blue california

Promise Health Plan

Blue Shield of California Promise Health Plan

5010 Companion Guide

Transactions based on ASC X12 Implementation Guides, Version 005010X223A1, Version 005010X222A2, Version 005010X221.

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Document History

Version	Date (M/D/CCYY)	Author	Sections Updated
1.0	10/01/2022	BSC EDI Platform Services	New document for Blue Shield Promise Health Plans. Removed 835 and Blue Shield Classic Claims/Encounters information.
2023.01	3/17/2023	BSC EDI Platform Services	Removed EDI Mailbox. Updated Adjustments information for Encounters. Update Loop 2400.HCP03 to HCP15 for Rejection Reason Code.
2024.01	2/08/2024	Claims Exchange	Updated Loop 2300 REF02 notes to 'original claim number' Changed Loop 2400 reference to HCP13 & name to Network Indicator Updated Appendix B: Claims and Encounters – add 'the original claim number' Data Elements – remove (Blue Shield Promise Claim ID) Removed FDA's searchable database information and link under National Drug Code (NDC) Removed How to Locate NDC on Package page
2024.02	9/12/2024	EDI Business Operations	APL 14-019 Policy and Procedure documentation requirements: Updated National Coding Standards section: • Procedure: Revenue, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code(s) • Modifier(s) • Diagnostic code(s) Updated 837 Professional segment 2400, Notes/Details Use standard format for Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes

This document is intended to provide informational guide for EDI data exchange. This includes information about registration, testing, support, and specific information about control record setup.

Throughout this document we may refer to Blue Shield of California Promise Health Plan as Blue Shield Promise and/or BSCPHP and/or Promise.

Intended Use

The Companion Guide is not intended to replace the X12N Implementation Guides. It is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

Scope

This Companion Guide is to provide information to Trading Partners on the procedures necessary to transmit or receive Electronic Data Interchange (EDI) transactions to/from Blue Shield Promise.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Blue Shield Promise supports the following EDI transactions:

Transaction Code	Transaction Description
270	Eligibility Benefit Inquiry
271	Eligibility Benefit Response
276	Claim Status Request
277	Claim Status Response
278	Service Review. Request for Review and Response (Referral/Authorization Request)
820	Premium Payment
834	Benefit Enrollment and Maintenance
835	Claim Payment/Advice (Electronic Remittance Advice/ERA, Electronic Funds Transfer/EFT)
837	Institutional Professional Dental
999	Implementation Acknowledgement for Health Care Claim

References

A TR3 is a set of standards developed by the ASC X12N subcommittee that specify format and data requirements to be used for the electronic transactions for that specific TR3. These TR3 documents are available for purchase at https://x12.org/products/glass or Glass | X12

Contact Information

Contact Blue Shield of California for any EDI related inquiries, use any of the forms on contact below:

- **EDI Help Desk** is available from 8 a.m. to 4 p.m., Monday through Friday: **(800) 480-1221**
  - The EDI Help Desk support representatives are available to assist with urgent questions or issues related to EDI Transaction Transmissions. When calling the Help Desk, press "1" to be connected to a representative.

- **General inquiries**:
  - See Provider Connection for additional contact information based on the type of inquiry.
  - https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/contact-us

Trading Partner Agreement

Trading Partner Agreements (TPAs) are not required by HIPAA, at this time. TPAs define the duties and responsibilities of the partners that enable business documents to be electronically interchanged between them.

TPAs are requested by Blue Shield Promise clearinghouses that assist in processing electronic transactions on behalf of their clients. TPAs define Trading Partner, Blue Shield of California Promise and mutual obligations under the contract.

Trading Partners

An EDI Trading Partner is defined as any Blue Shield customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from Blue Shield Promise.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

Receiving the Transaction

The SFTP (Sterling) server provides a path for electronic transmissions of confidential data to and from Blue Shield' Promise Trading Partners. The server is protected behind a firewall. A unique login ID and password is created for each Trading Partner.

Connection to the server is only possible through the firewall using standard FTP connections or SSH SFTP connections over the internet. We use PGP encryption to ensure the data is kept confidential when using standard FTP connections. In most cases the Trading Partner will be responsible to pushing and pulling their files through the Blue Shield of California FTP server.

A Trading Partner's password to access SFTP is assigned by Blue Shield Promise system administrators. A password may be reset by Blue Shield upon request from the Trading Partner.

Important: If the Trading Partner chooses to not receive this file and they are a clearinghouse, Blue Promise requires that the Trading Partner provides notification to all Encounters submitters.

File Naming Convention for 837- Promise Health Plan and Specialty Vendors

Blue Shield Promise Health Plan has a standardized file naming convention for file submissions. All Trading Partners must adhere to the file naming convention.

All files must be named using capitalized letters only (case sensitive).

The maximum number of characters allowed in the file is 60 characters.

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN.dat

Element	Description	Requirement
SENDER-ID	ID assigned to each Trading Partner by BSCPHP	Must match the ISA06 segment
FILE-FORMAT	Transaction format	837I for Institutional or 837P for Professional records
TRANSACTION-TYPE-CODE	Record type	RP for Encounters CH for Claims Fee-for-Service
YYYYMMDD	Date of submission	Year, Month, Day
NNNN	Unique, sequential, numeric transaction identifier used to differentiate between files submitted on the same day by the same submitter	Must be 4 digits and padded with leading zeros so it is 4 digits long.

Transaction Components

Below are characters use for the transaction syntax and delimiter use.

Delimiter Type	Character Used	Character Description
Data Element Separator	*	Asterisk
Component Element Separator	>	Greater than
Segment Terminator	~	Tilde

File Size Limitations

Claims & Encounter data files submitted to BSC should not exceed 5,000 records within a file, regardless of the structure of the ST-SE within the file. Do not combine claims and encounters in the same file, submit claims and encounters as separate files.

