Indemnification: any user of this 837P/I/D Companion Guide shall indemnify, defend and hold harmless Blue Cross & Blue Shield of Mississippi, its officers, employees, directors, affiliated companies and agents from and against any and all third-party claims, actions, demands and lawsuits and all resulting costs, liabilities, damages and expenses, including reasonable attorney's fees arising out of any associated trading partner's use or misuse of these materials.

Claims Transactions (837P/I/D)

Business use

The 837P/I/D transactions are used by providers (or their designees – such as billing agencies or clearinghouses) to submit claims electronically to a payer entity (such as an insurance company.) The transactions contain detailed data items for all aspects of a claim. There are three different versions of electronic transactions which correspond to the three major types of claims:

- 837P – a professional claim, equivalent to using a CMS-1500 claim form
- 837I – an institutional claim, equivalent to using a UB04 claim form
- 837D – a dental claim, similar in nature to the 837P

In order to utilize the 837P/I/D transaction for submission of medical or dental claims for consideration of payment by BCBSMS, the provider must complete the necessary enrollment and receive a submitter ID. After that, the following actions must take place prior to production use of the 837P/I/D transaction:

- Technical communications must be established and tested (refer to the *Communications Specifications* section of this document for more details.)
- Testing of the transaction processing must be performed with good results (again, refer to the *Communications Specifications* section of this document for more details.)

Testing can begin as soon as communications have been established, but all of these requirements must be met in order to begin use of the 837P/I/D transaction in a production environment

Transaction Details

The three transactions for which this Companion Guide gives information are as follows:

- Professional claims transaction (837P) - Version 5, Release 1, Sub-release 0 (5010) - Version/Release/Industry Identifier code for this transaction is 5010X222A1
- Institutional claims transaction (837I) - Version 5, Release 1, Sub-release 0 (5010) - Version/Release/Industry Identifier code for this transaction is 5010X223A2
- Dental claims transaction (837D) - Version 5, Release 1, Sub-release 0 (5010) - Version/Release/Industry Identifier code for this transaction is 5010X224A2

BCBSMS maintains system compatibility with the transaction rules as outlined in the official Technical Report for the above named transactions. The following BCBSMS Usage details are meant to clarify BCBSMS interpretation and usage of the transactions.

Header Information – Envelope and Transaction Level Segments

BCBSMS will only accept transactions which contain one interchange envelope (ISA-IEA segments) per unique submitter ID (ISA06) with one functional group (GS-GE) per envelope, and one transaction set (ST-SE) per functional group.

The ISA, GS, and ST segments should be formatted with the following values (if not noted in this list then follow the usage as specified by X12):

ISA01	Always '00'
ISA03	Always '00'
ISA05	ZZ
ISA06	BCBSMS Submitter ID assigned by EDI Services (see the *Communications Specifications* section of this document)
ISA07	ZZ
ISA08	00230
ISA12	00501
ISA14	Indicates whether an acknowledgement is requested – if requested BCBSMS will generate a 999 transaction with a TA1 segment included
ISA15	Indicates whether these claims are Production (P) or Test (T)
GS01	HC
GS02	Same as ISA06
GS03	Same as ISA08
GS08	005010X222A1 or 005010X223A2 or 005010X224A2
ST01	837
ST03	Same as GS08
GE01	1
IEA01	1

Claim Detail Information

Destination Payer Subscriber Information – loop 2000B

Within the 2000B loop, the SBR09 element must contain the appropriate claim filing indicator for the claims within this loop. The following are valid for BCBSMS processing:

- BL – Blue Cross Blue Shield
- ZZ – State of Mississippi employees

If submitting transactions destined for other payers (where BCBSMS is acting as a clearinghouse), the following SBR09 values are valid:

- MB – Medicare part B (professional) is destination payer
- MA – Medicare part A (institutional) is destination payer
- MC – Medicaid is destination payer
- OF – Railroad Medicare is destination payer
- CI – Commercial insurance (other than Blue Cross Blue Shield)

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Payer Name – loop 2010BB

If submitting transactions destined for other payers (where BCBSMS is acting as a clearinghouse), the 2010BB NM1 information is required as outlined below:

- For Medicare claims: NM108=PI and NM109=00512
- For Medicaid claims: NM108=PI and NM109=77032
- For Railroad Medicare claims: NM108=PI and NM109=00882

Secondary Claims filed to BCBSMS

On claims where BCBSMS is the destination payer, BCBSMS requires prior payment information on claims where a prior payer exists. This information (which includes prior paid amount, contractual adjustments, and patient responsibility amounts) must balance. This information, as stated in the X12 documentation, should be included in loop 2320 – Other Subscriber Information.

