X12N Electronic
Submitter Guide

Batch 837 Professional/Institutional Claims
And
Batch 835 Electronic Remittance Advice

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Introduction:

The purpose of this document is to provide Trading Partners/Direct Submitters with Inbound/Outbound X12N-837/835 submission requirements specific for CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice). This document has been created as a supplement to the ANSI ASC X12N 837 Institutional and Professional Health Care Claim Implementation Guides and to the CareFirst Companion Guide. It is intended only to address the technical requirements to achieve our undertaking of assisting the provider/vendor community with HIPAA compliant electronic claim submissions. It does not address the submission of Encounters or Dental claims.

We expect all registered Trading Partners to deliver claims to CareFirst and CareFirst BlueChoice in valid ANSI ASC X12N formats utilizing the HIPAA standard 4010A1 Implementation Guides. CareFirst and CareFirst BlueChoice acknowledge that the Trading Partner will perform both data format and content translations to achieve this end. In addition, CareFirst and CareFirst BlueChoice will send the electronic remittance to the Trading Partner in ANSI ASC X12N 835 format.

All contractual issues, including billing/pricing and Service Level Agreements, will be handled outside of this document.

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Summary of Electronic Billing Guidelines

The following guide provides information to assist with effective electronic claim submission to CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice). Our processing systems require specific adjudication rules for certain types of claims. The information below includes these adjudication rules and other helpful information for Maryland and National Capital Area (NCA) products.

Electronic Inhibitors

Listed below are types of claims that we suggest not be submitted electronically, as additional information may be required to expedite processing.

- **MD and NCA Institutional**- Coordination of benefits claims
- **MD Institutional-**
  - Psychiatric halfway house claims
  - Rehabilitation facility claims
- **NCA Professional**- Coordination of benefits claims
- **MD Professional-**
  - Coordination of benefits claims
  - Claims reporting modifiers 21, 22, 62, 66 & 78

Do not electronically submit claims requiring attachments

We suggest that claims requiring attachments not be submitted electronically. Please see the chart below to see what attachments are required for which area.

Professional and Institutional Claims	Required Attachments	Maryland	NCA
Coordination of benefits	Other carrier EOB statements	YES	YES
Subrogation	Letters to determine if coordination is required	YES	Upon Request
Professional Claims	**Required Attachments**	**Maryland**	**NCA**
Those billed with modifiers 21, 22, 62, 66 & 78	Doctor's notes, Doctor's orders, Sleep study reports, etc.	YES	Submit required notes electronically
Specialized surgery or complicated procedure	Medical necessity statement, itemized bills, operative notes, or other additional information	YES	Upon Request
Institutional Claims	**Required Attachments**	**Maryland**	**NCA**
Ambulatory Surgery Center claims billed with Revenue code 270 (surgical supplies)	Surgical supply invoice	YES	NO

Disclaimer*: Accepting claims for certain services does not guarantee payment. You must verify member eligibility and benefits prior to rendering services.*

Note= Notes are accepted on electronic institutional claims
N/A = type of service is not billed on the type of claim.
YES = Service is allowed to be billed electronically for that type of claim
NO = Service should not be billed electronically for that type of claim

*NASCO – National Accounts Service and Claims Operations

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Professional and Institutional Services Accepted Electronically for Maryland and NCA Indemnity, Federal Employee Program and National Accounts (NASCO*)

Professional and Institutional Services	Professional Electronic	Institutional Electronic
Surgery (Incl. Oral)	YES	YES
ASC (Except when billing revenue code 270)	YES	YES
Litho	YES	YES
ESRD (Freestanding)	YES	YES
Donor Surgery	YES	YES
Physician Assistant at Surgery	YES	YES
Elective Abortion	YES	YES
Maternity	YES	YES
Birthing Center	YES	YES
Anesthesia	YES	YES
Emergency Medical Care (Incl. Accident)	YES	YES
Pre-Admission Testing	YES	YES
Professional Component	YES	**N/A**
Diagnostic Radiation, Nuc. Med. & Ultrasound	YES	YES
Concurrent Care	YES	**N/A**
Well Baby Care/Visit	YES	YES
Diagnostic Machine Test	YES	YES
Psychiatric Care	YES	YES
Second Opinion Program	YES	**N/A**
Alcohol Rehabilitation	YES	YES
Consultations	YES	YES
Drug Rehabilitation	YES	YES
Medical Care - I/P & O/P Medical	YES	YES
Chemotherapy	YES	YES
Physical Therapy	YES	YES
Radiation Therapy	YES	YES
Occupational Therapy	YES	YES
Speech Therapy	YES	YES
Respiratory Therapy	YES	YES
Therapeutic Services	YES	YES
Diagnostic Path/Lab	YES	YES
Whole Blood	**N/A**	YES
Hospice Care	**N/A**	YES
Ambulance	YES	YES
Phys. Access.- Purchase (Ortho/Prosthetic)	YES	YES
Phys. Access.- Rental (Ortho/Prosthetic)	YES	YES
DME	YES	YES
Pharmacy (Vendor processing)	**N/A**	**N/A**
Routine Vision Care (Examination ONLY)	YES	**N/A**
Home Health Care Service	YES	YES
Visiting Nurse Services	YES	YES
Private Duty Nursing	YES	YES
Skilled Nursing Facilities	YES	YES
Hearing Care	YES	YES
Medicare Submitted Secondary Claims	YES	YES

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837 Claim File Requirements

Claims Collection from Providers through a Billing Agent or Clearinghouse

1. At this time, CareFirst and CareFirst BlueChoice do not expect changes to claims collection methods from providers if the provider is utilizing a Billing Agent or Clearinghouse to submit claims.

2. If a provider does not have the capability to send valid X12N formats, CareFirst and CareFirst BlueChoice acknowledge that Trading Partners will accept non-X12N formats and translate the formats into a valid X12N file for submission to CareFirst and CareFirst BlueChoice. The translation of the transaction and code sets by the Trading Partner must follow defaults and code set translation guidelines described in this Submitter Guide.

3. The Trading Partner will run a compliance check of all claims prior to sending to CareFirst and/or CareFirst BlueChoice.

Naming Conventions

1. For Secure File Transfer (SFT) the naming convention of the file should be "*Trading Partner name or Trading Partner ID-837(I or P)-yymmdd-unique identifier.ZIP"*. (Such as: Carefirst-837P-051031-0000001.ZIP)

2. For FTP/VPN the naming convention of the file should be *"Date & timestamp-Trading Partner ID-837.ZIP.OK"* (Such as: 051031081233-999999999-837.ZIP.OK)

Batch Conventions

1. CareFirst and CareFirst BlueChoice require separate payer ID numbers to be submitted for each X12N 837 transaction: MD Professional (00690), MD Institutional (00190), NCA Professional (00580), NCA Institutional (00080).

2. CareFirst and CareFirst BlueChoice will generate a 997 acknowledgement transaction for each claim file received from a Trading Partner.

3. CareFirst and CareFirst BlueChoice will generate daily proprietary file acknowledgements. Two files will be generated per day: One (1) for MD & NCA Institutional and one (1) for MD & NCA Professional. (See **Appendix B** – Proprietary Acknowledgement File.)

Batch Requirements - (Clearinghouse/Billing Agent Only)

1. 837I:
   Functional Group – generated per Pay-To-Provider
   The current provider batch will be the equivalent of a Transaction Set within the Functional Group. One (1) ST/SE per Pay-To-Provider, per facility code value/claim frequency code (type of bill)

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2. 837P:
   Functional Group – generated per Pay-To-Provider
   The current provider batch will be the equivalent of a Transaction Set within the Functional Group. One (1) ST/SE per Pay-To-Provider

Batch Editing - (Clearinghouse/Billing Agent Only)

1. To minimize rejections the Trading Partner's will invoke claim edits using the Pre-Processing Edits contained in this document prior to sending X12N files. (See **Appendix A** – Pre-Processing Edits V1.0.)

Claims Submission – Trading Partner submission to CareFirst and CareFirst BlueChoice – (Clearinghouse/Billing Agent Only)

1. Files are limited to the following claim volumes per file.

File Type	Claim Limit per File
MD Professional	40,000
MD Institutional	No limit
NCA Professional	No limit
NCA Institutional	No limit

NOTE: If MD Professional files are larger than 40,000 claims, please contact your Vendor Relationship Manager for further instructions.

2. Trading Partner must individually zip each file submitted, without using subfolders. A zip file should contain only one (1) physical file (ISA/ISE)

3. Preferred method for claim submission is via SFT (Secure File Transfer) method. Trading Partners will be issued a logon and ID during the registration process. Once logged into the website (https://www.carefirst.com/filexfer), click on the "User Guide" link (upper right hand corner of the screen) to obtain a copy of the guide.

4. The Trading Partner will submit four individual claim files daily (excluding holidays) using the (ANSI ASC X12N 837 004010X096A1 or 004010X098A1) format, including compliant HIPAA code sets. These files are: MD Professional, MD Institutional, NCA Professional and NCA Institutional. If sending one of each file is not possible on a particular day, the Trading Partner is required to notify CareFirst and/or CareFirst BlueChoice via email to **edidirectsubmission@carefirst.com.**

5. Trading Partners are expected to send only one (1) file per day per file type and should be submitted between 12 a.m. (Midnight) EST and 4:30 a.m. EST to meet current date processing. Claims received after the cut-off time will be processed the following business day.

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6. CareFirst and CareFirst BlueChoice observe the below listed holidays. You will be notified by your Vendor Relationship Manager if claim files will be accepted on these days or other events that may affect the current processing schedule.
   - New Year's Day
   - Martin Luther King's Birthday
   - President's Day
   - Memorial Day
   - Independence Day
   - Labor Day
   - Thanksgiving
   - Day after Thanksgiving
   - Christmas Eve
   - Christmas Day

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Duplicate 837 File Detection

CareFirst and CareFirst BlueChoice have an automated process in place to prevent duplicates of previously submitted 837 files from entering our front-end claims system. There are several key identifiers of a duplicate file:

- Total claim count within one Interchange (ISA through IEA segments of an X12 file)
- Total service line count within one Interchange
- Total dollar amount from all claim headers within one Interchange
- Record count of internal load ready file format
- Hash Total- Internally generated number from claim data

If the file is identified as a duplicate, an Error Response will be returned to the Trading Partner's mailbox **within 1 hour** of file upload. The Trading Partner is responsible for checking their mailbox for an Error Response. There will be one Error Message for each duplicate file or validation error detected.

Messages may be combined into one Error File in the Sender's Mailbox and will be displayed along with the ISA Control Number of the file in error.

The Error Response will contain error messages advising the Trading Partner of what triggered the Duplicate Error Response and how to correct the data in order to resubmit the file.

Resubmitting a File

In order to resubmit a file the Trading Partner must correct the data in error per the Error Response. The Trading Partner must notify their contact prior to uploading the file.

Example of Error Response:

```
H201SCRI: ERROR NOTIFICATION TO SENDER: General Hospital-Inst
H201SCRI: ISA SENDER ID: 111100031
H201SCRI:  GS SENDER ID: 111100031
H201SCRI:  ISA CNTL NBR: 000631004
H201SCRI:    ICHNG DATE: 2004-11-05  TIME: 15.23.00

H201SCRI: DUPLICATE FILE NOT ACCEPTED
ISA CNTL NBR 000631004 PREVIOUSLY RECVD 2004-11-04 AT 14.45

H201SC38: DUPLICATE FILE NOT ACCEPTED
CONTENTS MATCH PREV FILE: ISA NBR: 000610022 SENT 2004-09-16
```


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Claims Processing

In accordance with the Clean Claim requirements, CareFirst and CareFirst BlueChoice make every effort to identify all potential errors before actual adjudication of the claim. The steps are described in this section.

1. CareFirst and CareFirst BlueChoice will process the files through Common Component Application (CCA) and perform the following:
    - Unzip Files
    - Archive Files
    - HIPAA Compliance Editing through Sybase, WEDI/SNIP levels 1 through 4
    - Creation of a Functional Acknowledgement file in valid X12N format
        a. 997 within ASC X12N 004010
        b. 997 within ASC X12N 004010
    - Perform Transaction Routing (may cause Payer code to change)
    - Perform Data Reconciliation (provider/patient validation)
    - Perform Pre-processing Editing
    - Perform High-level claim splitting (DCN assignment)

2. CareFirst and CareFirst BlueChoice will create a Functional Acknowledgement in valid X12N format per input file. The Trading Partner will retrieve the zipped 997 from CareFirst or CareFirst BlueChoice from their SFT mailbox. File name for the 997 is "original-filename.A997.R".runid."txt.zip").