Processing Schedule

Files from Trading Partners are accepted 24 hours a day, 7 days a week. Trading Partners are notified prior to any scheduled system maintenance. Files are to be submitted after system maintenance is completed.

Acknowledgement and Response Files

Acknowledgement and response files will be sent to the Trading Partners at the designated location communicated during the initial set up of claim and/or encounter submissions.

Validation is performed at all levels including, but not limited to, the Header level, Claim Detail level, Member Level, Payer detail and Service Line level. However, record status is determined at the claim level. If one line in a claim or encounter is rejected, the entire claim or encounter is rejected.

TA1 – Interchange Acknowledgement

A TA1 acknowledgement report will be generated for each 837I file submitted to BSC. The TA1 report provides information to the Trading Partner on whether the file was successfully received. The 837I file does not progress to the next step if a rejection occurs at this level.

The TA1 acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPECODE_YYYYMMDD_NNNN.CCYYMMDDHHMMSS.TA1

999 – Functional Group Acknowledgement

A 999-acknowledgement report will be generated for each 837 file that was accepted at the TA1 level. The 999 report provides information to Trading Partners on whether functional groups were accepted or rejected, including validation on syntactical errors and any functional group errors. The claims or encounters within this transaction do not progress to the 277CA level if a rejection occurs at this level. The transaction will progress to the 277CA validation if it is accepted or accepted with error.

The 999-acknowledgement report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN.
CCYYMMDDHHMMSS.837.999

CCYYMMDDHHMMSS represents the file receipt date

277CA – Claim Acknowledgement

The Health Care Claim Acknowledgment 277CA transaction report will be created for claims or encounters within a transaction that are "accepted" or "accepted with errors" at the 999 level. The 277CA report provides accepted or rejected status at the claim or encounter level, including validation on Blue Shield Promise custom validation checks as outlined in Sections 4, 5 and 6 of this document.

The 277CA report will mirror the submitted file name with an added designation, as follows:

SENDER-ID_FILE-FORMAT_TRANSACTION-TYPE-CODE_YYYYMMDD_NNNN.
CCYYMMDDHHMMSS.837_ HHmmsssSSSS.277

Where:

CCYYMMDDHHMMSS represents the file receipt date.

HHmmsssSSSS is the system time that the acknowledgement/response file was generated.

National Coding Standards

Trading Partners must adhere to all national coding standards including procedure, modifier, and diagnostic codes.

- Procedure: Revenue, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code(s)
- Modifier(s)
- Diagnostic code(s)

Any claims or encounters submitted must use ICD-10 diagnosis codes. Diagnostic codes must be coded to the highest specificity. External cause codes should not be used as a primary diagnosis code.

The tables contained in this section of the Companion Guide is intended to provide information on how Blue Shield Promise expects data information for critical elements or those unique to the Payer.

Abbreviations used in "Details" column to identify lines of business are as follows:

Claims = BHT06=CH, from providers

Encounters = BHT06 =RP, from medical groups and IPAs.

SV = BHT06=RP from specific vendors that Blue Shield Promise has identified as Specialty Vendors.

If the type of record is not specified, then the information in the "Details" column applies to all types of records or the data element follows the X12 5010 Implementation Guide.

Control Segments

The following loops and segments for the Control Segments tables contain information for Sender and Receiver IDs.

Loop ID	Reference	Name	Usage	Details
	ISA	Interchange Control Header	R	
	ISA06	Interchange Sender ID	R	Sender ID as assigned by BSCPHP
	ISA08	Interchange Receiver ID	R	954468482
	ISA15	Usage Indicator	R	P- Production Data T- Test Data
	GS	Functional Group Header	R	
	GS02	Application Sender's Code	R	Sender ID as assigned by BSCPHP
	GS03	Application Receiver's Code	R	954468482
	GE	Functional Group Trailer	R	
	GE01	Number of Included Segments	R	Number should match the number of ST-SE segments in the file.

Header

The following loops and segments for the Header table.

Loop ID	Reference	Name	Usage	Details
	ST	Transaction Set Header	R	
	ST01	Transaction Set Identifier Code	R	837
	ST03	Implementation Convention Reference	R	005010X223A2 for 837I
	BHT	Beginning of Hierarchical Transaction	R	
	BHT06	Transaction Type Code	R	CH = Use when transaction contains only fee for service claims with at least one chargeable line item. RP = Reporting, for encounter records. Do not combine claims and encounters in the same file, they should be sent in separate files.

Billing Provider Detail

The following loops and segments for the Billing Provider Detail Table contains information for the name and details of the provider of service and its associated information needed for an acceptable encounter.

Loop ID	Reference	Name	Usage	Notes/Details
2000A	**PRV**	**Billing Provider Specialty Information**	**R**	
	PRV03	Taxonomy Code	R	Must submit taxonomy code
2010AA	**NM1*85**	**Billing Provider Name**	**R**	**Encounters:** Send original billing provider, do not send capitated entity data
	NM103	Billing Provider Last or Organizational Name	R	**Encounters:** Name of the provider that was received on the claim that the capitated entity received for processing
	NM104	Billing Provider First Name	S	**Encounters:** First Name of the provider that was received on the claim that the capitated entity received for processing
	NM109	Identification Code	R	NPI must be submitted For Atypical Providers NM109 should not be populated and the secondary identifier should be used; otherwise populate with NPI.
	N3	Billing Provider Address	R	**Encounters:** Physical Address for the Billing Provider that was received on the claim that the capitated entity received for processing PO Box information should be sent in the Pay To Address Loop 2010AB if Necessary

Billing Provider Detail, Continued

Loop ID	Reference	Name	Usage	Notes/Details
2010AB	**NM1**	**Pay to Address Information**	**S**	**Encounters:** Billing Provider PO Box Information.
	N3	Pay to Address	**R**	**Encounters: PO** Box Address for the Billing Provider that was on the claim that the capitated entity received for processing
	N4	Pay to City, State, Zip	**R**	**Encounters:** PO Box City, State, Zip for the Billing Provider that was on the claim that the capitated entity received for processing

Subscriber Detail

The following loops and segments are for the Subscriber Detail Table.