On Institutional claims (837I), denials for prior payment should be sent as one of the following occurrence codes with the corresponding denied dates:

- Occurrence Code 24 – Not a covered service
- Occurrence Code 25 – Not a covered member

Corrected and Void Claims filed to BCBSMS

Corrected claims should only be filed if there is a change in the clinical or member information. Corrected claims must contain the original BCBSMS assigned claim number. Corrections must be submitted within 12 months from the payment date of the original claim. Multiple corrections of the same original will not be accepted.

Void claims must also contain the original BCBSMS assigned claim number and should occur within 12 months from the original payment date.

Transaction Response Reports

Upon receipt of 837P/I/D Claims Transactions transactions, BCBSMS processes will edit the transactions for completeness and validity. Results of this processing are reported via both human readable reports and EDI transactions, which can be retrieved from our communications server. It is the responsibility of either the submitter or the end user provider to review the resulting report and/or EDI transactions to ensure accuracy of the Claims Transactions submissions and/or correct issues and resubmit.

BCBSMS currently provides for the following response reports:

Item	*Type / Frequency*	*Description*
EDI Front-end Processing Report	Text File (Report) Always generated	A human readable report which contains acceptance/rejection information for each claim submitted.
277CA Transaction	EDI transaction Always generated	An EDI transaction which contains acceptance/rejection information for each claim submitted.

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999 Transaction	EDI transaction Only present when X12 compliance errors are encountered, or if acknowledgement is requested	An EDI transaction which gives details regarding any X12 compliance errors which were encountered. Also may contain the TA1 acknowledgement when requested.

Each report or transaction is available on the BCBSMS EDI communications server for retrieval. See the *Communications Specifications* section for details on how to retrieve the report and/or transactions.

EDI Front-end Processing Report

The human readable processing report is designed for submitters to manually review results for each claim in the originally submitted transaction (837P/I/D). The report shows the status information of each claim transmitted to BCBSMS in the submission, along with control totals for the entire submission. The status defines whether that claim was accepted for adjudication, rejected for correction, or accepted but requiring more information in order to adjudicate (pended).

If the claim was not accepted, there is information on the report which can assist in determining why the claim was not accepted. More information to assist in understanding the error codes can be found in the separate BCBSMS Error Reference Manual for the appropriate claim type (Institutional, Professional, or Dental), available online at http://www.bcbsms.com

For an explanation of the processing report and a sample report, please refer to the *Appendix 1 – Processing Report* section of this document.

277CA Transaction

The 277 Health Care Claim Acknowledgement transaction (ASC X12 00501X214) is utilized by BCBSMS to report front-end processing results for each claim in the originally submitted transaction (837P/I/D). This allows for a systematic method to account for all claims which were submitted to a payer.

Within the 277CA, each claim received on the transmission is marked with industry standard Category and Status codes, along with an entity identification when it is required or when it's inclusion can assist in understanding the reason for a rejection or pending status. More information to assist in understanding these codes can be found in the separate BCBSMS Error Reference Manual for the appropriate claim type (Institutional, Professional, or Dental), available online at http://www.bcbsms.com.

999 Transaction

The 999 Implementation Acknowledgement for Health Care Insurance transaction (ASC X12 005010X231A1) is utilized by BCBSMS to report syntactical (compliance) errors within the originally submitted transaction (837P/I/D) and to respond with an acknowledgement (TA1) segment if one was requested via the ISA14 indicator on the originally submitted transaction (837P/I/D). If an acknowledgement was not requested, and no compliance

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errors were encountered, a 999 transaction will not be generated by the BCBSMS EDI front-end process. The following table shows the situations in which a 999 transaction will be generated, and when a TA1 segment will be present.