3. CareFirst and CareFirst BlueChoice will create two (2) zipped payer proprietary acknowledgements daily: One for Institutional and one for Professional. The Trading Partner will retrieve the payer acknowledgements from their SFT mailbox. File name for the Professional/Institutional proprietary acknowledgement is HACKIOUT.*Dccyymmdd-99999-9*.zip; HACKPOUT.*Dccyymmdd-99999-9*.zip. (The italicized characters are variables where *ccyymmdd* is the current system date in century, year, month, day format and *99999-9* is a randomly generated PERL process ID number, i.e., HACKPOUT.D20040429-78104-0.zip.)

4. The CareFirst and CareFirst BlueChoice processing schedule for when the 997 and the proprietary acknowledgement will be available for retrieval is as follows:

File Type	Retrieval Time
MD Professional 997	Immediately
MD Institutional 997	Immediately
NCA Professional 997	Immediately
NCA Institutional 997	Immediately
MD/NCA Professional Acknowledgement	4 p.m. (EST)
MD/NCA Institutional Acknowledgement	4 p.m. (EST)

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837 Claim Data Requirements

Data Translation and defaults – prior to submission - (Clearinghouse/Billing Agent Only)

1. CareFirst and CareFirst BlueChoice have published the CareFirst X12N 004010A1 Companion Guide at http://www.carefirst.com/Provider & Physicians/Electronic Services/EDI/EDI Manuals

2. CareFirst and CareFirst BlueChoice expects the Clearinghouse or Billing Agent to make every attempt to supply the data as required by HIPAA. However, if submitters do not have the capacity to send a valid X12N format, the Trading Partner will accept the current proprietary non-X12N formats from providers and translate these formats into a valid X12N format for submission. The Trading Partner will default data into fields where none is provided by the submitter on the 837 based on the data value instructions provided by CareFirst and CareFirst BlueChoice (Contact your Vendor Relationship Manager for the most recent versions of the Institutional and Professional Default mapping documents.)

837 Code Set Translation – Summary

When in receipt of a non-X12N format, the Trading Partner will translate codes sets from the legacy CareFirst and CareFirst BlueChoice code set to the equivalent HIPAA compliant code set based upon the precise "one-to-one" translation rules provided by CareFirst and CareFirst BlueChoice (See MD & NCA Conversion Tables below). It is expected that if providers are sending non-X12N formats to the Trading Partner, they most likely are utilizing proprietary or pre-HIPAA code sets. If providers do not utilize pre-HIPAA code sets, the Trading Partner will not be able to determine if the Code Set Translation should be invoked. The Trading Partner will communicate this expectation to all CareFirst and CareFirst BlueChoice providers.

Field Name	**X12 Data Element Name (Loop & Segment)**	**NCA Prof 00580**	**MD Prof 00690**	**NCA Inst 00080**	**MD Inst 00190**
Accident Code		N/A	Included	N/A	N/A
Admit-Dischg Hour Codes		N/A	N/A	Not Used	Included
Admit Type		N/A	N/A	Included	No X-walk
Assignment Indicator **Assignment of Benefits Certification Indicator**	Medicare Assignment Code 2300-CLM08	Included	Included	Included	Included
Condition Related Indicator	Related Causes Code 2300-CLM11-1 2300-CLM11-2 2300-CLM11-3	Included	N/A	N/A	N/A
Medicare B Assignment Indicator		Included	Included	N/A	N/A
Other Insurance Indicator **Other Primary Insurance Code**		Included	Included	N/A	N/A
Patient Relationship Codes	Ind. Relationship Code 2000B-SBR02 2000C-PAT01 2320-SBR02	Included	Included	Included	Included

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Place of Service	Facility Code Value 2300-CLM05-1 Claim Freq. Type Code 2300-CLM05-3	Included	N/A	N/A	N/A
Release of Info Code **Release of Information Certification Indicator**	Release of Information Code 2300-CLM09 2320-OI06	N/A	N/A	Included	Included
Worker's Comp Indicator	Related Causes Code 2300-CLM11-1 2300-CLM11-2 2300-CLM11-3	Included	N/A	N/A	N/A

MD & NCA Professional Conversion Table

Plan	Field Name	X12 Data Element Name (Loop/Segment)	Old Code	Old Description (Proprietary Formats)	New Code	New Description (X12 837 Formats)
00580	Assignment Indicator	Assignment of Benefits Indicator (2300-CLM08)	1 2	Pay Subscriber Pay Provider	N Y N	No Yes No
00580	Condition Related Indicator	Related Causes Code 2300-CLM11-1 2300-CLM11-2 2300-CLM11-3	1 2 3 4 5 6	Not Applicable Auto Accident Work Related Home Accident Auto/Work Rel. Other	 AA EM OA AP OA	 Auto Accident Employment Other Accident Other Party Responsible Other Accident
00580	Patient Relationship Code	Individual Relationship Code 2000B-SBR02 2000C-PAT01 2320-SBR02	1 2 3 4	Self Spouse Child Other	20 01 19 19	Employee Spouse Child Child
00580	Place of Service Code		30 11 3S OG B1 B2 40 12 4S 10 21 1S 20 22 2S 2A 2F 2Z 58 2E 23 BF 24 BM 25 26	Office Not used prior to HIPAA Hospice Svc in Prov office Hemophilia Trtmnt Ctr Urgent Care Fac Urgent Care Prof. Corp Home Home Hospice Svc in patient home Inpatient Hospital Inpatient Hospital Hosp Affiliated Hospice Urgent Care Facility Outpatient Hospital Hosp, OP Hospice Svc Hosp, OP Observation Rm Hosp based Ambulatory Surg OP Rehab Hospital Hosp, partial hospitalization Emergency Room, Hosp Emergency Room, Hosp Freestanding ASC ASC Birthing Center Birthing Center Military Treatment Facility	11 11 11 11 20 20 12 12 12 21 21 21 22 22 22 22 22 22 22 23 23 24 24 25 25 26	Office Office Office Office Urgent Care Fac/Prof Corp Urgent Care Fac/Prof Corp Home Home Home Inpatient Hospital Inpatient Hospital Inpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient Hospital Emergency Room, Hosp Emergency Room, Hosp Ambul. Surgery Center Ambul. Surgery Center Birthing Center Birthing Center Military Treatment Fac Skilled Nursing Facility

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			80 31 70 32 33 BS 34 90 41 9A 9C 42 B0 50 51 BT BV 52 53 54 55 56 57 59 1Z 61 62 BD 65 71 72 81 BR BU 99 00 C0 03 04 05 06 07 08 15 60 13 14 49	Skilled Nursing Facility Skilled Nursing Facility Nursing Facility Nursing Facility Custodial Care Facility Hospice care not in patient's home Hospice care not in patient's home Ambulance – Land Ambulance – Land Ambulance – Air Ambulance – Sea Ambulance – Air or Water Freestanding Ambulatory Med Fac Federally Qualified Health Ctr Inpatient Psychiatric Facility IP Freestanding Substance Abuse Fac Freestanding Substance Abuse Fac OP Psychiatric Facility Community Mental Health Ctr Intermed Care Fac- Mentally retarded Resid Subst. Abuse Trtmt Fac OP Subst. Abuse Trtmt Fac Non-Resid. Subst Abuse Trtmt Fac Intensive OP Treatment Prog Compreh. IP Rehab Facility Compreh. IP Rehab Facility Compreh OP Rehab Facility ERSD Treatment Facility ERSD Treatment Facility Public Health Clinic Rural Health Clinic Independent Laboratory Freestanding Cardiac Rehab Fac OP Free Subst. Abuse Fac Other Unlisted Facility Other Pharmacy Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA Not used prior to HIPAA	31 31 32 32 33 34 34 41 41 42 42 42 50 50 51 51 52 52 53 99 55 99 57 99 61 61 62 65 65 71 72 81 99 57 99 99 99 99 04 05 06 07 08 15 60 13 14 49	Skilled Nursing Facility Nursing Facility Nursing Facility Custodial Care Facility Hospice Hospice Ambulance – Land Ambulance – Land Ambulance – Air/Water Ambulance – Air/Water Ambulance – Air/Water Federally Qualified Hlth Ctr Federally Qualified Hlth Ctr Inpatient Psychiatric Facility Inpatient Psychiatric Facility Psych Fac., partial Hosp. Psych Fac., partial Hosp. Community Mental Hlth Ctr Other Resid Subst Abuse Trtmt Fac Other Non-Res Subst Abuse Trtmt Fac Other Compreh. IP Rehab Facility Compreh. IP Rehab Facility Compreh OP Rehab Facility ERSD Treatment Facility ERSD Treatment Facility State/local Public Hlth Clinic Rural Health Clinic Independent Laboratory Other Non-Res Subst Abuse Trtmt Fac Other Other Other Other Homeless Shelter Indian Hlth Svc Free Fac Indian Hlth Svc Prov Fac Tribal 638 Free Facility Tribal 638 Free Prov Fac Mobil Unit Mass Immunization Center Assisted Living Facility Group Home Independent Clinic
00580	Worker's Comp Indicator	Related Causes Code 2300-CLM11-1 2300-CLM11-2 2300-CLM11-3	Y N P	Yes No Possible	EM EM	Employment Employment
00690	NSF Patient Relationship	Individual Relationship Code 2000B-SBR02 2000C-PAT01 2320-SBR02	01 02 03 04 05 06 07 09	Insured Spouse Child Child No $ Responsibility Step Child Foster Child Ward Unknown	18 01 19 43 17 10 15 21	Self Spouse Child Child No $ Responsibility Step Child Foster Child Ward Unknown

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			10 11 12 13 14 15 16 17 18 19	Handicap Dependent Organ Donor Cadaver Donor Grandchild Niece/Nephew Injured Plaintiff Sponsored Dependent Minor Dependent of Dependent Parent Grandparent	22 39 40 05 07 41 23 24 32 04	Handicap Dependent Organ Donor Cadaver Donor Grandchild Niece/Nephew Injured Plaintiff Sponsored Dependent Minor Dependent of Dep Mother Grandparent
00690	Sub Signature Indication		N Y	No Yes	P C	Signature on file Signed signature on file
00690	Accident Code	Related Causes Code 2300-CLM11-1 2300-CLM11-2 2300-CLM11-3	A O N	Auto Accident Other Accident	AA OA	Auto Accident Other Accident
00690	Medicare B Assign Indicator		N Y	No Yes spaces	C A C	Not Assigned Assigned Not Assigned
00690	Other Insurance Indicator		1 2 3	Yes, other Insurance Yes, other Insurance No other Insurance	S S P	Secondary Secondary Primary

MD & NCA Institutional Conversion Table

Plan	Field Name	Data Dictionary Name (Loop/Segment)	Old Code	Old Description	New Code	New Description
00080	Admit Type	Admission Type Code	0 1 2 3 4 5 6 7 8 9	Not Applicable Emergency Urgent Elective Newborn Newborn Boarder Baby GYN (Non-OB admission) OB Admission Psychiatric Admission Information Not Available	 1 2 3 4 4 9 9 9 9	 Emergency Urgent Elective Newborn Newborn Information Not Available Information Not Available Information Not Available Information Not Available
00080	Admit/Discharge Hour		99	Unknown Note: Others remain the same	00	Midnight Note: Others remain the same
00080	Patient Relationship to Insured	Individual Relationship Code 2000B-SBR02 2000C-PAT01 2320-SBR02	01 02 03 04 05 06 07 08 09 10 11 12 13 14	Patient is Insured Spouse Child Child/Insured not $ responsible Step Child Foster Child Ward of Court Employee Unknown Handicapped Dependent Organ Donor Cadaver Grandchild Niece/Nephew	18 01 03 43 17 10 15 20 21 22 39 40 05 07	Self Spouse Child Child/Insured not $ Respons. Step Child Foster Child Ward of court Employee Unknown Handicapped Dependent Organ Donor Cadaver Grandchild Niece/Nephew