Loop ID	Reference	Name	Usage	Notes/Details
2000B	**SBR**	**Subscriber Information**	**R**	**SV**: Required to allow Specialty Service Vendor to submit member cost share information for claims that have adjudicated
	SBR01	Payer Responsibility Sequence	R	S: Secondary
	SBR03	Reference Identification	R	
2010BA	**NM1**	**Subscriber Name**	**R**	
	NM101		R	IL = Insured or Subscriber
	NM109	Subscriber Primary Identifier	R	Subscriber ID from Blue Shield of California Promise Health ID Card, MBI or HICN. **Important:** • Subscriber ID is recommended. Any other type of ID# will not be recognized and will be rejected as unable to identity the member. • HICN will not be recognized if a member has provided Blue Shield Promise their MBI ID.
2010BB	**NM1**	**Payer Name**	**R**	
	NM101	Entity ID Code	R	PR
	NM103	Name Last Or Organization Name	R	BSC Promise Health Plan
	NM109	Identification Code	R	954468482

Patient Detail

The following loops and segments are for the Patient Detail Table which include Claim level and Line level information.

Loop ID	Reference	Name	Usage	Notes/Details
2300	**CLM**	**Claim Information**	**R**	
	CLM01	Claim Control Number	R	Must be unique value per Submitter, **voids and replacements refer to Appendix B*
	CLM05-3	Claim Frequency Type	R	1: Original encounter submission 2: Interim – First Claim 3: Interim – Continuing Claim 4: Interim – Last Claim 7: Replacement submission 8: Void submission **voids and replacements refer to Appendix B*
	DTP	**Statement Dates**	**R**	
	DTP*434	Date/Time Qualifier	R	**Statement and Service** Dates will be used to determine earliest date of service to validate use of codes. **Example:** Statement Date: 01/01/2022 – 02/01/22 Line 1 DOS: 01/01/2022 Line 2 DOS: 01/15/2022 Line 3 DOS: 02/01/2022 Date 01/01/2022 is the earliest date present on the claim/encounter and will be used to validate all codes (i.e. diagnosis, procedure codes) billed on the claim/encounter irrespective of the dates billed on the other service lines.

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2300	**CN1**	**Contract Information**	**R**	Required for Medicare. Use code as appropriate per Implementation Guide
	REF	**Payer Claim Control Number**	**R**	
	REF01 Refer to Appendix B	Reference Identification Qualifier	R	Code = F8
	REF02 Refer to Appendix B	Payer Claim Control Number	R	**Claims & Encounters: :** Original claim number (CLM01 from original accepted submission) **SV**: Vendor Original Claim ID
	AMT	**Patient Estimated Amount Due**	**R**	
	AMT*F3	Amount Qualifier Code	R	**SV:** Submit if Patient has an estimated amount due. Patient Responsibility Amount **Important**: Do not submit if zero dollars
	K3	**File Information**	**S**	
	K301	Fixed Format Information	S	**Encounters:** Required if an MSO was used for submission
	NTE	**Claim Note**		
	NTE01	Note Reference Code	S	**Claims**: MED
	NTE02	Description	S	**Claims:** Name of drugs. Show in order of service lines. Up to 80 bytes. Example: NTE*MED*J9265

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2300	**HCP**	**Claim Pricing / Repricing Information**	**S**	
	HCP01	Claim Pricing/Repricing Information		**Encounters & SV:** Claim Level Allowed Amount See Implementation Guide for codes.
	HCP02	Monetary Amount	S	Allowed Amount
2310A	**NM1**	**Attending Provider Name**	**R**	Required when the claim or encounter contains any services other than non-scheduled transportation
	NM101	Entity Identifier Code	R	71- Attending Physician
	NM109	Identifier Code	R	NPI must be submitted
	PRV	**Attending Provider Specialty Information**	**S**	
	PRV01	Attending Physician Provider Code	S	Code = AT
	PRV03	Reference Identification	S	The Attending Provider's Taxonomy Code that also identifies the specialty
2310F	**NM1**	**Referring Provider Name Last or Organization Name**	**S**	
	NM103	Referring Provider Name Last or Organization Name	S	
	NM109	Identification Code	S	

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2320	**SBR**	**Other Subscriber Information**	**R**	**Claims**: Used for prior carrier/payer processing information **Encounters & SV:** Submit cost share information for adjudicated services
2320	SBR01	Payer Responsibility Sequence Number	R	Indicate the payer sequence number
	CAS	**Claim Level Adjustments**	**S**	Claim Level Adjustment Amounts if services were calculated at claim level.
	CAS01 Refer to Appendix A	Claim Adjustment Group Code	**R**	CAS*PR*1*9*7.93~ CAS*OA*93*15.06~ CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility
	CAS02	Claim Adjustment Reason Code*		Use appropriate adjustment reason codes Examples: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount
	AMT	**COB Payer Paid Amount**	**S**	
	AMT01	COB Payer Paid Amount Qualifier Code	R	Code = D
	AMT02	COB Total Non-Covered Amount	R	Code = A8 **SV:** Total non-covered charges
	AMT	**Remaining Patient Liability**	**S**	
	AMT01	Remaining Patient Liability	S	Code = EAF Remaining patient liability

**For the entire list of Claims Adjustment Group Codes and Adjustment Reason Codes (CARC), refer to X12.org:* https://x12.org/codes/claim-adjustment-reason-codes or External Code Lists | X12