Compliance errors?	*ISA14 value*	*999?*	*TA1?*
None encountered	0 (ack not requested)	N	N
None encountered	1 (ack requested)	Y	Y
Some encountered	0 (ack not requested)	Y	N
Some encountered	1 (ack requested)	Y	Y

Please refer to the ASC X12C 005010X231 Technical Report Type 3 documentation for more information on how to interpret a 999 transaction. Please refer to the originally submitted transaction's TR3 for more information on the TA1 acknowledgement segment.

Frequently Asked Questions

1. ***How do I connect to Blue Cross & Blue Shield of Mississippi?***
   Refer to the *Communications Specifications* section of this document for information about connection options.

2. ***How do I test once the connection with BCBSMS is in place?***
   Testing should begin with a simple transmission of a generic text file of some sort to confirm that the connection is set up correctly. Once that is complete, a retrieval of a generic text file should be tested as well. Once that is complete, testing of the Claims Transactions transaction can begin. EDI Services can assist in this testing; refer to the *Communications Specifications* section of this document for more information

3. ***What time of day should I send a file?***
   You can send a file at any time of day, 24x7, depending on the transmission method used. As a general rule, files must be received at BCBSMS by 6:00 pm on any given business day for the claim to be loaded into our adjudication system that night. Payment decisions can then vary greatly depending upon the information submitted with the claim.

4. ***How can I determine the status of the claims which were sent to BCBSMS in a transmission?***
   Each claims transmission should result in at least one type of transaction response report from BCBSMS. These reports are available for retrieval via the same server which you sent transmissions to. Refer to the *Transaction Response Reports* section of this document for more information about the reports, and refer to the *Communications Specifications* section of this report for information about how to retrieve your reports.

5. ***After I send a file, how long before the processing reports are available?***
   The reports are typically generated within 30 minutes of successful receipt of a file, but can be later depending upon the system load at BCBSMS. Contact BCBSMS EDI Services at 601-664-4357 if your reports take more than an hour to appear.

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Communications Specifications

Prior to submitting any data to BCBSMS, trading partners must establish electronic communications capabilities with the BCBSMS EDI communications server. To begin this process, contact our EDI Services group at 601-664-4357.

The EDI Services group will:

- Record the trading partner information and establish the proper credentials for logging into the EDI server and transmitting data
- Supply technical details about one of the available communications options (outlined below) and assist with basic setup
- Assist with issues in both the test and production environments

The BCBSMS EDI communications server has the following communications capabilities:

- Secure FTP (FTPS) over any internet connection. This option allows trading partners to use their existing internet connection to securely share data with BCBSMS across an encrypted FTP connection. BCBSMS can provide a free software client that can be installed on Windows PCs for this option.
- Asynchronous dialup connections. This option allows trading partners to use a standard dialup modem to connect directly to our modem bank and transfer data via one of several standard modem protocols. Most computers have built in functionality to be able to communicate with other computers via standard modem protocols.

When transmitting Claims Transactions to the BCBSMS EDI communications server, the data file should be named ASC837 (BID=ASC837). Files with other names may not be recognized as claims data. The server will allow multiple transmissions with the same name. NOTE: while multiple ISA/GS transactions are allowed within a single physical file, all transactions must be of the same type (GS08).

Data within the Claims Transactions lets our system know the following:

- Whether the transmission contains **test or production** claims (**ISA15** – Usage Indicator)
- Whether the transmission contains Institutional, Professional, or Dental claims (GS08 – Version / Release / Industry Identifier Code)

Once your transaction has processed through our EDI front-end process, the processing report and transactions as outlined in the *Transaction Response Reports* section will be available to retrieve from the communications server with the following file names (where x=T for test or P for production, and y=I (institutional), P (professional), or D (dental):

- RPTxCLMSy
- 277CAxCLMSy
- 999xCLMSy

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Once claims have been paid, electronic remittance advices (ERA transaction 835) will be placed on the EDI server for retrieval by those providers that have requested them. The ERAs will be named 5010835SHIELD and 5010835CROSS.

For transactions destined for other payers (where BCBSMS is acting as a clearinghouse), reports will be named differently: CLHS replaces BLUE in the file names outlined above.

