strong>Billing Provider</strong>&lt;br&gt;National Provider Identifier</td>
<td>2010AA Billing Provider Name Loop&lt;br&gt;NM1 Segment; NM109</td>
</tr>
<tr>
<td><strong>Service Location ZIP Code</strong>&lt;br&gt;(if different than Billing Provider ZIP Code)</td>
<td>If services occur at primary location:&lt;br&gt;2010AA Billing Provider Loop&lt;br&gt;N4 Segment; N403&lt;br&gt;If services occur at a secondary location:&lt;br&gt;2310E Service Facility Name&lt;br&gt;N4 Segment; N403</td>
</tr>
<tr>
<td><strong>Treatment Code Information</strong>&lt;br&gt;(for Home Health Claims)</td>
<td><strong>Correction</strong>&lt;br&gt;2300 Claim Information Loop&lt;br&gt;REF Prior Authorization or Referral Number Segment&lt;br&gt;REF01 = G1</td>
</tr>
<tr>
<td><strong>Height and Weight for ESRD Patients</strong></td>
<td>2300 Claim Information Loop&lt;br&gt;HI Value Information Segment&lt;br&gt;HIXX-1 = BE&lt;br&gt;HIXX-2 = Value Code (A9 or A8)&lt;br&gt;HIXX-5 = Height or Weight (based upon the value code)&lt;br&gt;Up to 24 value codes may be reported</td>
</tr>
<tr>
<td><strong>Core Based Statistical Area</strong>&lt;br&gt;(for Home Health and ESRD claims)</td>
<td>2300 Claim Information Loop&lt;br&gt;HI Value Information Segment&lt;br&gt;HIXX-1 = BE&lt;br&gt;HIXX-2 = Value Code (61)&lt;br&gt;HIXX-5 = Core Based Statistical Area (CBSA)&lt;br&gt;Up to 24 value codes may be reported</td>
</tr>
<tr>
<td><strong>Ambulance Pick Up ZIP Code</strong></td>
<td>2300 Claim Information Loop&lt;br&gt;HI Value Information Segment&lt;br&gt;HIXX-1 = BE&lt;br&gt;HIXX-2 = Value Code (A0)&lt;br&gt;HIXX-5 = ZIP Code</td>
</tr>
<tr>
<td><strong>Source of Referral for Admission</strong>&lt;br&gt;(for Home Health Claims)&lt;br&gt;(One alpha-numeric character indicating transfer or admission)</td>
<td>2300 Claim Information Loop&lt;br&gt;CL1 Segment; CL102</td>
</tr>
<tr>
<td><strong>Admitting Diagnosis Code</strong></td>
<td>2300 Claim Information Loop&lt;br&gt;HI Principal, Admitting, E-Code, and Patient Reason for Visit&lt;br&gt;H102-2</td>
</tr>
<tr>
<td><strong>Present On Admission (POA) Indicator</strong></td>
<td>2300 Claim Information Loop&lt;br&gt;K3 Segment</td>
</tr>
<tr>
<td><strong>HIPPS Code for Home Health, Skilled Nursing and Inpatient Rehabilitation</strong></td>
<td>2400 Service Line Number&lt;br&gt;SV2 Segment; SV202-1 = ZZ; SV202-1</td>
</tr>
</tbody>
</table>
Functional Acknowledgement/Reports

1.8 997 Transaction Acceptance Report

Upon receipt of an 837, BCBSRI will respond with a 997 functional acknowledgement transaction to inform the submitter that the transaction has arrived. The 997 transaction may include information regarding the syntactical quality of the 837 transmission, or the extent to which the syntax complies with the standards for transaction sets and functional groups.

```
997.txt
ISA*00*        *00*       *ZZ*610017     *ZZ*T0094675
*090411*1223*U*00401*000000001*0*P*
GS*FA*610017*T0094675*20090111*1223*1*X*004010X096A1
ST*997*0001
AK1*HS*1
AK2*837*0001
AK5*A
AK9*A*1*1*1
SE*6*0001*
GE*1*1
IEA*1*000000001
```

1.9 997 Plain Language Report (Acceptance)

A plain language report confirming the acceptance of a transmission will be issued for the convenience of the trading partner.

```
BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND
PAPERLESS TRANSMISSION ACKNOWLEDGEMENT
FUNCTIONAL ACKNOWLEDGEMENT REPORT
Sender ID Number: 610017
ISA CTRL#: 000000012

FUNCTIONAL GROUP INFORMATION
REPORT DATE-20090414
REPORT TIME-17: 15: 29
SUBMITTER ID: T0001799
Report Id: 20090414171529-120001-850

TRANSACTION INFORMATION
FUNCTIONAL GROUP CONTROL #: 850
NUMBER OF INCLUDED TRANSACTION SETS: 1
NUMBER OF RECEIVED TRANSACTION SETS: 1
NUMBER OF ACCEPTED TRANSACTION SETS: 1

TRANSACTION SET INFORMATION
TRANSACTION SET CONTROL #: 0001
TRANSACTION SET ACKNOWLEDGEMENT STATUS: ACCEPTED
```
1.10 997 Plain Language Report (Rejection/Error)