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2320	**OI**	**Other Insurance Coverage Information**	**S**	All information contained in the OI segment applies only to the payer identified in Loop ID-2330B in this iteration of Loop ID-2320
2330A	**NM1**	**Other Subscriber Name**	**R**	
	NM108	Identification Code Qualifier	R	MI = Member Identification Number
	NM109	Identification Code	R	**Encounters:** Delegated Medical Groups Member ID / Subscriber ID
2330B	**NM1**	**Other Payer Name**	**R**	**Encounters:** Capitated entity data **SV:** Vendor Name **Claims:** Other Payer Name
	NM103	Name Last or Organization Name	R	
	NM108	Identification Code Qualifier	R	PI
	NM109	Identification Code	R	Please check with your clearinghouse for specific identification code that must be used

Service Line Detail

Loop ID	Reference	Name	Usage	Notes/Details
2400	**SV2**	**Institutional Service Line**	**R**	
	SV201	Service Line Revenue Code	R	Populate with 4-digit revenue code. If Revenue Code is 2 digits, add leading zeros. E.G. '23' = '0023'
	SV202	Composite Procedure Medical Identifier	S	
	SV202-01	Product or Service ID Qualifier	R	For LA County Medi-Cal submissions, populate with HP if revenue code is '0022', '0023', '0024'. If revenue code is not '0022', '0023' or '0024', and the service is outpatient, populate with 'HC'
2400	SV202-02	Procedure Code	R	For LA County Medi-Cal Submissions populate with valid HIPPS code if SV202-01 is 'HP'. Populate with valid HCPC code if SV202-01 is 'HC'
	SV202-07	Description	S	
	SV204	Unit or Basis for Measurement Code	R	Codes DA, UN If the revenue code submitted is a Room and Board Revenue code, then populate with 'DA' and the corresponding line days in SV205. Otherwise, use 'UN' and populate the corresponding quantity in SV205

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2400	**DTP**	**Date Service Date**	**S**	
	DTP*472	Service Date	R	**Statement and Service Dates** will be used to determine earliest date of service to validate use of codes. **Example:** Statement Date: 01/01/2022 – 02/01/22 Line 1 DOS: 01/01/2022 Line 2 DOS: 01/15/2022 Line 3 DOS: 02/01/2022 Date 01/01/2022 is the earliest date present on the claim/encounter and will be used to validate all codes (i.e. diagnosis, procedure codes) billed on the claim/encounter irrespective of the dates billed on the other service lines. **Important:** Formerly Blue Shield Promise Medicare Members with DOS prior to 2020, submit as Promise. Any DOS 2021 and after must be submitted as BSC.
	HCP See Appendix A for examples	**Line Pricing/Re- pricing Information**	S	Required for Medicare and Cal MediConnect For **Medi-Cal**: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2400	HCP01	Pricing Methodology	R	**Encounters & SV:** See Implementation Guide for codes Note: See Implementation Guide for codes
	HCP02	Monetary Amount	R	Allowed Amount
	HCP13	Reject Reason Code	S	**SV:** Populate with 'TI' if out of network. If in network, do not populate. Utilize for Network Indicator.
2410	**LIN**	**Drug Identification**	**S**	BSC can take adjudicative action on only the first of any 2410 loops received.
	LIN02	Product Service ID/Qualifier	R	Code N4
	LIN03	National Drug Code See Appendix D		National Drug Code in 5-4-2 Format. 11 bytes.
	REF	**Prescription or Compound Drug Association**	**S**	Required when a prescription number is available
	CTP	**Drug Quantity**	**R**	If the price of the NDC drug reported in LIN03 is different from the charges reported in SV203, create a CTP segment in loop 2410.

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2430	**SVD** See Appendix A for examples	**Line Adjudication Information**	**S**	For **Medi-Cal**: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	SVD01	Identification Code	S	Must match Loop 2330B NM109
	SVD02	Monetary Amount	S	Paid Amount Note: Loop 2400 SV103 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary Amount(s) = SVD02

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2430	**CAS** See Appendix A for examples	**Line Level Adjustment**	**S**	Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it. For **Medi-Cal**: If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment.
2430	CAS01	Claim Adjustment Group Code	R	
	CAS02	Claim Adjustment Reason Code*	R	Common codes: 1 = Deductible Amount 2 = Co-Insurance Amount 3 = Co-pay Amount

**For the entire list of Claims Adjustment Group Codes and Adjustment Reason Codes (CARC), refer to X12.org or External Code Lists | X12*

837 Professional Transaction Loops and Segments

The tables contained in this section of the Companion Guide is intended to provide information on how Blue Shield Promise expects data information for critical elements or those unique to the Payer.

Abbreviations used in "Details" column to identify type of record are as follows:

Claims = BHT06=CH, from providers

Encounters = BHT06 =RP, from medical groups and IPAs.

SV = BHT06=RP from specific vendors that BSC has identified as Specialty Vendors.

If the type of record is not specified, then the information in the "Details" column applies to all types of records or the data element follows the X12 5010 Implementation Guide.

Control Segments

The following loops and segments for the Control Segments tables contain information for Sender and Receiver IDs.

Loop ID	Reference	Name	Usage	Details
	ISA	Interchange Control Header	R	
	ISA06	Interchange Sender ID	R	Sender ID as assigned by BSCPHP
	ISA08	Interchange Receiver ID	R	954468482
	ISA15	Usage Indicator	R	P- Production Data T- Test Data
	GS	Functional Group Header	R	
	GS02	Application Sender's Code	R	Sender ID as assigned by BSCPHP
	GS03	Application Receiver's Code	R	954468482
	GE	Functional Group Trailer	R	
	GE01	Number of Included Segments	R	Number should match the number of ST-SE segments in the file.

Header

The following loops and segments for the Header table.

Loop ID	Reference	Name	Usage	Details
	ST	Transaction Set Header	R	
	ST01	Transaction Set Identifier Code	R	837
	ST03	Implementation Convention Reference	R	005010X222A1 for 837P
	BHT	Beginning of Hierarchical Transaction	R	
	BHT06	Transaction Type Code	R	CH = Use when transaction contains only fee for service claims with at least one chargeable line item. RP = Reporting, for encounter records. Do not combine Claims and Encounters in the same file, send them in separate files.