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			15 16 17 18 19	Injured Plaintiff Sponsored Dependent Minor Dependent of a Dependent Parent Grandparent	41 23 24 32 33 04	Injured Plaintiff Sponsored Dependent Minor Dep of a Dependent Mother Father Grandparent
00080	Release of Information Code	Release of Information Code 2300-CLM09 2320-OI06	R Y N	Restricted or Modified Release Yes Not	M Y N	Restricted ability to release Yes No
00080	Sequence Number	Payer Responsibility Sequence No. Code 2000B-SBR01 2330- SBR01	01 02 03	Primary Payment Responsibility Secondary Payment Respons. Tertiary Payment Responsibility	P S T	Primary Secondary Tertiary
00080	Medicare Assignment	Benefits Assignment Certification Indicator 2300-CLM08	Y N	Yes No	Y N	Yes No
00190	Release of Information Code	Release of Information Code 2300-CLM09 2320-OI06	R Y N	Restricted Yes No	M Y N	Restricted Yes No
00190	Patient Relationship to Insured	Individual Relationship Code 2000B-SBR02 2000C-PAT01 2320-SBR02	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19	Patient is Insured Spouse Child Child/Insured not $ responsible Step Child Foster Child Ward of Court Employee Unknown Handicapped Dependent Organ Donor Cadaver Grandchild Niece/Nephew Injured Plaintiff Sponsored Dependent Minor Dependent of a Dependent Parent Grandparent	18 01 19 43 17 10 15 20 21 22 39 40 05 07 41 23 24 32 33 04	Self Spouse Child Child/Insured not $ Respons. Step Child Foster Child Ward of court Employee Unknown Handicapped Dependent Organ Donor Cadaver Grandchild Niece/Nephew Injured Plaintiff Sponsored Dependent Minor Dep of a Dependent Mother Father Grandparent
00190	Accept Assignment Indicator	Benefits Assignment Certification Indicator 2300-CLM08	Y N	Yes No	Y N	Yes No

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Trading Partner Instructions for Setting Date Fields in the X12N 837P

(004010X098A1) (Clearinghouse/Billing Agent Only)

If a CareFirst and/or CareFirst BlueChoice proprietary NSF or MEDS professional claim format is received from the provider, the Trading Partner will evaluate the Diagnosis on the claim and then map the appropriate Date Segment on the X12N 837P. **The driver for mapping the appropriate segment is always the diagnosis.**

Override the Accident Date Indicator (ADI) or Symptom Indicator, if it is different than the diagnosis, when mapping the appropriate date segment (i.e., Maternity ADI with a diagnosis of sore throat).

Accident Segment

For Maryland claims (Plan Code 00690) if the **PRIMARY** diagnosis is accident, to include diagnosis code values of V015, 53511 and 800 thru 9998, then check for a date in the accident/onset/LMP date field. If a date is present, set the Accident Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 439
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

If the diagnosis is accident and the date is not present and the Place of Service is not equal to “81”, reject the claim back to the provider.

For NCA claims (Plan Code 00580) if **ANY** diagnosis is accident, to include diagnosis code values of V015, 53511 and 800 thru 9998, then check for a date in the accident/onset/LMP date field. If a date is present, set the Accident Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 439
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

If any diagnosis is accident and the date is not present and the Place of Service is not equal to “81” and the Subscriber ID number is equal to FEP (R + 8 digits), reject the claim back to the provider.

Related-Cause Codes (for both MD and NCA Plan Codes)

If the Related Cause code is not present and the diagnosis is an accident of any kind, then map code “OA” - Other Accident in the Related-Causes Code field (CLM11-1).

LMP Segment

For Maryland claims (Plan Code 00690) if the **PRIMARY** diagnosis is Maternity, to include diagnosis code values of 630 thru 677, V22 thru V242, V27 thru V279, V615 thru V617 & V724, then check for a date in the accident/onset/LMP date field. If a date is present, set the LMP Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 484
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

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If the PRIMARY diagnosis is maternity and the date is not present and the Place of Service is not equal to "81", reject the claim back to the provider.

For NCA claims (Plan Code 00580) if the **ANY** diagnosis is Maternity, to include diagnosis code values of 630 thru 677, V22 thru V242, V27 thru V279, V615 thru V617 & V724, then check for a date in the accident/onset/LMP date field. If a date is present, set the LMP Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 484
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

For NCA (00580) claims with any diagnosis of maternity, if the date is not present, do not edit. Send the claims to CareFirst.

Onset Segment

For Maryland claims (Plan Code 00690) if the **PRIMARY** diagnosis is not accident or maternity (see above), then check for a date in the accident/onset/LMP date field. If a date is present, set the Onset of Current Illness/Symptom Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 431
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

If the PRIMARY diagnosis is maternity and if the date is not present and the Place of Service is not equal to "81", reject the claim back to the provider.

For NCA claims (Plan Code 00580) DO NOT edit for Onset date. If there is no Accident or Maternity diagnosis, or if the provider supplies ADI as Onset, set the Onset of Current Illness/Symptom Segment on the X12N 837P to the following:

- DTP01 (Qualifier) equal 431
- DTP02 (Format Qualifier) equal to D8
- DTP03 (Date Time Period) equal to Date (CCYYMMDD)

If multiple diagnosis codes are present (for NCA claims ONLY) all applicable segments should be mapped according to the instructions above.

To determine onset diagnosis, go to www.carefirst.com\Providers & Physicians\Medical Policies\Table of Contents\10. Administrative\10.01.11A Emergency Services Autocodes

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Mapping instruction summary for setting date fields:

Maryland (plan code 690):
If accident/onset/LMP date field is present, then
    If Primary Diagnosis = Accident (see above), then
        DTP01 = 439
        DTP02 = D8
        DTP03 = date from accident/onset/LMP date field
    If Primary Diagnosis = Maternity (see above), then
        DTP01 = 484
        DTP02 = D8
        DTP03 = date from accident/onset/LMP date field
    Else
        DTP01 = 431
        DTP02 = D8
        DTP03 = a date from accident/onset/LMP date field

NCA (plan code 580):
If accident/onset/LMP date field is present, then
    If any Diagnosis = Accident (see above)
        DTP01 = 439
        DTP02 = D8
        DTP03 = accident/onset/LMP date
    If any Diagnosis = Maternity (see above), then
        DTP01 = 484
        DTP02 = D8
        DTP03 = accident/onset/LMP date
    If there is no Accident or Maternity Diagnosis, or if ADI is Onset,
        DTP01 = 431
        DTP02 = D8
        DTP03 = accident/onset/LMP date

Related-Causes Codes (For Both NCA and MD Plan Codes)

If the Related Cause code is not present and the diagnosis is an accident of any kind, then map code 'OA' – Other Accident in the Related-Causes Codes fields (CLM11-1).

When Multiple Diagnosis Codes are Present (NCA Claims Only)

For NCA Claims, when multiple diagnosis codes are present, all applicable segments should be mapped according to the instructions above.

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Tax ID and Provider Number Formatting (Loops 2010AA & 2010AB)

Provider Tax ID must be submitted as 9 digit numeric, and should not contain any special characters.

For Maryland (Plan Code 00190) X12N 837I claims the provider number should be submitted as follows:
- 6 + 2 digit provider number (i.e. 537180 02)

For Maryland (Plan Code 00690) X12N 837P claims the provider number should be submitted as follows:
- 4 digit +1-2 UPPER CASE initial (i.e. 6347DP)

For NCA (Plan Code 00080) X12N 837I claims the provider number should be submitted as follows:
- 3 digit Provider ID

For NCA (Plan Code 00580) X12N 837P claims the provider number should be submitted as follows:
- Position 1 = Provider ID Type (1=Social Security Number, 2=Tax ID, 4 = Participating Provider)
- Positions 2-10 = ID number (can be 4 digit number and 5 spaces or 9 digit Tax ID number)
- Positions 11-14 = Member Number (Cannot be 0000 and must be numeric)
- Example: REF|1B|**43995   0032**

Subscriber Address Requirement (Loop 2010BA)

- The Subscriber Address (2010BA Loop) is always required for both MD and NCA, Professional and Institutional claims, regardless of the Patient relationship. Even when the patient is different from the subscriber the Subscriber Address must be present.

Referral Number Qualifier Assignment (Loop 2300 REF01)

- The qualifier assigned, by either provider or the Trading Partner, instructs CareFirst as to the type of number that is being submitted
  G1 indicates a Pre-Authorization number
  9F indicates a Referral Number
- If the number submitted in Loop 2300 REF02 contains a prefix of "RE" then the REF01 qualifier **must** be 9F.
- If the number submitted in Loop 2300 REF02 does not contain the prefix "RE" then that number should be considered a Pre-Authorization number and the qualifier in REF01 should be set to G1.
- FEP (memberships that begin with 'R') consultations require a Referring Physician Name. If a Referring Physician name is provided and not a Referring Physician number, then default the Referring Physician number to 99990001. No "RE" referral number is required for this situation.

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Testing/Acceptance Criteria

During the testing phase the Trading Partner is required to produce test files based on the criteria established for CareFirst and CareFirst BlueChoice acceptance. Any failure points or modifications must be documented. Any action steps identified by CareFirst and CareFirst BlueChoice or the Trading Partner need to be communicated. Trading Partner submissions must meet current CareFirst and CareFirst BlueChoice performance levels. Prior to the Trading Partner testing with CareFirst and CareFirst BlueChoice, a testing schedule will be developed and communicated.

1. Trading Partners shall produce test files using CareFirst and CareFirst BlueChoice production data.

2. Test files are processed once a day at 4 p.m. EST. If files are submitted after 4 p.m. EST they will be processed the next day.

3. Trading Partner must be registered and able to send and receive data files via Secure File Transfer (SFT) or FTP (VPN).

4. Applies only to 837 and 835 Institutional and Professional transactions.

5. CareFirst and CareFirst BlueChoice require at least three (3) cycles of testing; two (2) files per Payer or destination system; and one (1) set of Institutional and Professional claims each.

6. Initial test file or pre-test must contain a minimum of 100 claims per payer, per transaction.

7. Test files, thereafter must be full CareFirst and CareFirst BlueChoice production data files or a combination of several days to meet the requirements stated below.

8. If a test file fails to meet CareFirst and CareFirst BlueChoice requirements, we will request additional test files.

9. Submitters will send files through compliance software prior to sending to CareFirst and CareFirst BlueChoice

10. Must achieve and maintain 97% claims first pass rate at point of proprietary acknowledgement; not the 997.

11. Files should represent a cross section of a normal day's claim submissions to include commercial, NASCO, FEP, etc.

12. Files should include claims with unique or special considerations/concerns to submitters.

13. Each file must contain batches from at least three (3) different providers:
    - Batch requirements for 837I: one (1) ST/SE per billing provider, per facility code value/claim frequency code (type of bill) for 837I
    - Batch requirements for 837P: one (1) ST/SE per provider