In the event that a transmission is rejected, a plain language report detailing the reasons for rejection will be issued for the convenience of the trading partner. This is a 997 Rejection Report converted to plain language. The following is a sample report:

```
ISA*00*          *00*          *ZZ*610017         *ZZ*T00XXXXX
*090308*1439*U*00401*000000044*0*T*:
GS*FA*610017*T00XXXXX*20090308*143910*440001*X*004010X096A1
ST*997*0001
AK1*HC*38624-------------AK1-01 Health Care Claim
-------------AK1-02 is your inbound transaction batch id
AK2*837*000000001--------AK2-01 Type of transaction set
AK2-02 The transaction set control number
Carried over from the 837 file in ST segment.
AK3*SV2*2**8-------------AK3-01 Segment in error
AK3-02 Numerical Count position of data that is in error.
AK3-04 Only populated if syntax error is identified Segment Syntax Error Code. “8” means segment has data errors See back of implementation guide for complete listing of syntax error codes.
AK5*R*5------------------AK5-01 Indicates syntax error within entire transaction set.
AK5-02 Will only be populated if a syntax error is identified. “5” means one or more segments in error. See back of Implementation Guide for complete listing of syntax error codes.
AK9*R*1*1*0--------------AK9-01 Functional Group, accept reject condition
AK9-02 Indicates syntax error within Functional Group
AK9-03 Total transaction sets. Carried from 837, GE segment, element 01
AK9-03 Total Received transaction sets
AK9-04 Number of Accepted transaction sets
SE*7*0001
GE*1*440001
IEA*1*000000044
```

Certification and Testing

BCBSRI has partnered with Foresight to provide a 24/7 online tool for self-service transaction validation. To use this tool, download the Trading Partner Agreement (TPA) and Trading Partner Registration (TPR) form from the www.bcbsri.com Web site. Complete the form and return to the Director of EDI & Electronic Information Exchange (refer to page 1). Upon receipt of the signed TPA and TPR, BCBSRI will provide you with a User ID and password allowing you to access the Foresight HIPAA Web site.
<table>
<thead>
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<tr>
<td>1.0</td>
<td>July 18, 2003</td>
<td>Kinkead</td>
<td>Published version incorporating all previous draft versions</td>
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</table>
| 1.1            | November 1, 2003 | Kinkead Santos LePage Reischl | **Section 4.1:** Revised Contact Information  
**Section 7.0, Enveloping Data:** Added “Multiple providers are billed under on submitter” language  
**Section 7.0:** Revised Item # 2, 4, 15, 17, 19, 21, and 24  
**Section 7.0:** Added Item # 5, Subscriber Information, Item # 14 Principle Procedure Code, and Item # 26, Drug ID Contingency  
**Section 7.0, Item # 22:** Deleted “You may want to consider doing this in your system instead of relying on the BCBSRI split process” language |
| 1.2            | December 30, 2003| Kinkead                | **Section 7.0:** Revised Items # 1, 2, 4, 5, 6, 7, 14, 21, 22, 24 and 25  
**Sections 8.1, 8.2 and 8.3:** Revised language  
**Attachment 1:** Revised                                           |
| 1.3            | February 13, 2004| Kinkead                | **Section 1.0:** Deleted reference to Medicare                                                                                                           |
| 1.4            | May 1, 2004      | Kinkead                | **Section 3.0:** Revised language relating to TPR and TPA  
**Section 4.1:** Revised contact information  
**Section 7.0:** Items # 10, 17, and 21 revised  
**Section 8.3:** Revised 997 Error Report  
**Section 9.0:** Revised  
**Attachment 1:** Deleted                                           |
| 1.5            | September 20, 2004| Powers                 | **Section 3.0:** Revised language  
**Section 4.1:** Revised contact information  
**Section 7.0:** Revised #10                                          |
| 1.6            | December 17,2004 | Powers                 | Renaming BCBSRI/BlueCHIP                                                                                                                                     |
| 1.7            | September 28, 2006| Santos                 | **Section 7.0:** Added language for Admitting Diagnosis/Reason for Visit requirement Item # 13                                                              |
| 1.8            | January 4, 2008  | Merola / Santos        | Updated Version, and added NPI requirements  
**Section 7.0:** Revised Items # 4, 5, 6, 21                                                                                                               |
| 1.9            | February 3, 2009 | Merola                 | **Section 7:** Item# 24 Service Line Updated with 10.2 Implementation changes.                                                                          |
| 2.0            | October 29, 2009 | L. Merola D. Santos J. Daniels | **Section 3.0:** Revised contact information  
**Section 4.1:** Revised business hours  
**Section 6.2:** Revised grid  
**Section 7.0:** Revised Claim Editing; Items #4, 8, 13, 17 and 21  
**Section 9.0:** Revised language                                                                                   |
<p>| 2.1            | January 4, 2010  | L. Merola              | <strong>Section 7.0</strong> Revised Item# 13: POA Indicator Implementation Date                                                                                      |
| 3.0            | January 25, 2010 | L. Merola J. Daniels   | <strong>Section 7.0</strong> Revised Item# 13: POA Indicator Implementation Date and POA Examples                                                                     |
| 3.1            | July 14, 2010    | L. Merola S. Romano J. Harvey | <strong>Section 7.1</strong> Added billing requirements for Medicare Advantage claims.                                                                                  |
| 3.2            | September 2, 2010| L. Merola              | <strong>Section 7.1</strong> Correction to: Treatment Code Information (for Home Health Claims)                                                                      |</p>
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<td>October 4, 2010</td>
<td>L. Merola</td>
<td>Section 7.1 Correction to: Treatment Code Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J. Harvey</td>
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