Billing Provider Detail

The following loops and segments for the Billing Provider Detail Table contains information for the name and details of the provider of service and its associated information needed for an acceptable encounter.

Loop ID	Reference	Name	Usage	Notes/Details
2000A	**PRV**	**Billing Provider Specialty Information**	**R**	
	PRV03	Taxonomy Code	R	Must submit taxonomy code
2010AA	**NM1*85**	**Billing Provider Name**	**R**	
	NM109	Identification Code	R	NPI must be submitted. For Atypical Providers NM109 should not be populated; otherwise populate with NPI.
2010AB	**NM1**	**Pay to Address Information**	**S**	**Encounters:** Billing Provider PO Box Information.
	N3	Pay to Address	**R**	**Encounters: PO** Box Address for the Billing Provider that was on the claim that the capitated entity received for processing
	N4	Pay to City, State, Zip	**R**	**Encounters:** PO Box City, State, Zip for the Billing Provider that was on the claim that the capitated entity received for processing

Subscriber Detail

The following loops and segments are for the Subscriber Detail Table. Each beneficiary is viewed as an individual subscriber. As such, each member must be identified in the Subscriber loop (2010BA).

Loop ID	Reference	Name	Usage	Notes/Details
2000B	**SBR**	**Subscriber Information**	**R**	**SV**: Required to allow Specialty Service Vendor to submit member cost share information for claims that have adjudicated
	SBR01	Payer Responsibility Sequence	R	
	SBR03	Reference Identification	R	
2010BA	**NM1**	**Subscriber Name**	**R**	
	NM101	Entity Identifier Code	R	IL = Insured or Subscriber
	NM109	Subscriber Primary Identifier	R	Subscriber ID from Blue Shield of California ID Card, MBI or HICN. Important: • Subscriber ID is recommended. Any other type of ID# will not be recognized and will be rejected as unable to identity the member. • HICN will not be recognized if a member has provided BSC their MBI ID.

Subscriber Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2010BB	**NM1**	**Payer Name**	**R**	
	NM101	Entity Identifier Code	R	Code = PR
	NM103	Name Last Or Organization Name	R	BSC Promise Health Plan
	NM109	Identification Code	R	954468482
	REF	**Billing Provider Secondary Identification**	**S**	
	REF01	Reference Identification Qualifier	R	G2
	REF02	Reference Identification	R	IP00# - Unique Blue Shield Promise IPA number (assigned by Blue Shield Promise Provider Relations)

Patient Detail

The following loops and segments are for the Patient Detail Table which include Claim level and Line level information.

Loop ID	Reference	Name	Usage	Notes/Details
2300	**CLM**	**Claim Information**	**R**	
	CLM01	Claim Control Number	R	Must be unique value per Submitter, ~~no more than 12 characters.~~ **voids and replacements refer to Appendix B*
	CLM05-3	Claim Frequency Type	R	1: Original encounter submission 2: Interim – First Claim 3: Interim – Continuing Claim 4: Interim – Last Claim 7: Replacement submission 8: Void submission Note: (note on Void) Only send if voiding an entire encounter with No replacement***Do not send Negative Monetary Values*** **voids and replacements refer to Appendix B*
2300	**CN1**	**Contract Information**	**S**	Required for Medicare Use code as appropriate per Implementation Guide

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2300	**AMT**	**Patient Amount Paid**	**S**	
	AMT01	Patient Paid Amount	R	Code = F5 Required for Medicare Important: Zero is an acceptable value.
	REF	**Payer Claim Control Number**	**S**	
	REF01 Refer to Appendix B	Payer Claim Control Number	R	Code = REF*F8
	REF02 Refer to Appendix B	Payer Claim Control Number	R	**Claims & Encounters: :** Original claim number (CLM01 from original accepted submission) **SV**: Vendor Original Claim ID
	K3	**File Information**	**S**	
	K301	Fixed Format Information	R	**Encounters**: MSO Group Name
	HI	**Health Care Diagnosis Code**	**R**	If more than 12 diagnosis codes need to be reported, submit a subsequent claim/encounter with Billed Amount as zero charge, and key the additional diagnosis codes at the claim level.
	HCP	**Claim Pricing/Repricing Information**	**S**	**Encounters/SV:** Claim Level Allowed Amount
2310A	**NM1**	**Referring Provider Name**	**S**	Required when Place of Service is a Lab. (CLM05-1, Loop 2300 = 81)
	NM101	Identification Code	R	Code = DN
	NM103	Referring Provider Name Last or Organization Name	R	
	NM104	Name First	S	
	NM109	Identification Code	S	Referring Provider NPI

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2310B	**NM1**	**Rendering Provider Name**	**S**	Required when the rendering provider is different than the billing provider in loop 2010AA; must submit Last Name, First Name and NPI
	NM109	Rendering Provider Identifier	S	For Atypical Providers NM109 should not be populated; otherwise populate with NPI.
	PRV	**Rendering Provider Specialty Information**	**S**	
	PRV01	Provider code	R	PE = Performing
	PRV03	Reference Identification	R	The Performing Provider's Taxonomy Code that also identifies the specialty
2310C	**NM1**	**Service Facility Location**	**S**	Required when the location of the healthcare service is different than the billing provider in loop 2010AA
2320	**SBR**	**Other Subscriber Information**	**S**	**SV:** Specialty Service Vendor to submit cost share information for service adjudication
	SBR01	Payer Responsibility Sequence Number	R	
	CAS	**Claim Level Adjustments**	**S**	**SV:** Claim Level Adjustment Amounts if services were calculated at claim level