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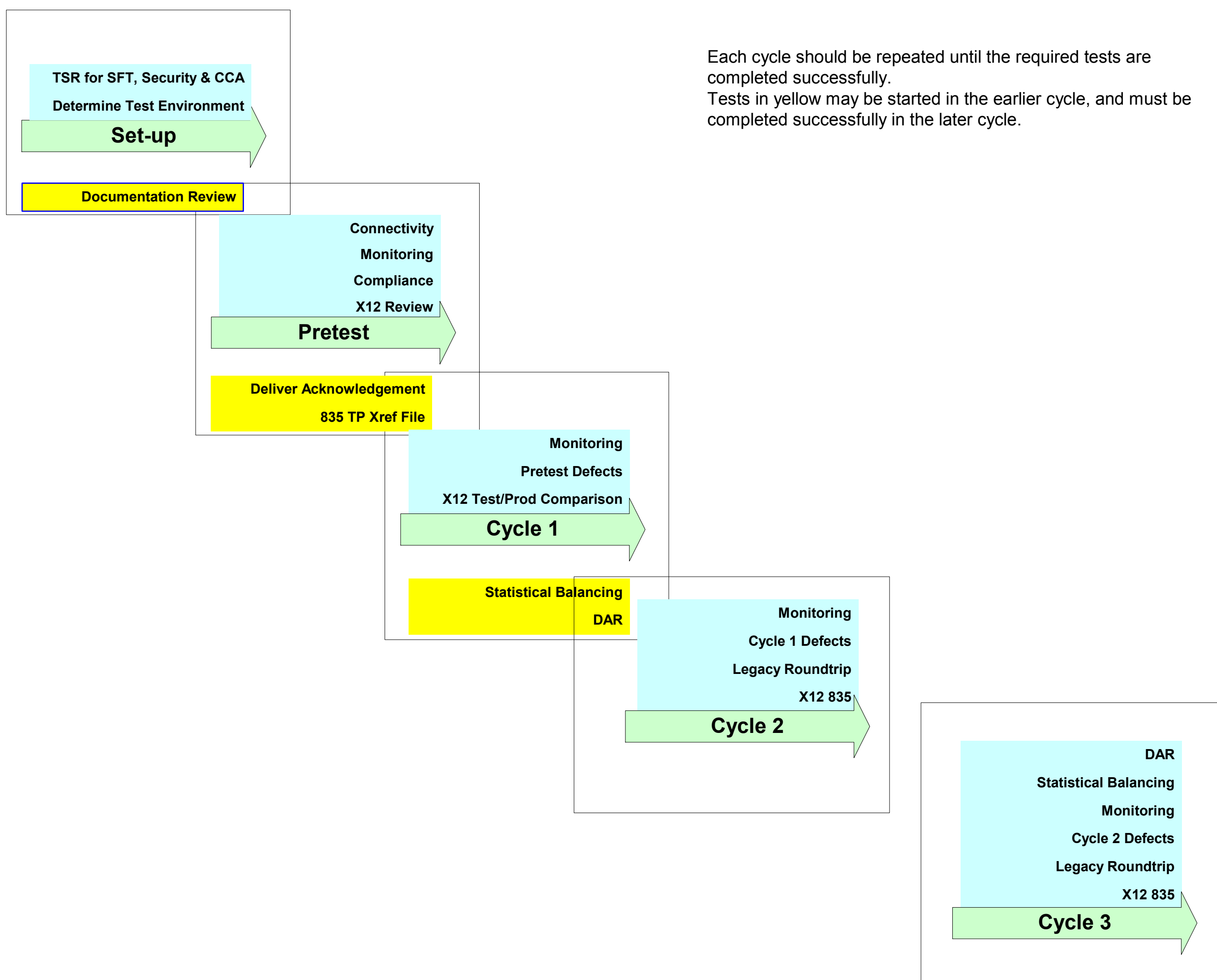
14. Minimum claim situations (if applicable):
    - Professional
        - Diagnostic Services - Lab, Radiology, etc.
        - Medical Services
        - Surgery and assisted surgery
        - Anesthesia procedures
    - Institutional claims
        - Mix of inpatient and outpatient claims with typical services and multiple diagnoses

15. Estimated turnaround time 5 -10 business days per cycle.

Testing Process and Steps



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Report Requirements

Daily Acceptance Report (DAR) (Clearinghouse/Billing Agents Only)

CareFirst and CareFirst BlueChoice are required to monitor and reconcile electronic claims submission on a daily basis. The DAR report will provide a way to track electronic claims submission from each individual provider from the Trading Partner to CareFirst and CareFirst BlueChoice. If report data is not made available, the reconciliation process would not be possible and could result in an increased risk of losing claims.

Trading Partners is required to supply CareFirst and CareFirst BlueChoice with Daily Acceptance Reports (DAR) containing the claims data submitted for that day.

- Four Daily Acceptance Reports (DAR) need to be generated by the Trading Partner:
  - NCA institutional (00080)
  - NCA professional (00580)
  - MD institutional (00190)
  - MD professional (00690)
- Automated transfer of the report will occur via SFT or FTP/VPN if applicable
- Report size requirement is 133 byte fixed block in report format (non-EDI). First byte is reserved for carriage control character (cannot contain report printable character).
- Do not zip DAR files. Upload in the .txt version. No specific file naming convention required.

SAMPLE

Daily Acceptance Report (DAR)

CareFirst Institutional Daily Acceptance Report
For 10/5/2003 thru 10/5/2003

Payer ID: CareFirst Maryland BlueCross Institutional

Provider Name	Provider ID	TOB	Total Count	Total Amount	Reject Count	Reject Amount	Accept Count	Accept Amount	Accept Rate
Provider A	12345601	111	5	20614.38	0	0.00	5	20614.38	100.0
Provider A .	12345601	131	150	21937.15	4	529.15	146	21408.00	97.3
Provider B	56789001	111	8	37700.32	0	0.00	8	37700.32	100.0
Provider B	56789001	114	1	22948.48	0	0.00	1	22948.48	100.0
Payer Total			164	103,200.33	4	529.15	160	102,671.18	97.6

CareFirst Professional Daily Acceptance Report
For 10/5/2003 thru 10/5/2003

Payer ID: CareFirst Maryland Blue Shield Professional

Provider Name	Provider ID	Total Count	Total Amount	Reject Count	Reject Amount	Accept Count	Accept Amount	Accept Rate
Provider A	H123DF	5	614.38	0	0.00	5	614.38	100.0
Provider B .	H056DF	150	21937.15	4	529.15	146	21408.00	97.3
Provider C	W456LF	67	37700.32	0	0.00	67	37700.32	100.0
Provider D	W789LF	1	48.48	0	0.00	1	48.48	100.0
Payer Total		223	60,300.33	4	529.15	219	59,771.18	97.6

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837 – Q & A's

What type of validator does CareFirst use? What level of edits do CareFirst and CareFirst BlueChoice enforce?
Sybase. WEDI/SNIP levels 1 through 4.

Does CareFirst have any custom edits or requirements for the 837?
CareFirst specific requirements are found in the Companion Guide located at http://www.carefirst.com/Providers & Physicians/Electronic Services/EDI/EDI Manuals, as well as, the 837 Claim Data Requirements, and Pre-Processing edits sections of the Submitter Guide. In addition, as issues arise with the transition to 837 claims, it is sometimes necessary to have the clearinghouses implement custom edits until changes can be made to our systems. We will provide these temporary coding requirements during development and testing.

What do CareFirst and CareFirst BlueChoice expect to see in the ISA06/GS02?
Trading Partner Tax ID.

What segment terminator do CareFirst and CareFirst BlueChoice prefer?
~ (tilde).

What do CareFirst and CareFirst BlueChoice expect to see in the ISA08/GS03?
Maryland Plan Codes (00190, 00690) or NCA Plan Codes (00080, 00580).

Do CareFirst and CareFirst BlueChoice accept claims from non-provider billing entities?
Yes. CareFirst and CareFirst BlueChoice have assigned specific "Submitter IDs" to Billing Providers/Agents who submit on behalf of a provider. The Billing Provider/Agent data should be submitted in Loop 2010AA REF segment when the provider utilizes a Billing Agent to create their claims. The Pay-To-Provider data should then be sent in Loop 2010AB as directed in the Implementation Guides.

What if the provider does not use a Billing Agent?
Pay-To-Provider data should be submitted in Loop 2010AA when there is NO Billing Provider/Agent. As specified in the Implementation Guides, there would be no 2010AB Loop for this scenario.

Can CareFirst and CareFirst BlueChoice accept multiple Rendering Provider numbers at the line level?
No. CareFirst and CareFirst BlueChoice do not consider line level provider information for claim adjudication, but will consider multiple provider numbers in the 2300 Loop.

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Electronic Remittance/835 File Requirements

Electronic Remittance – Trading Partner retrieval from CareFirst and CareFirst BlueChoice

1. CareFirst and CareFirst BlueChoice will process claims for payment and produce a payer specific Electronic Remittance Advice (ERA) through the Common Component Application (CCA). The ERA will be in valid X12N format (ASC X12N 835 004010X091A1).

2. ERA files will be zipped files. This is a batch transaction and the zipped file will contain remittance information from multiple claims payment systems for multiple providers.

3. CareFirst and CareFirst BlueChoice have established a processing schedule for ERA retrieval. During a holiday week, the schedule may shift by one day. Your Vendor Relationship Manager will communicate any schedule change to the Trading Partner via email. (See CareFirst Companion Guide for the schedule http://www.carefirst.com/Providers & Physicians/Electronic Services/EDI/EDI Manuals).

4. The Trading Partner will retrieve the 835 from their SFT mailbox. File name for the 835 is ("O835."CCYYMMDD".zip"). Zipping occurs once (1) each day at **8**:00 p.m. for all Trading Partners. **Any attempts to retrieve 835 files before this time may result in non-zipped files**.

Provider Request and Submission Process

1. Before implementation, the Trading Partner will be required to deliver a file (via email) of all providers that have designated the Trading Partner to receive the 835 transaction. (See "Trading Partner Cross Reference File".)

2. After implementation, the Trading Partner will be required to deliver a file (via email) of all providers that have changed the designation of the Trading Partner to receive the 835 transaction. This file will include providers that are establishing a new relationship with the Trading Partner, and providers that are terminating the existing relationship with the Trading Partner. Providers with a new relationship can include providers that have never received an 835, and providers that are transferring from one Trading Partner to another.

Trading Partner Cross-Reference File

1. The Trading Partner Cross Reference File was developed to maintain the CCA Trading Partner Cross-Reference Table so CareFirst and CareFirst BlueChoice can properly route the 835 X12N transaction.

2. An Excel spreadsheet template will be provided. The Trading Partner is asked to send only the providers who will receive the 835 in an Excel spreadsheet to include the following fields:

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Field Name	Data Type	Len	Description / Expected Values	Req/Opt
PROV_TAX_ID	CHAR	9	Provider Tax ID. This is the Tax ID of the Pay-to Provider.	Required
PROV_LOCL_ID	CHAR	30	Provider Local ID. This is the CARE, FLEXX, or TBS assigned provider ID for the provider group (not Member Level). For MD (plan code 690), this should be: • Professional: the 4 digit Maryland number • Institutional: the 6+2 rendering/pay-to-provider number. For NCA (plan code 580): • Professional: 4 character alpha numeric • Professional Non-Par: 9 character numeric which may or may not be the same as the tax ID Institutional: 3 character alphanumeric	Required
X12N_TRNTN_TYP	CHAR	3	This is the X12 transaction number: '835'	Required
SRCE_SYS_ID	CHAR	3	The system that assigned the Provider Local ID: CARE (Maryland) = '690', FLEXX (D.C.) = '580'.	Required
TPTNER_ID	CHAR	35	This is the identifier that will populate the GS03 (receiver) data element. The value is determined during the trading partner registration process.	Required
TP_EFFT_DT	DATE	10	The date that the trading partner will be receiving the specified transaction (X12N-TRNTN_TYP) for the provider. Must be a valid date in the format ccyy-mm-dd.	Required
TP_THRU_DT	DATE	10	The date that the trading partner will no longer receive the specified transaction (X12N-TRNTN_TYP) for the provider. May be blank. If presentmust be a valid date in the format ccyy-mm-dd.	Optional
PROV_OTH_ID_TYP	CHAR	2	For future use (currently blank)	Optional
PROV_OTH_ID	CHAR	30	For future use (currently blank)	Optional
NATL_PROV_ID	CHAR	10	For future use. The National Provider ID will be required by HIPAA as of May, 2007.	Optional
PROV_LAST_NM	CHAR	35	Provider Last Name (not currently used)	Optional
INFO_SRCE	CHAR	30	Trading Partner Name	Required
MULT_FILE_FLG	CHAR	1	Default is "M" = trading partner requests a separate file from each source system.	Default
CMT_TXT	CHAR	80	For future use	Optional

3. The Trading Partner will email the initial spreadsheet to the Vendor Relationship Manager as part of the trading partner set-up.

4. The Trading Partner will email all updates or changes to the provider table as they arise to **edidirectsubmission@carefirst.com**.

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Proprietary ERA Processing by WebMD

1. To avoid disruption in overall servicing to the provider community, an assessment of the "readiness" level of providers to accept the 835 X12N transaction was performed.
2. Based on this assessment, CareFirst and CareFirst BlueChoice have made the determination to continue sending proprietary ERA files to WebMD only to forward to providers who are not able to accept the 835 X12N transaction.
3. The conditions of these additional instructions are as follows:
   - No modifications will be made to the existing proprietary ERA file layout.
   - WebMD will be responsible for parsing, sorting, and distributing the appropriate file formats. No other Trading Partner will receive the proprietary format from CareFirst and/or CareFirst BlueChoice.
4. Proprietary ERA is scheduled to be discontinued in the future. Notice will be given 60 days prior to discontinuation.