Appendix 1 – Processing Report

The BCBSMS EDI front-end Processing Report allows the submitter to review information about all the claims submitted in the transaction. The report lists key information for each claim along with error information if the claim is rejected or pending. The report is divided into three sections:

1. Invalid Claims – lists all claims which were not accepted or accepted in a pending status. Information about the error or pending status is presented along with the key information on the claim.
2. Valid Claims – lists all claims which were accepted. Key information of each claim is presented.
3. Summary – gives transaction summary counts which can assist in balancing transmissions.

The header of the reports identifies batch level information associated with your transaction such as the submitter ID, what X12 version of claims were submitted, what the ISA control number was, and what BCBSMS internal batch number was assigned to the transmission.

For each claim submitted, there should be key information listed in either the Invalid or Valid section of the report. Key information from the claim is presented to assist in matching back to the original submission.

The Invalid section of the report contains an "error" line immediately following the key claim information. This line presents error codes that were encountered on the claim. If an error relates to a line item(s) on the claim, other line(s) may be presented along with the claim to show the errors that were related to those line items. Refer to the separate BCBSMS Error Reference Manual for the appropriate claim type (Institutional, Professional, or Dental) for an explanation of the error codes. This document is available online at http://www.bcbsms.com.

The following page shows a sample report.

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ESCB0837P-R1                                  BLUE CROSS AND BLUE SHIELD OF MISSISSIPPI                                    PAGE     1
17:05:45      INVALID  PROFESSIONAL 005010X222A1 CLAIMS TRANSMITTED BY SUBMX00    - CLINIC X 00 NAME                       03/11/2011
ISA CTRL # 386230001     BATCH # 1026427
TYPE  BILLING   RENDERING  PROVIDER   PATIENT             FROM     THRU   INSURANCE       PATIENT                  CLAIM
BILL  NPI       NPI        NUMBER     NAME                DATE     DATE   ID NUMBER       CONTROL #                CHARGES

111 1234567896 1234456780 111111110  M ASPEN         20110117 20110117 YAQ861231234M   001266055ABC             3,672.00 BCBSMS
 ERRORS: HB0119
211 1234567896 1234557894 222222220  D OAKES         20101214 20101214 YAQ863453451M   001266087ABC             2,456.00 BCBSMS
 ERRORS: HB0051
241 1234567896 1234566785 333333330E D WILLOWS       20110113 20110113 YAQ867891230M   001266102ABC             1,264.00 BCBSMS
 ERRORS: HB0117 HB0117

ESCB0837P-R2                                  BLUE CROSS AND BLUE SHIELD OF MISSISSIPPI                                    PAGE     1
17:05:45       VALID   PROFESSIONAL 005010X222A1 CLAIMS TRANSMITTED BY SUBMX00    - CLINIC X 00 NAME                       03/11/2011
ISA CTRL # 386230001     BATCH # 1026427
TYPE  BILLING   RENDERING  PROVIDER   PATIENT             FROM     THRU   INSURANCE       PATIENT                  CLAIM
BILL  NPI       NPI        NUMBER     NAME                DATE     DATE   ID NUMBER       CONTROL #                CHARGES

111 1234567896 1234456780 111111110  B MAGNOLIA      20101216 20101216 R09991234       001264067DEF               317.00 FEP
111 1234567896 1234557894 222222220  D JOSHUA        20110118 20110118 R08881234       001264068DEF                82.00 FEP
111 1234567896 1234566785 333333330E R PINER         20110111 20110111 XYO111222333    001264667ABC               105.00 BCBS

ESCB0837P-R3                                  BLUE CROSS AND BLUE SHIELD OF MISSISSIPPI                                    PAGE     1
17:05:45      SUMMARY  PROFESSIONAL 005010X222A1 CLAIMS TRANSMITTED BY SUBMX00    - CLINIC X 00 NAME                       03/11/2011
ISA CTRL # 386230001     BATCH # 1026427
TYPE  BILLING   RENDERING  PROVIDER   PATIENT             FROM     THRU   INSURANCE       PATIENT                  CLAIM
BILL  NPI       NPI        NUMBER     NAME                DATE     DATE   ID NUMBER       CONTROL #                CHARGES

               ----------CLAIMS----------   ---------SEGMENTS---------         ----------------CHARGES----------------
               RECEIVED ACCEPTED REJECTED   RECEIVED ACCEPTED REJECTED           RECEIVED       ACCEPTED      REJECTED
                      6        3        3        300      220     180            7,896.00         504.00      7,392.00
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