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2320	CAS01	Claim Level Adjustment Group Codes		CO: Contractual Obligations CR: Correction and Reversals OA: Other adjustments PI: Payor Initiated Reductions PR: Patient Responsibility Examples: CAS*PR*1*9*7.93~ CAS*OA*93*15.06~
	CAS02	Claim Adjustment Reason Code*		Use appropriate adjustment reason codes Examples: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount
	AMT	**COB Payer Paid Amount**	**S**	
	AMT01	COB Payer Paid Amount	R	Code = D Claim Level Specialty Service Vendor Paid Amount if services were calculated at claim level
	AMT	**COB Total Non-Covered Amount**	**S**	
	AMT01	Amount Qualifier Code	S	Code = A8 Total non-covered charges
	AMT	**Remaining Patient Liability**	**S**	
	AMT01	Amount Qualifier Code	S	Code = EAF Remaining patient liability
	OI	**Other Insurance Coverage Information**	**R**	**SV:** All information contained in the OI segment applies only to the payer identified in Loop ID-2330B in this iteration of Loop ID-2320

Patient Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2330A	**NM1**	**Other Subscriber Name**	**R**	
	NM108	Identification Code Qualifier	R	Code = MI
	NM109	Identification Code		**Encounters:** Delegated Medical Groups Member ID/Subscriber ID
2330B	**NM1**	**Other Payer Name**	**R**	**Encounters:** Send Capitated entity data
	NM103	Name Last or Organization Name	R	**Encounters:** Name of Delegated Medical Group
	NM108	Name Last or Organization Name	R	Name of Delegated Medical Group
	NM109	Identification Code	R	Please check with your clearinghouse or Plan for specific identification code that must be used for electronic claims Tax ID / NPI for Loop 2330B NM103

Service Line Detail

Loop ID	Reference	Name	Usage	Notes/Details
2400	**SV1**	**Professional Service**	**R**	**Use standard format for Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes**
	SV101-2	Product/Service ID	S	Use J codes for home infusion drugs
	SV101-07	Description	S	Required for Medicare if a non-specific procedure code is submitted in SV101-02
	DTP	**Service Date**	**R**	
	DTP01	Date/Time Qualifier	R	Code = 472 **Service Dates** will be used to determine earliest date of service to validate use of codes. **Example:** Statement Date: 01/01/2022 – 02/01/22 Line 1 DOS: 01/01/2022 Line 2 DOS: 01/15/2022 Line 3 DOS: 02/01/2022 Date 01/01/2022 is the earliest date present on the claim/encounter and will be used to validate all codes (i.e., diagnosis, procedure codes) billed on the claim/encounter irrespective of the dates billed on the other service lines. **Important:** Formerly BSCPHP Medicare Member with DOS prior to 2020, submit as BSCPHP. Any DOS 2021 and after must be submitted as BSC.

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2400	**HCP**	**Line Pricing/Repricing Information***	**S**	Line Allowed Amount Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it.
	HCP01	Pricing Methodology	R	See Implementation Guide for complete list of codes.
	HCP02	Monetary Amount	R	Allowed Amount
	HCP13	Reject Reason Code	S	Populate with 'T1' if out of network. If in network, do not populate. Utilize for Network Indicator.
2410	**LIN**	**Drug Identification**	**S**	
	LIN02	Product Service ID/Qualifier	R	Code N4 for NDC **Medi-Cal also accepts the following qualifiers:** **UP - (Uniform Commercial Code 12-digit codes.** **EN - European Article Number Uniform Commercial Code (UCC 13 digits)** **EO - European Article Number Uniform Commercial Code (UCC 8 digits)** **HI- HIBC (Health Care Industry Bar Code)** **ON - Customer Order Number** **UK – GTIN 14- digit structure**
	LIN03 **See Appendix D**	Product/Service ID	R	National Drug Code in 5-4-2 Format, 11 bytes. When using N4 in LIN02. Otherwise, follow code structure based on what qualifier is reported in LIN02.
	REF	**Prescription or Compound Drug Association Number**	**S**	Required when a prescription number is available

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2420A	**NM1**	**Rendering Provider Name**	**S**	
	NM109	Identification Code	S	**BSCPHP**: For Atypical Providers NM109 should not be populated; otherwise populate with NPI.
	PRV	**Rendering Provider Specialty Information**	**S**	
	PRV01	Provider Code	R	PE = Performing
	PRV03	Reference Identification	R	The Performing Provider's Taxonomy Code that also identifies the specialty
	REF	**Rendering Provider Secondary Identification**	**S**	
	REF01	Reference Identification Qualifier	R	G2: Medi-Cal Provider Number LU: Location Number
2430	**SVD** See Appendix A for examples	**Line Adjudication Information**	**S**	
	SVD01	Identification Code	R	Must match Loop 2330B NM109
	SVD02	Monetary Amount	R	Paid Amount Note: Loop 2400 SV103 Line Item Charge Amount Loop minus (-) Loop 2340 CAS Monetary

Service Line Detail, continued

Loop ID	Reference	Name	Usage	Notes/Details
2430	CAS See Appendix A for examples	Line Level Adjustments	S	**Required** when the claim has been previously adjudicated by the payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to the member out of pocket responsibility: co-insurance, deductible, co-pay, and/or any other adjudication reasons, including denied reasons. **BSC PHP Medi-Cal:** If cost share information is available, submit appropriately. If cost share information is not available, do not submit this segment. **Important:** Claim Adjustment Group Code and Claim Adjustment Reason Code will be applied based on how the service was adjudicated, including any denials.
	CAS01	Claim Adjustment Group Code*	R	
	CAS02	Claim Adjustment Reason Code*	R	Common codes: 1: Deductible Amount 2: Co-Insurance Amount 3: Co-pay Amount

**For the entire list of Claims Adjustment Group Codes and Adjustment Reason Codes (CARC), refer to https://x12.org/codes or* External Code Lists | X12

837 Professional Transaction Loops and Segments- Ambulance

The tables contained in this section of the Companion Guide is intended to provide information on how Blue Shield Promise expects data information for critical elements or those unique to the Payer.

Abbreviations used in "Details" column to identify type of record are as follows:

Claims = BHT06=CH, from providers

Encounters = BHT06 =RP, from medical groups and IPAs.