835 X12N Testing

1. The Trading Partner must be able to accept an X12N (ASC X12N-835 00410X091A1) transaction.
2. The Trading Partner must be able to parse the 835 X12N transactions to send to the individual providers/submitters who can accept HIPAA compliant transactions.
3. The Trading Partner will provide CareFirst and CareFirst BlueChoice with a detailed report of all errors encountered on the 835 test files within 48 hours following the receipt of the test file.
4. If the Trading Partner is testing the 835 with individual providers/submitters, then the expected turnaround time should be communicated to CareFirst and CareFirst BlueChoice and accommodated in the testing schedule.

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835/ERA – Q & A's

What delimiters do you utilize? Do you use carriage return line feeds? If so, where?
Segment delimiter = carriage return, element delimiter = asterisk (*), sub-element delimiter = carat (^). There is a line feed after each segment.

Are you able to support issuance of ERAs at a service address location within a Tax ID Number? If so, what provider location ID will be given? In what segment will it be given?
We issue checks and 835 transactions based on the pay-to provider that is associated with the rendering provider in our system. If the provider sets it up with us that way, we are able to deliver 835s to different locations for a single Tax ID Number based on our local provider number. The local provider number is in 1000B REF02 of the 835.

How many transaction files will CareFirst and CareFirst BlueChoice release each day?
CareFirst and CareFirst BlueChoice will release separate transaction files for each claims processing system. Each file can contain multiple 835 transactions. Each claims processing system operates on a separate schedule. The schedule is available in the Companion Guide located at http://www.carefirst.com/Providers&Physicians/Electronic Services/EDI/EDI Manuals.

What level of validation do you do, if any? What level of validation do you require the Trading Partner to perform?
The Sybase translator performs compliance checks for WEDI-SNIP types 1-4. We expect The Trading Partner to perform WEDI-SNIP types 1 and 2.

What will happen if the CareFirst translator detects a compliance error?
CareFirst and CareFirst BlueChoice will release any 835 transaction, whether it has a compliance error or not. If there is a compliance error, the compliant and non-compliant remittances for each claims processing system will be released as separate files.

What type of acknowledgment is expected? Is the Trading Partner expected to deliver a reconciliation file or email?
CareFirst and CareFirst BlueChoice do not require any type of acknowledgement. However, if your compliance check is negative, CareFirst and CareFirst BlueChoice would appreciate a phone call or email.

What is the preferred transmission/connectivity method?
Zipped files via SFT. However, we will consider the FTP process.

What are the provider enrollment requirements? What expectations are there of the Trading Partner?
The Trading Partner must submit a file with all of the 835 providers at start up, and then an update (changes only, not full file) with any additions, deletions, or changes on a weekly basis as needed.

Is there a paper remit elimination policy?
There are no plans to eliminate paper remits at this time.

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Does it matter how/from where the claim was submitted to be included in the ERA?
No, except that certain data elements may use default values if the claim was submitted on paper.

What are the possible values that can be utilized in the ISA06?
CareFirst and CareFirst BlueChoice expect the Trading Partner's Tax ID Number (TIN) or other identifier submitted on the registration form.

What Payer ID should be utilized?
Professional MD = 00690, NCA = 00580
Institutional MD = 00190, NCA = 00080

Will the ISA13 value always be unique?
No. In most cases, the value will be unique. However, if the compliance checker found a compliance error, the compliant and non-compliant files will have the same ISA13 value.

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Appendix A

Develop Pre-Processing Edits

Requirement Description:

Developing Pre-Processing Edits, by the submitter, ensures claims are edited consistently and will enable the passing of "clean data" to CareFirst and CareFirst BlueChoice. These edits should be performed on incoming X12N formats, as well as any proprietary claims formats (UB92, NSF, MEDS, UB82)

Overview

Editing for Code Validation for ICD-9-CM Diagnosis and Procedure Codes, CPT4 / HCPCS Procedure Codes and NUBC codes such as Revenue Codes, Value Codes, Occurrence Codes, etc., will be performed against HIPAA compliant external code set sources listed in the 837 ASC X12N Implementation Guides for both MD and NCA.

The editing for Date Sequencing is independent of destination system and type of claim (i.e., Institutional vs. Professional.)

All remaining edits are common Institutional or Professional edits for CareFirst and CareFirst BlueChoice or are specific by type of claim and are unique to MD and NCA.

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LOGIC:

Common Legacy Code Validation Edits

Edit	MD	NCA	Logic	ERROR CODE
Principal Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BK'	X	X	Institutional Only. Must be a valid 3 to 5 position ICD-9-CM Code. DC must be a specific code.	53512
Principal Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BK'	X	X	For Institutional only. Must be valid code for patient's gender.	53956
Admitting Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BJ'	X	X	Institutional Inpatient only. Must be a valid 3 to 5 position ICD-9-CM Code. DC must be a specific code.	53512
Admitting Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BJ'	X	X	Institutional Inpatient only. Must be valid code for patient's gender.	53906
Other Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BF'	X	X	If present, must be a valid 3 to 5 position ICD-9-CM Code. DC must be a specific code.	53513
Other Diagnosis Code Data Element - 1271 837I Loop 2300 HI01-2 though HI12-2 CD-QL = 'BF'	X	X	If present, must be valid code for patient's gender.	53956
Principal Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BR'	X	X	Institutional Inpatient only. If present, must be a valid 3 or 4 position ICD-9-CM procedure code.	53514
Principal Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BP' or 'BR'	X	X	Institutional only. If present, must be valid code for patient's gender.	53105
Other Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BO'	X	X	Institutional Inpatient only. If present, must be a valid 3 or 4 position ICD-9-CM Code.	53972
Other Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BO' or 'BQ'	X	X	Institutional only. If present ,must be valid code for patient's gender.	53973
Primary Diagnosis Code Data Element - 1271 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BK'	X	X	Professional only. Must be entered, must be a valid 3 or 5 position ICD-9-CM Code.	53512

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Edit	MD	NCA	Logic	ERROR CODE
Primary Diagnosis Code Data Element - 1271 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BK'	X	X	Professional only. Must be valid code for patient's gender.	53956
Procedure Code Data Element - 234 Source - 837P, Loop 2400, SV101-2 QL =HC	X	X	Professional only. For all destinations must be a valid 5 position CPT-4 or HCPCS procedure code. At least one required.	53520
Procedure Code Data Element - 234 Source - 837P, Loop 2400, SV101-2 QL =HC	X	X	Professional only. Procedure Code must be compatible with Patient's Age to validate CPT and HCPCS.	53106
Procedure Code Data Element - 234 Source - 837P, Loop 2400, SV101-2 QL =HC	X	X	Professional only. Procedure Code must be compatible with Patient's Sex to validate CPT and HCPCS.	53105
Procedure Code Data Element - 234 Source - 837P, Loop 2400, SV101-2 QL =HC	X	X	Professional only. If procedure code not equal to anesthesia procedure code (00100-01995, 01999, 02100-02101), qualifier must not equal MJ.	53911
Revenue Code Data Element - 234 Source - 837I, Loop 2400, SV201	X	X	Institutional Only. If inpatient and Claim Frequency Type Code is not '5' or facility type code is not 81X, then there must be at least one Room & Board Revenue code (010X-021X).	53970
Revenue Code Data Element - 234 Source - 837I, Loop 2400, SV201	X	X	Institutional only. At least one must be present and a valid 3 to 4 position Revenue Code.	53971

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Date Sequence Validation Edits

Edit	MD	NCA	Logic	ERROR CODE
Patient Date of Birth Data Element - 1251 Source - 837I, 837P, Loop 2010CA, DMG02	X	X	Must be entered must be valid (must not be equal to spaces or low-values)	53251
Patient Date of Birth Data Element - 1251 Source - 837I, 837P, Loop 2010CA, DMG02	X	X	Cannot be greater than Current System Date.	53262
Patient Date of Birth Data Element - 1251 Source - 837I, 837P, Loop 2010CA, DMG02	X	X	If Institutional, must be less than or equal to Statement Covers From Date If Professional, must be less than or equal to First Date of Service	53137
Admission Date Data Element - 1251 Source – 837I, 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If Facility Type Code = INPATIENT, Admission Date is required (INPATIENT = IP Inst. or IP-Prof (21, 51, 61)	53131
Admission/Start of Care Date Data Element - 1251 Source – 837I, 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If present, cannot be greater than Current System Date.	53129
Admission/Start of Care Date Data Element - 1251 Source – 837I, 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If presen tmust be greater than or equal to Patient Birth Date	53130
Admission/Start of Care Date Data Element - 1251 Source – 837I, 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If Admission Date and Discharge Date are present, Admission Date must be less than or equal to Discharge Date.	53135
Dates of Service Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD first date and RD second date	X	X	If Institutional, Statement Cover Thru Date must be greater than or equal to Statement Cover From Date.	53139
Dates of Service Data Element - 1251 Source - 837P, Loop 2400, DTP03 for DTP01 = 472 and DTP02 = RD8 first date and RD second date	X	X	If Professional, Service End Date must be greater than or equal to Service Begin Date.	53139
Dates of Service Data Element - 1251 Source 837I, Loop 2400, DTP03 for DTP01 = 472 Data Element - 1251 Source - 837D, Loop 2300, DTP03 for DTP01 = 472	X	X	If Institutional, Service End Date must less than or equal to Statement Covers Thru Date.	53901

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Edit	MD	NCA	Logic	ERROR CODE
Dates of Service Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 Data Element - 1251 Source - 837P, Loop 2400, DTP03 for DTP01 = 472	X	X	If Institutional, Statement Covers Thru Date cannot be greater than Current System Date. If Professional, Service End Date cannot be greater than Current System Date.	53144
Dates of Service Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD first date Data Element - 1251 Source - 837P, Loop 2400, DTP03 for DTP01 = 472 and DTP02 = RD8 first date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 431	X	X	Service Begin Date must be greater than or equal to Date of Onset or Claim First Service Date If Present.	53133
Discharge Date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 096	X	X	Professional Only; If present, cannot be greater than Current System Date.	53826
Discharge Date Data Element - 1251 Source 837P, Loop 2300, DTP03 for DTP01 = 096	X	X	Professional only; If present, must be greater than or equal to the Admission Date.	53135
Statement Covers From Date Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD first date	X	X	Institutional only. Must be entered, must be valid.	53143
Statement Covers Thru Date Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD8 second date	X	X	Institutional only. Must be entered, must be valid.	53138
Principal Procedure Date Data Element - 1251 Source - 837I, Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X	X	Institutional only. Must be present if Principal Procedure Code is present.	53831
Other Procedure Dates Data Element - 1251 Source - 837I, Loop 2300 HI021-4 though HI12-4 for HI02-3 through HI12-3 = D8	X	X	Institutional only. Must be present if Other Procedure Code is present	53832
Date of Onset Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 431	X	X	Professional only. If present, must be valid date prior to or equal to the First Date of Service.	53127

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Edit	MD	NCA	Logic	ERROR CODE
Date of LMP Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 484	X	X	Professional only: If present, must be valid date prior to or equal to the First Date of Service.	53127
Date of Accident Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 439 first-tenth occurrence	X	X	Professional only. If present, must be valid date prior to or equal to the First Date of Service.	53127
Initial Treatment Date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 454	X	X	Professional only: If present, must be valid date prior to or equal to the First Date of Service.	53127

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Common Institutional and Professional Edits