SV = BHT06=RP from specific vendors that Blue Shield Promise has identified as Specialty Vendors.

If the type of record is not specified, then the information in the "Details" column applies to all types of records or the data element follows the X12 5010 Implementation Guide.

Loop ID	Reference	Name	Usage	Notes/Details
2300	**CLM**	**Claim Information**	**R**	
	CLM05	Health Care Service Location Indicator (Place of Service)	R	41- Land 42 - Air or Water Use for 'Type of Transport'
	REF	**Referral Number**		
	REF02	Reference Identification		Indicate if 911, plus any free form comments up to 26 characters
	NTE	**Claim Note**		
	NTE01	Note Reference Code		**ADD**- Used in conjunction with NTE02 to identify the purpose of the notes in NTE02
	NTE02	Description		Report location where patient was transported to. Include facility name, city and zip

Loop ID	Reference	Name	Usage	Notes/Details
2300	**CR**	**Ambulance Transport Information**		
	CR103	Ambulance Transport Code		Value = I, R, T, X Use for 'transport information.' All values are accepted.
	CR106	Quantity		Use to report transport distance
	CR109	Description		Free format field. Use to clarify the purpose for the round-trip service up to 80 characters. Used with CR103 =X; otherwise not used.
	CR110	Description		Free format field. Use to clarify details regarding use of a stretcher during service.
2310D	NM1	**Service Facility Location Address**		
	NM101	Entity Identifier Code		Value = 77 Service location. Qualifies patient pick-up location.
	NM102	Entity Type qualifier		Value = 2 Non-Person Entity Qualifier.
	NM103	Organization Name		Name of location where patient was picked-up, e.g., RESIDENCE (up to 35 characters).
2310D	**N3**	**Service Facility Location Information**		
	N301	Service Facility Location Address		Address of location where patient was picked up (up to 55 characters)
	N4	**Service Facility Location City/State/Zip**		
	N401	City		City in which patient was picked up
	N402	State		State in which patient was picked up
	N403	Zip Code		Zip code of location where patient was picked up

Loop ID	Reference	Name	Usage	Notes/Details
2400	**SV1**	**Professional Service**		
	SV105	Place of Service		Line Level place of service value
	CR1	**Ambulance Transport Information**		Use only if different than in CR1 at claim level (Loop 2300)
	CR103	Ambulance Transport Code		I, R, T, X Use for 'transport information.' All values are accepted.
	CR106	Quantity		Use to report transport distance
	CR109	Description		Free format field. Use to clarify the purpose for the round-trip service up to 80 characters. Used with CR103 =X; otherwise not used.
	CR110	Description		Free format field. Use to clarify details regarding use of a stretcher during service.
	NTE	**Line Note**		
	NTE01	Note Reference Code		ADD Use in conjunction with NTE02 to identify the purpose of the notes in NTE02.
	NTE02			Free format field. Use for any additional comments. (up to 80 characters)

APPENDIX A: ENCOUNTER COST SHARE INFORMATION

Balanced Cost Share Information for Encounter submission is critical for Blue Shield/Blue Shield Promise to understand how the services were adjudicated by the IPA/MG. The information below provides the data elements that is balanced along with examples.

Data Elements	Loop	Segment Position	Example
Allowed Amount	2400	HCP02	HCP*10*100
Paid Amount	2430	SVD02	SVD*IPA*60
Any other Adjudicated Amounts (Not part of balancing, only shown here as an example that CAS segments are used for non-Member Out of Pockets as well)	2430	CAS03 where CAS02, CAS05, etc. does not = 1, 2, 3, 66, 241, 247, 248	CAS*CO*45*50
Member Out of Pockets Examples			
Deductible	2430	CAS03 where CAS02, CAS05, etc. = 1, 66, 247	CAS*PR*1*10
Coinsurance	2430	CAS03 where CAS02, CAS05, etc. = 2, 248	CAS*PR*2*10
Copayment	2430	CAS03 where CAS02, CAS05, etc. = 3, 241	CAS*PR*3*10
Any other Patient Responsibility Amounts	2430	CAS03 where CAS01, CAS04, etc. = PR	CAS*PR*96*10

Scenario A: No member out of pocket dollars: Paid at 100% of Allowance

LX*1~
SV1*HC>88305>>>>>TISSUE EXAM BY PATHOLOGIST*3000*UN*12***1~ *[BILLED AMOUNT: $3000]*
DTP*472*D8*20200219~
REF*6R*4038349309Z1~
HCP*10*883.73~ *[ALLOWED AMOUNT: $888.73]*
SVD*IPA*883.73*HC>88305**12~ *[PAID AMOUNT: $888.73]*
CAS*CO*45*2116.27~ *[OTHER ADJUDICATED AMOUNTS: $2116.27]*
DTP*573*D8*20200318~

Scenario B: Member out of pocket: Member Out of Pocket Amounts + Paid Amount = Allowance

Variation 1: ($5 + $76.73 = $81.73)
LX*1~
SV1*HC>99214>>>>>OFFICEOUTPATIENT VISIT, EST*178.14*UN*1***1~ *[BILLED AMOUNT: $178.14]*
DTP*472*D8*20200206~
REF*6R*403837896921~
HCP*10*81.73~ *[ALLOWED AMOUNT: $81.73]*
SVD*IPA*76.73*HC>99214**1~ *[PAID AMOUNT: $76.73]*
CAS*CO*45*96.41~ *[OTHER ADJUDICATED AMOUNTS: $96.41]*
CAS*PR*3*5~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAY AMOUNT: $5]*
DTP*573*D8*20200227~