Edit	MD	NCA	Logic	ERROR CODE
Patient's Last Name Data Element - 1035 Source - 837I, 837P, Loop 2010CA, NM103	X	X	Cannot be numeric: Cannot be all blank.	53256
Patient's First Name Data Element - 1036 Source, 837I, 837P, Loop 2010CA, NM104	X	X	Cannot be numeric: Cannot be all blank.	53253
Insured's Last Name Data Element - 1035 Source - 837I, 837P, Loop 2010BA, NM103	X	X	Cannot be numeric: Cannot be all blank.	53082
Insured's First Name Data Element - 1036 Source - 837I, 837P, Loop 2010BA, NM104	X	X	Cannot be numeric: Cannot be all blank.	53080
Patient's Relationship to Insured Data Element - 1069 Source - 837I, 837P, Loop 2000C, PAT01	X	X	Must be a valid Patient Relationship Code.	53258
Patient's Sex Data Element - 1068 Source - 837I, 837P, Loop 2010CA, DMG03	X	X	Must be equal to “M”, “F” or "U".	53260
Claim Original Reference Number (Claim Number) Data Element - 127 Source - 837I, 837P, Loop 2300, REF02 for REF01 = F8	X	X	If Adjustment (Clm Freq NE 1-5), Clm Orig Ref Number must be present	53845
Patient Account Number Data Element - 1028 Source - 837I, 837P, Loop 2300, CLM01	X	X	Cannot be all spaces.	53837
Release of Information (Subscriber Signature not on File) Data Element - 1363 Source 837I, 837P ,Loop 2300, CLM09	X	X	If Subscriber signature is not on file, reject the claim.	53083
Claim Frequency Data Element - 1325 Source - 837I, 837P, Loop 2300, CLM05-3		X	Claim Frequency cannot = 0 (Encounters).	53844
Claim Frequency Data Element - 1325 Source - 837I, 837P, Loop 2300, CLM05-3	X	X	Claim Frequency cannot = 6 (Adjustment Prior Claim).	53846

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Common Institutional Validation Edits

Edit	MD	NCA	Logic	ERROR CODE
Admission/Start of Care Date Data Element - 1251 Source - 837D, 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If Inpatient, If Clm Freq Cd = 3 or 4, then Statement Covers From Date must be greater than Admission Date. If Inpatient, If Clm Freq Cd = 1 or 2, then Statement Covers From Date must = Admission Date.	53141
Admission Type Codes Data Element - 1315 Source - 837I, Loop 2300, CL101	X	X	If claim is INPATIENT, Type of Admission must be any of the following values: ‘1’ thru '5' and ‘9’.	53975
Admission Type Codes Data Element - 1315 Source - 837I, Loop 2300, CL101	X	X	If Admit Type = 4 (Newborn), patient DOB must be within 30 days of Admission.	53932
Admission Source Data Element - 1314 Source - 837I, Loop 2300, CL102	X	X	If Type of Admission = 4 (Newborn), Source of Admission must be 1 thru 4 or 9.	53929
Admission Source Data Element - 1314 Source - 837I, Loop 2300, CL102	X	X	If claim is INPATIENT must be entered, must be valid. Valid values 1 thru 9 and A-D.	53974
Condition Codes Data Element - 1271 837I, 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BG'	X	X	If present must be valid values.	53977
Occurrence Code Data Element - 1271 837I, 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'	X	X	If present must be valid values.	53978
Occurrence Code Data Element - 1271 837I, 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'	X	X	If Principal Diagnosis Code = MATERNITY = '630' THRU '677' 'V22' THRU 'V242' 'V27' THRU 'V279' 'V615' THRU 'V617' ‘V724’ then Occurrence Code must equal 10.	53918
Occurrence Date Data Element - 1251 Source - 837I, 837P, Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X	X	The Occurrence Date must be a valid date if the Occurrence Code is given.	53998
Occurrence Date Data Element - 1251 Source - 837I, 837P, Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X	X	If Occurrence Code is 01-06, (Accident Related), Occurrence Date must be less than or equal to Statement From Date.	53922
Occurrence Date Data Element - 1251 Source - 837I, 837P, Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X	X	If inpatient, and if Occurrence Code is 10 (Last Menstrual Period), then Occurrence Date must be less than or equal to Admission Date.	53924

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Patient Discharge Status Data Element – 1352 Source - 837I, Loop 2300, CL103	X	X	If Inpatient, must be present, must be valid.	53976
Patient Discharge Status Data Element - 1352 Source - 837I, Loop 2300, CL103	X	X	If Inpatient, If Claim Freq Code = 2 or 3, Patient Status must equal 30.	53925
Patient Discharge Status Data Element - 1352 Source - 837I, Loop 2300, CL103	X	X	If Inpatient, If Claim Freq Code = 1 or 4, Patient Status cannot equal 30.	53926
Discharge Hour Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 096	X	X	If Inpatient and Admission Date is equal to Statement Covers Thru Date, then Discharge Hour must be greater than or equal to Admission Hour.	53915
Facility Type Code (Pos. 1 & 2 of TOB) Data Element - 1331 Source - 837I, Loop 2300, CLM05-1	X	X	Must be present, must be valid.	53301
Value Codes Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BE'	X	X	If present must be valid values.	53979
Value Codes Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BE'	X	X	If Revenue Code 011x, 014x or 0164 is present, Value Codes 01or 02 are required.	53943
Value Amount Data Element - 782 Source - 837I, 837P, Loop 2300 HI01-5 though HI12-5 CD-QL = 'BE'	X	X	If Value Code is present and is not equal to 02, 12, 13 or 45, Value Amount must be greater than zero (0).	53938
Values Codes Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BE'	X	X	If Revenue Code 038X present, then Value Code 37 and 39 are required.	53942
Value Amount Data Element - 782 Source - 837I, 837P, Loop 2300 HI01-5 though HI12-5 CD-QL = 'BE'	X	X	Value Amount for Value Code 45 must be in whole dollars and must be 00-23 or 99.	53941
Units of Service Data Element - 380 Source - 837I, Loop 2400, SV205	X	X	Units/Days for Revenue Code 038X and Value Amount for Value Code 39 must be less than or equal to Value Amount for Value Code 37.	53510
Principal Procedure Code (ICD-9-CM Surgical) Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = “BR”	X	X	ICD9 procedure code required if Revenue Code 036x, 0723, 0811, 0813. Inpatient Only.	53927

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Edit	MD	NCA	Logic	ERROR CODE
Revenue Code Data Element - 234 Source - 837I, Loop 2400, SV201	X	X	If Condition Code equals 38 or 39 (Private Room explanation), then Revenue Code must equal 011x or 014x or 0164 on one or more lines.	53944
Revenue Code Units Data Element - 380 Source - 837I, Loop 2400, SV205		X	Units must be numeric and > zero (MD Inst present for specific Inpat or Outpat, Inpat Only or Outpat Only revenue codes).	53834
Total Charges Data Element - 782 Source - 837I, Loop 2300, CLM02	X	X	Total Charges must be > zero.	53202
Other Carrier Paid Data Element - 782 Source - 837I, Loop 2320, AMT02 for AMT01 = C4	X	X	The “Other Insurance Paid” amount less than or equal to Total Charge Amount.	53232

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Common Professional Validation Edits

Edit	MD	NCA	Logic	ERROR CODE
Admission Date Data Element - 1251 Source 837P, Loop 2300, DTP03 for DTP01 = 435	X	X	If Inpatient, must be less than or equal to earliest Date of Service on any bill line where the Facility Type Code is Inpatient.	53141
Discharge Date Data Element - 1251 Source 837P, Loop 2300, DTP03 for DTP01 = 096	X	X	If Inpatient, If present, must be greater than or equal to latest Date of Service on any bill line where the Facility Type Code is Inpatient.	53955
Anesthesia Time Data Element - 235 Source - 837P, Loop 2400, SV101-1 Data Element - 234 Source - 837P, Loop 2400, SV101-2 Data Element - 355 Source - 837P, Loop 2400, SV103	X	X	If Procedure Code equals “00100 THRU 01995” or “01999”, “02100 thru 02101”, excluding Temp. Codes (Anesthesia minutes), then unit count must be greater than zero (0).	53035
NOC/IC Procedure Code without Narrative Data Element - 352 Source - 837D, 837P, Loop 2400, NTE02 first occurrence	X	X	A “Not Otherwise Classified” or “Individual Consideration” Procedure Code was submitted electronically without a narrative explanation.	53952
Number of Services Data Element - 380 Source - 837P, Loop 2400, SV104	X	X	Must be greater than ‘0001’ if To Date of Service is greater than From Date of Service.	53145
Facility Type Code (Place of Service or Treatment) Data Element - 1331 Source - 837P, Loop 2300, CLM05-1	X	X	Must be a valid HCFA Facility Type Code.	53503
Frequency (Units) Data Element - 380 Source - 837P, Loop 2400, SV104	X	X	Must be numeric and > zero.	53510
Total Claim Charges Data Element - 782 Source - 837P, Loop 2300, CLM02	X	X	Total Charges must be numeric and Balance to BILLED LINE CHARGES.	53204
Diagnosis Number Pointer Data Element - 1328 Source - 837P, Loop 2400, SV107-1-4	X	X	Must be entered, must be valid code “01” thru “08” and point to a valid Diagnosis code on the claim.	53839
Billed Line Charge Data Element - 782 Source - 837P, Loop 2400, SV102	X	X	Billed Line Charge must be greater than zero.	53202

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System Specific Institutional Edits

Edit	MD	NCA	Logic	ERROR CODE
Condition Codes Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BG'	X		If Revenue Code = 82x, 83x, 84x, 85x or 88x (Dialysis), then Condition Code must = 06 or 70-76 (ERSD related).	53912
Condition Codes Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BG'	X		If Condition Codes (31-34) OR (36-39) OR (06, 70-76) are present, only one Condition Code in each series is acceptable per claim.	53913
Occurrence Date Data Element - 1251 Source - 837I, Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X		If Occurrence Code is 42 (Date of Discharge), Admission Date year must be equal Occurrence Date year.	53921
Occurrence Date Data Element - 1251 Source - 837I Loop 2300 HI01-4 though HI12-4 for HI01-3 through HI12-3 = D8	X		If Occurrence Code is 22 (Date Active Care Ended), Occurrence Date must be greater than or equal to Statement From Date and less than or equal to Statement Thru Date.	53923
Discharge Hour Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 096	X		The DISCHARGE HOUR must be entered if Claim equal Inpatient and Condition Code = 40 (same day transfer).	53914
Principal Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BP'	X		Required if Facility Type Code (Type of Bill) = 83x and Revenue Code = 0490.	53928
Revenue Code Data Element - 234 Source - 837I, Loop 2400, SV201	X		If Revenue Code = 0724, the 1st 3 positions of Principal Diagnosis Code must = 650.	53916
Bill Line Charge Data Element - 782 Source - 837I, Loop 2400, SV203	X		Billed Line charge must be greater than “0”.	53202
Occurrence Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'	X		If Principal Diagnosis Code = ACCIDENT values 'V015' '52511' '800' THRU '9998' Occurrence Codes must equal 01-06.	53917
Occurrence Code Data Element - 1271 837I, 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'	X		If Occurrence Code = 01-06, Value Code must equal 45.	53919
Occurrence Code Data Element - 1271 837I, 837P, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'	X		Only one Occurrence Code = 01-06, can be entered per claim.	53920
Facility Type Code (Pos. 1 & 2 of TOB) (Pos. 1 & 2 of TOB) Data Element - 1331 Source - 837I, Loop 2300, CLM05-1	X		If Facility Type Code = 83X, then Revenue Codes 0490 or 079X must be present.	53933

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Edit	MD	NCA	Logic	ERROR CODE
Covered Days Data Element - 380 Source - 837I, Loop 2300, QYT02 for QTY01 = CA	X		If Inpatient and Clm-Freq = 0 (non-payment zero claim, Inpatient) then Covered Days must = 0.	53959
Covered Days Data Element - 380 Source - 837I, Loop 2300, QYT02 for QTY01 = CA	X		If Inpatient and Condition Code = 40 (Same Day Transfer), then, Covered Days must = 01.	53960
Covered Days Data Element - 380 Source - 837I, Loop 2300, QYT02 for QTY01 = CA	X		If Inpatient and Condition Code NE 40 (Same Day Transfer) Covered Days must be greater than 0	53961
Principal Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BP'	X	X	Outpatient only. HCPCS/CPT procedure code required if Revenue Code 036x, 049x, 0723, 0811, 0813.	53930
Principal Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BP'	X	X	Institutional Outpatient only. If present must be a valid 5 position CPT-4 or HCPCS procedure code.	53843
Other Procedure Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BO'	X	X	Institutional Outpatient only. If present must be a valid 5 position CPT-4 or HCPCS procedure code.	53843
Notes (Remarks) Data Element - 352 Source - 837I, Loop 2300, NTE02 for NTE01 = ADD Data Element - 352 Source -, 837I Loop 2300, NTE02 for 837I NTE01 not = ADD first occurrence	X		Claim Header Notes cannot be blank if Revenue Code requires remarks.	53907
Billed Line Charge Data Element - 782 Source - 837I, Loop 2400, SV203 Data Element - 1371 Source - 837I, Loop 2400, SV20 Data Element - 380 Source - 837I, Loop 2400, SV205	X		If Inpatient, accommodations line item revenue code = 0100 to 0219 and unit qualifier = DA and the room rate is greater than 0 then room rate multiplied by number of days billed must equal billed line charge.	53204
Occurrence Code Data Element - 1271 837I, Loop 2300 HI01-2 though HI12-2 CD-QL = 'BH'		X	If any Diagnosis Code = ACCIDENT values 'V015' '52511' '800' THRU '9998' then Occurrence Codes must equal 01-06	53917
Facility Type Code Data Element - 1331 Source - 837I, Loop 2300, CLM05-1		X	If the Facility Type Code = 81 or 82 (Hospice) and the Revenue Code = 655 or 656 (Inpatient Respite, General Inpatient), the Frequency Code must equal the difference between the Service From Date and the Service Thru Date.	53947

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Edit	MD	NCA	Logic	ERROR CODE
Facility Type Code Data Element - 1331 Source - 837I, Loop 2300, CLM05-1		X	If the Facility Type Code = 81 or 82 (Hospice), the Revenue Code = 655 or 656 (Inpatient Respite, General Inpatient), and the Statement Covers From Date and Statement Covers Thru Date are the same, the frequency code must equal 001.	53948
Revenue Dates Data Element - 1251 Source - 837I, Loop 2400, DTP03 for DTP01 = 472 and DTP02 = D8 Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD first date Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD8 second date		X	If Outpatient and Statement Covers From Date is not equal Statement Covers Thru Date, at least one Revenue Date must equal the Statement Covers From Date.	53967
Revenue Dates Data Element - 1251 Source -, 837I, Loop 2400, DTP03 for DTP01 = 472 and DTP02 = D8 Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD first date Data Element - 1251 Source - 837I, Loop 2300, DTP03 for DTP01 = 434 and DTP02 = RD8 second date		X	If Outpatient and Statement Covers From Date is not equal Statement Covers Thru Date, at least one Revenue Date must equal the Statement Covers Thru Date.	53968
Notes (Remarks) Data Element - 352 Source - 837I, Loop 2300, NTE02 for NTE01 = ADD Data Element - 352 Source -, 837I Loop 2300, NTE02 for 837I NTE01 not = ADD first occurrence		X	Claim Header Notes cannot be blank if Revenue Code requires remarks for codes 0189, 0229, 0259, 0299, 0459, 0519, 0529, 0679, 0689, 0769, 0779, 0789, 0799, 0809, 0819, 0919, 0949.	53907
Coinsurance/Prior Payment Amount Data Element - 782 Source - 837I, Loop 2320, AMT02 for AMT01 = C4		X	Must be numeric or zero filled.	53835

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System Specific Professional Edits

Edit	MD	NCA	Logic	ERROR CODE
Anesthesia Procedure Code Data Element - 234 Source - 837P, Loop 2400, SV101-2	X		If Anesthesia Procedure Code,excluding Temp. codes, must have at least one of the following Procedure Code modifiers AA, AD, QK, QX, QY, or QZ.	53526
Procedure Code Modifier Data Element - 1339 Source - 837P, Loop 2400, SV101-3	X	X	If Procedure Code equal B9000-B9006, E0100-E0117, E0130-E0149, E0153-E0182, E0184-E0188, E0192-E0194, E0196-E0200, E0205-E0230, E0238-E0251, E0255-E0297, E0305-E0316, E0325-E0326, E0350, E0372, E0455, E0457, E0459-E0460, E0462-E0482, E0500, E0550-E0585, E0600-E0601, E0605-E0606, E0610-E0617, E0620-E0669, E0671-E0673, E0690-E0730, E0740-E0748, E0751-E0752, E0754-E0758, E0760- E0776, E0780-E0786, E0779, E0830-E0930, E0940, E0942-E1001, E1011-E1027, E1031-E1038, E1050-E1090, E1092-E1340, E1372, E1399, E1353, E1355, E1360, E1500-E1699, E1700-E1818, E1821-E1830, K0001-K0007, K0009-K0012, K0014-K0108, K0115-K0116, K0195, K0268, K0531-K0534, K0541-K0547, K0549-K0551, K0600-K0605 and modifier occurrence 1-4 is blank or does not equal BP, BR, BU, KA, KH, KI, KJ, KM, KN, KR, KS, KX, LL, MS, NR, NU, QE, QF, QG, QH, RP, RP, RR, UE, K0-K4 reject as invalid modifier.	53509
Procedure Code Modifier Data Element - 1339 Source - 837P, Loop 2400, SV101-3	X		If present, Procedure Code modifier must be valid.	53509
Other Carrier Paid Amount Data Element - 782 Source - 837I, 837P, Loop 2430, SVD02	X		The "Other Carrier Paid" amount cannot be greater than billed line charge.	53232
Accident Date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 439 (1-10)	X		Must be present if the Primary Diagnosis Code is accident related and Provider is not an Independent Lab (INDPNT-LAB-INDC) ACCIDENT values = V015' '52511' '800' THRU '9998'.	53953
LMP Date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 484	X		Must be present if Primary Diagnosis Code is Maternity and provider is not an Independent Lab (INDPNT-LAB-INDC), LMP values = '630' THRU '677' 'V22' THRU 'V242' 'V27' THRU 'V279' ‘V28’ THRU ‘V289’ 'V615' THRU 'V617' ‘V724’.	53908
Medical Emergency Onset Date Data Element - 1251 Source - 837P, Loop 2300, DTP03 for DTP01 = 431	X		Must be present if Primary Diagnosis Code is a Medical Emergency Code related and Provider is not an Independent Lab (INDPNT-LAB-INDC).	53142
Accident Date Data Element - 1251 Source 837P, Loop 2300, DTP03 for DTP01 = 439 (1-10)		X	Must be present if any Diagnosis Code is accident related and Provider is not an Independent Lab (INDPNT-LAB-INDC) ACCIDENT values = V015' '52511' '800' THRU '9998' **This edit is for FEP only.**	53953
Assignment of Benefits Indicator Data Element - 1073 Source 837P, Loop 2300, CLM08		X	If Tax ID or Social Security Number are used for Provider Number, the Assignment of Benefits Indicator must be present	53836

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Appendix B

Proprietary Acknowledgement File

The CareFirst and CareFirst BlueChoice Business Acknowledgement provides claim acceptance and rejection information back to the clearinghouse/provider. One Business Acknowledgement will be generated per X12N 837 file. Each Acknowledgement will be distributed back to the Trading Partner in report file format each business day.

A separate Acknowledgement will be produced for each electronic transaction type: one (1) for NCA & MD Institutional claims, and one (1) for NCA & MD Professional claims.

A separate Acknowledgement will be generated for each registered Trading Partner, and routed via the Trading Partner Database to their SFT mailbox, for distribution to the Trading Partner

Each Acknowledgement will provide total number of claims submitted, detailed rejection of claims returned for errors identified in CCA and in the FEP subscriber validation process, and the total number of claims accepted. The 5-digit Corporate Message Code will be reported back on the Acknowledgement along with the data field in error.

- A common Acknowledgement record will be generated for each claim. All passed and rejected claims will be reported on the Acknowledgement.
- If CareFirst and/or CareFirst BlueChoice passes the claim, the transaction status (GLBL-TRNTN-STUS) on the Acknowledgement record will be “P”.
- If CareFirst errors are found, the transaction status (GLBL-TRNTN-STUS) on the Acknowledgment record will be “R”.
- If the claim is identified that the Payer ID has been switched, the switched indicator (SWITCHED-INDC) will be “S”. The appropriate Corporate Message Code (53900, 53902) will be set in the Error-Data section of the Acknowledgement record.
- CareFirst and/or CareFirst BlueChoice will pass the 5 digit Corporate Message Code (CORPT-MSG-CD), the errors message (DATA-ELEM-COPY) along with the error on the Acknowledgement.

Overview

The file will contain multiple batch records that correspond to batches sent by NCA/MD Trading Partners. There will be one-to-many detail records, each record representing a claim. For each detail record, there will be zero-to-many error records. Only one error will be specified per error record. At the completion of the batch a batch record will be generated. This file will not contain a trailer record. Fixed length of the file is 400 bytes.

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Standard Acknowledgement Detail Record:

DETAIL STANDARD ACKNOWLEDGEMENT RECORD LAYOUT		
RECORD-TYPE	PIC X(01)	Record Type: D - Detail Acknowledgement
SUBMITTER-ID	PIC X(80)	Submitter Number/Billing Agent
GUID-CLM	PIC 9(15)	CareFirst or CareFirst BlueChoice HIPAA Claim Number
GLBL-TRNTN-STUS	PIC X(01)	Transaction Status: P - Passed Edits R - Rejected Edits
SWITCHED-INDC	PIC X(01)	Payor Switched Indicator: S - Payor ID Switched
SYSTEM-SOURCE	PIC X(01)	CareFirst or CareFirst BlueChoice System Source
PATN-ACCT-NBR	PIC X(38)	Patient Account Number
CLRGHOUS-ID (REFD9)	PIC X(30)	Clearinghouse Document Control Number/Trace Number
SUBR-ID	PIC X(30)	Subscriber ID
NUM-ERROR-CODES	PIC 9(02)	Number of Errors on Claim
CLM-LINE-CNTR	PIC S9(05)	Number of Detail Lines on Claim
XWLKED-PROV-ID	PIC X(17)	Switched Provider Number
PYPV-ID1	PIC X(30)	Provider Number Used to Process Claim unless claim is switched
PAYR-ID	PIC X(05)	Original Payor ID Submitted
CLM-DCN	PIC X(15)	Adjudication Claim Number (i.e., FLEXX or CARE)
X12N-TOT-CLM-CHRGS	PIC S9(15)V9(2)	Billed Charges for the Claim
PATN-LAST-NM	PIC X(35)	Patient Last Name
PATN-FRST-NM	PIC X(25)	Patient First Name
CLM-FRST-SERVC-DT	PIC X(10)	Claim First Date of Service
CLM-LAST-SERVC-DT	PIC X(10)	Claim Last Date of Service
FILLER	PIC X(32)	

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Standard Acknowledgement Error Record:

ERROR STANDARD ACKNOWLEDGEMENT RECORD LAYOUT		
RECORD-TYPE	PIC X(01)	Record Type: E - Error Detail Acknowledgement
SUBMITTER-ID	PIC X(80)	Submitter Number/Billing Agent
GUID-CLM	PIC 9(15)	CareFirst HIPAA Claim Number
CORPT-MSG-CD	PIC X(05)	CareFirst Error Code
LINE-NBR	PIC S9(06)	Line Number Error Occurred On: 000000 - Header 00001 - 99999 Detail
DATA-ELEM-NM	PIC X(30)	Data Element Name Found in Error
DATA-ELEM-COPY	PIC X(80)	Data Element Values Found in Error or Error Message
FILLER	PIC X(183)	

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Standard Acknowledgement Batch Record:

BATCH STANDARD ACKNOWLEDGEMENT RECORD LAYOUT		
RECORD-TYPE	PIC X(01)	Record Type: B - Batch Acknowledgement
SUBMITTER-ID	PIC X(80)	Submitter Number/Billing Agent
TRNTN-SET-CNTL-NBR	PIC X(09)	Clearinghouse Batch Number
CREATE-DATE	PIC X(10)	Clearinghouse Create Date
TOT-BATCH-CLAIMS	PIC 9(05)	Total Claims in Batch
TOT-REJECT-CLAIMS	PIC 9(05)	Total Rejected Claims in Batch
TOT-BATCH-CHRGS	PIC 9(09)V99	Total Charges in Batch
ACKN-SOURCE	PIC X(2)	Payor that produced Acknowledgement: NCA - District of Columbia DE - Delaware MD – Maryland
CLAIM-TRANSACTION-TYPE	PIC X(01)	837 transaction qualifier: I - Institutional P- Professional
TYPE-OF-BILL	PIC X(3)	Institutional Type of Bill (837I only)
FILLER	PIC X(273)	

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Proprietary Error Codes

Code	Description
53000	Return to submitter. Prefix must be valid alpha/numeric.
53028	Membership number is not on file.
53035	The field Anesthesia Time Minute is required when the service rendered is Anesthesia.
53080	Invalid Subscriber First Name.
53082	Invalid Subscriber Last Name.
53083	Subscriber Signature must be on file.
53105	Procedure code not compatible with patient sex.
53106	Procedure code not compatible with patient age.
53127	RETURN TO SUBMITTER, VALID DATE OF SERVICE REQUIRED.
53129	ADMISSION DATE cannot be greater than today or current system date.
53130	ADMISSION DATE must be greater than or equal to patient's date of birth.
53131	Admission Date required when Place of Service is inpatient.
53133	ONSET DATE, SERVICE DATE and/or BIRTHDATE are incompatible.
53135	DISCHARE DATE (if coded) must be greater than or equal to Admission Date.
53137	Incurred From Date must be equal to or greater than patient's Date of Birth.
53138	Invalid Incurred Thru Date.
53139	Incurred Thru Date must be equal to or greater than Incurred From Date.
53141	Admission Date must be less than or equal to Incurred From Date.
53142	Condition Onset Date is required.
53143	Incurred From Date is required.
53144	Incurred thru date must be less than or equal to current date.
53145	Days, visits, treatments must be greater than one.
53177	Provider number and/or initials not on file for Date Of Service.
53189	Provider number not valid.
53194	Tax ID and provider number do not match provider file.
53202	Billed Charge must be greater than zero.
53204	Invalid Billed Charge.
53232	Other Insurance Amount Paid must be equal or less than Billed Charges.
53251	Patient's Date of Birth is required.
53253	First Name of patient required.
53256	Invalid Last Name of patient.
53258	Invalid Patient Relationship to Subscriber.
53260	Invalid Sex of patient.
53262	Patient date of birth cannot be greater than today's or current system date
53301	RETURN TO SUBMITTER, a valid Facility Type Code is required.
53503	Invalid Facility Type Code/Place of Service.
53504	Place of Service is not compatible with Procedure.
53509	Invalid CPT Modifier Code.

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53510	Invalid Units/Days/Visits/Treatments.
53512	Must be present, must be valid 3-5 position ICD-9-CM code. For DC must be specific.
53513	If present, must be valid 3 to 5 position Other ICD-9-CM Diagnosis code. For DC must be specific.
53514	If present, must be a valid 3-4 position ICD-9-CM surgical procedure code. For DC must be specific.
53520	Must be valid 5 position CPT-4 or HCPCS PROCEDURE CODE. One code must be present.
53526	If HCPCS Procedure codes are within the range of 00100-01995, 01999, 02100-02101 then at least one of the following modifier values must be submitted: AA, AD, QK, QX, QY or QZ.
53562	Modifier is not valid with the procedure code submitted on this claim line.
*53810	Cannot convert Medicare Provider #, no match or multiple matches on crosswalk table.
*53811	Cannot convert Medicare Provider #, match on crosswalk table termed for dates of service.
53821	CareFirst is not the Utilization Management review agent (278).
53826	DISCHARGE DATE cannot be greater than Current System date. Professional Only.
53828	This claim must be resubmitted with a valid BCBS of Delaware prefix
53827	Units qualifier must = MJ for procedure modifier range 80-82.
53831	Principal Procedure Date must be present if Principal Procedure Code is present.
53832	Other Procedure Date must be present if Other Procedure Code is present.
53833	If REV_CD = 010X-015X, 020X, 021X, number of days must be greater than 0(zero).
53834	Revenue Code units must be numeric and greater than 0 (zero).
53835	Coinsurance Amount must be numeric or zero (0) filled.
53836	Assignment of Benefits Indicator must be present.
53837	Patient Account Number required.
53838	Reserved for HIPAA.
53839	Invalid Diagnosis Code Pointer.
53840	Missing or Invalid Provider UPIN Number.
53841	Invalid Treatment Authorization Code.
53842	Invalid Prior Authorization Number.
53843	Invalid Procedure Code reported.
53844	Claim Frequency Code cannot equal 0 (zero).
53845	ICN/DCN is required for adjustment.
53846	Claim Frequency Code cannot equal 6 (Adjustment Prior Claim).
53867	Reserved for HIPAA.
53900	Claim was forwarded to the BCBSNCA Plan using your NCA Provider Number.
53901	Date of Service must be less than or equal to Statement Covers Thru Date.
53902	Claim was forwarded to the BCBSMD Plan using your MD Provider Number.

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53903	Provider Number submitted is not on file.
53904	Cannot identify patient.
53905	NON COVERED line charges may not exceed TOTAL CLAIM CHARGES.
53906	Admitting Diagnosis Code is not valid for patient's sex.
53907	REVENUE CODE requires REMARKS.
53908	If DIAGNOSIS CODE is Maternity, LAST MENSTRUAL DATE is required.
53910	Subscriber Identification Number format in Invalid. Must not be blank or contain embedded blanks or special characters.
53911	Units Qualifier "MJ" only valid with Anesthesia procedure codes “00100 THRU 01995” or “01999”, "02100-02101".
53912	If Revenue Codes = 082X, 083X, 084X, 085X, or 088X (dialysis), then Condition Code must equal 06, 70-76 (ESRD related).
53913	If Condition Codes (31-34) or (36-39) or (06, 70-76) are present, only one Condition Code per series is acceptable per claim.
53914	The DISCHARGE HOUR must be entered if Claim Frequency = Inpatient and if Condition Code = 40 (same day transfer).
53915	DISCHARGE HOUR must be greater than or equal to ADMISSION HOUR (same day transfer) if the ADMISSION DATE is equal to the STATEMENT COVERS FROM DATE .
53916	If the INPATIENT ANCILLARY REVENUE CODE or OUTPATIENT REVENUE CODE equals 0724, the PRINCIPAL DIAGNOSIS CODE must equal 650.
53917	OCCURRENCE CODE must equal 01-06, if the PRINCIPAL DIAGNOSIS CODE equals V015, 52511, 800-9958, 99653, 9982.
53918	OCCURRENCE CODE must equal 10 if PRINCIPAL DIAGNOSIS CODE equals 630-6769, 76490, 7965-v1329, v22-v222, v23-v242, v27-v289, v616-v617, v724.
53919	If OCCURRENCE CODE equals 01-06, VALUE CODE must equal 45.
53920	Only one OCCURRENCE CODE of 01-06, can be entered per claim.
53921	If the OCCURRENCE CODE equals 42 (date of discharge) the ADMISSION DATE year must equal the OCCURRENCE DATE year.
53922	If the OCCURRENCE CODE equals 01-06 (accident related), the OCCURRENCE DATE must be less than or equal to the STATEMENT FROM DATE.
53923	OCCURRENCE DATE must be greater than or equal to STATEMENT FROM DATE and less than or equal to STATEMENT THRU DATE.
53924	If OCCURRENCE CODE = 10 (last menstrual period), OCCURRENCE DATE must be less than or equal to ADMISSION DATE.
53925	If CLAIM FREQUENCY CODE equals 2 or 3, then PATIENT STATUS must equal 30.
53926	If CLAIM FREQUENCY CODE equals 1 or 4, then PATIENT STATUS cannot equal 30.
53927	ICD-9 PROCEDURE CODE is required if the REVENUE CODE equals 036X, 0723, 0811, 0813.

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53928	PRINCIPAL PROCEDURE CODE is required if the Facility Type Code equals 83X and REVENUE CODE equals 0490.
53929	SOURCE OF ADMISSION must equal 1-4 or 9 if the TYPE OF ADMISSION equals 4.
53930	HCPCS/CPT PROCEDURE CODE is required if the REVENUE CODE equals 036X, 0723, 0811, 0813.
53932	If TYPE OF ADMISSION equals 4 then PATIENT DATE OF BIRTH must be within 30 days of ADMISSION DATE.
53933	If TYPE OF BILL equals 83X then REVENUE CODE must equal 490 or 79X.
53937	REVENUE CODE submitted requires HCPCS code.
53938	VALUE AMOUNT must be present if VALUE CODE is not equal to 02, 12, 13 or 45.
53941	If VALUE CODE = 45 then VALUE AMOUNT must be formatted as whole dollars when values = 00-23 or 99.
53942	VALUE CODES 37 and 39 are required if REVENUE CODE 038X is present.
53943	VALUE CODE 01 or 02 is required if REVENUE CODE 011X, 014X or 0164 are present.
53944	If Condition Code equals 38 or 39 (Private Room explanation), then Revenue Code must equal 011x or 014x or 0164 on one or more lines.
53947	If FAC TYPE CODE equals 81X, 82X (hospice) and REVENUE CODE equals 0655 or 0656 (inpatient respite, general inpatient) then the FREQUENCY must be equal to the difference between the FROM DATE OF SERVICE and TO DATE OF SERVICE.
53948	If FACILITY TYPE CODE equals 81X or 82X (hospice) and REVENUE CODE equals 0655 or 0656 (inpatient respite, general inpatient) and FROM DATE OF SERVICE and TO DATE OF SERVICE are the same, then the FREQUENCY must equal 001.
53949	If PATIENT STATUS equals 1-20 or 40-42 (discharged or expired), then FACILITY TYPE CODE must equal 1X, 21X, 31X, 41X, 51X, 61X, 81X, 82X (inpatient).
53952	ADDITIONAL INFORMATION must be present if a Not Otherwise Classified or Individual Consideration procedure code is submitted.
53953	ACCIDENT DATE must be present if DIAGNOSIS CODE is accident related.
53955	DISCHARGE DATE cannot be less than the latest DATE OF SERVICE on any bill line where the PLACE OF SERVICE is inpatient
53956	The DIAGNOSIS CODE is invalid for PATIENT'S SEX.
53959	COVERED DAYS must equal zero if the CLAIM FREQUENCY equals 0 (non-payment zero claim, inpatient).
53960	COVERED DAYS must equal 01 if the CLAIM FREQUENCY equals Inpatient and CONDITION CODE equals 40 (same day transfer).
53961	COVERED DAYS must equal 1-365 if the CLAIM FREQUENCY equals Inpatient and CONDITION CODE does not equal 40 (same day transfer).
53963	ANCILLARY UNITS required with this REVENUE CODE.

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53965	ANCILLARY DATE must equal zero, for REVENUE CODES between 100-219.
53966	ANCILLARY UNITS must equal zero, for REVENUE CODES between 100-219.
53967	If Statement Covers From Date does not equal Statement Covers Thru Date, the Revenue Date must be equal to the Statement Covers From Date.
53968	If the Statement Covers From Date does not equal Statement Covers Thru Date, then the Revenue Date must equal the Statement Covers Thru Date.
53969	Outpatient Claims require REVENUE CODE and ANCILLARY UNITS.
53970	Valid REVENUE CODE is required if Type of Bill equals Inpatient.
53971	Must be present must be valid 3-4 position REVENUE CODE
53972	If present, must be valid 3-4 position ICD-9-CM CODE. For DC must be specific.
53973	Must be a valid OTHER PROCEDURE CODE for patient's sex.
53974	Must be a valid ADMISSION SOURCE CODE.
53975	Must be a valid ADMISSION TYPE CODE.
53976	Must be a valid PATIENT STATUS CODE.
53977	Must be a valid CONDITION CODE.
53978	Must be a valid OCCURRENCE CODE.
53979	Must be a valid VALUE CODE.
53981	If REVENUE CODE 036X is present, then the PRINCIPAL PROCEDURE CODE must be present.
53983	ANCILLARY DATE must be greater than or equal to STATEMENT FROM DATE.
53985	REVENUE LAB CODES are not permitted on Inpatient Claim.
53986	Invalid DISCHARGE STATUS for claim frequency type 2 & 3.
53988	VALUE CODE 05 must be less than or equal to the TOTAL CLAIM CHARGES.
53991	Date of Service not within allowable inquiry period (270).
53992	Please call 1-800-423-9791 for Eligibility Information on this patient (270).
53993	PATIENT DISCHARGE STATUS is incorrect for TYPE OF BILL.
53995	Invalid Facility Name.
53996	Subscriber cannot be identified in that Insurance Type Code.
53997	Service Type Code is not available for this patient.
53998	OCCURRENCE DATE must be present if OCCURRENCE CODE present.

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