Variation 2: ($222.32 + $871.47 = $ 1093.79)
LX*1~
SV1*HC>E0483>RR>KX>KJ>>HI FREQ CHST WALL AIR-PULSE GEN EA*1642.5*UN*1***1~ *[BILLED AMOUNT: $1642.5]*
DTP*472*D8*20200207~
REF*6R*403835709921~
HCP*10*1093.79~ *[ALLOWED AMOUNT: $1093.79]*
SVD*IPA*871.47*HC>E0483**1~ *[PAID AMOUNT: $871.47]*
CAS*OA*45*548.71~ *[OTHER ADJUDICATION AMOUNT: $548.71]*
CAS*PR*2*222.32~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COINSURANCE AMOUNT: $222.32]*
DTP*573*D8*20200228~

Variation 3: ($35 + $35 = $70)
LX*1
SV1*HC>99212*80*UN*1***1 *[BILLED AMOUNT: $80]*
DTP*472*D8*20200129
REF*6R*398877979621
HCP*10*70~ *[ALLOWED AMOUNT: $70]*
SVD*95414204477*35*HC>99212**1 *[PAID AMOUNT: $35]*
CAS*CO*45*10 *[OTHER ADJUDICATION AMOUNT: $10]*
CAS*PR*3*35 *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR" FOR COPAYMENT AMOUNT: $35]*
DTP*573*D8*20200228

Scenario C: Service is denied, Billed Amount equals Patient Responsibility with a valid CARC code

LX*1~
SV1*HC>90691*313*UN*1***1>2~ *[BILLED AMOUNT: $313]*
DTP*472*D8*20191230~
REF*6R*P1281605630-2~
LIN**N4*49281079020~
CTP****.5*ML~
HCP*00*0*~ *[ALLOWED AMOUNT: $0]*
SVD*002*0*HC>90691**1~ *[PAID AMOUNT: $0]*
CAS*PR*96*313~ *[ADJUDICATED AMOUNT APPLIED TO PATIENT RESPONSIBILITY "PR": $313]*
DTP*573*D8*20200228~

APPENDIX B: VOIDS AND REPLACEMENTS

The details below provide instruction on how to submit Voids and Replacements of a claim or encounter that have been submitted and accepted and are subsequently corrected by either a void or a replacement action. To submit a Replacement or Void claim of a previously accepted claim or encounter, the following data must be provided:

Claims and Encounters

- The Claim Control Number must be unique in CLM01 from original accepted record.
- A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code data element in CLM05-03.
- The original Claim Control Number (CLM01) of the previously accepted record must be populated in the REF Payer Claim Control Number in REF02 (REF01 qualifier F8).

Data Elements:

- CLM05-3 = 7 or 8
- REF02 (REF01 Qualifier = F8) = Original Provider Claim Number in CLM01 from original accepted record

Specialty Vendors

- The Claim Control Number must be unique in CLM01 from original accepted record..
- A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code data element in CLM05-03.
- The original Claim Control Number (CLM01) of the previously accepted encounter must be populated in the REF Payer Claim Control Number in REF02 (REF01 qualifier F8).

Data Elements:

- CLM05-3 = 7 or 8
- REF02 (REF01 Qualifier = F8) = Vendor's Claim Control Number in CLM01 from original accepted record

APPENDIX C: DUPLICATE VALIDATION FOR CLAIMS AND ENCOUNTERS

All submissions will be evaluated by duplicate validation checks at the File and Record Level.

File Level

- File Name
- Interchange Control Number

Duplicate File validation check is to verify the uniqueness of the file submitted, per submitter.

Record Level

The uniqueness of a record will be validated against received records that were accepted in the prior 365 days. Various claim and line data elements that are used for duplicate checks are on the following pages. Some data elements are situational and may not be needed for claim/encounter submission, as such only submitted data is used for duplicate validation.

Duplicate - High Level Examples

Example	Claim 1	Claim 2 (differences highlighted)	Duplicate?
1	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100	Yes All data elements are the same

Duplicate - High Level Examples, continued:

Example	Claim 1	Claim 2 (differences highlighted)	Duplicate?
2	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 Diagnosis: E1169 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 Billed Amount: $100	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 Diagnosis: E785 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 Billed Amount: $100	Yes Diagnosis is not a data element used for duplicate check
3	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 Rendering Provider: Daisy Jones LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100	No Rendering Provider submitted on Claim 2
4	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $200 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 LINE 2: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100	Patient Name: Jane Jones Sub ID: 996655441 DOB: 01/01/1999 Total Charge: $100 LINE 1: • DOS: 02/01/2022 • PROC: 99213 • Billed Amount: $100 No Line 2	No Total Charge is different and line 2 is not submitted

837 Professional Claims/Encounters Data Elements

Claim Section	Data Elements
Billing Provider Data	• Taxonomy Code (PRV03 Loop 2000A) • Provider Last /Organization Name (NM103 Loop 2010AA) • Provider First Name (NM104 Loop 2010AA) • NPI (NM109 Loop 2010AA) • Tax ID (REF02 Loop 2010A REF01 = "EI" or "SY") • Address 1 (N301 Loop 2010AA) • Address 2 (N302 Loop 2010AA) • City (N401 Loop 2010AA) • State or Province Code (N402 Loop 2010AA) • Postal Code (N403 Loop 2010AA) • Country Code (N404 Loop 2010AA) • Country Subdivision Code (N407 Loop 2010AA)
Patient Data	• Subscriber ID (NM109 Loop 2010BA) • Patient Last Name (NM103 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient First Name (NM104 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient Middle Name or Initial (NM105 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient Date of Birth (DMG02 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent)
Claim Level Data	• Claim Frequency Type Code (CLM05-3 Loop 2300) • Total Charge Amount (CLM02 Loop 2300)
Rendering Provider	• Last Name or Organization Name (NM103 Loop 2310B) • Provider First Name (NM104 Loop 2310B) • Middle Name of Initial (NM105 Loop 2310B) • NPI (NM109 Loop 2310B) • Taxonomy Code (PRV03 Loop 2310B)
Other Subscriber Information (can be repeated up to 5 instances)	• Adjustment Group Code (CAS01 Loop 2320) • Adjustment Reason Code (CAS02 Loop 2320) • Amount (CAS03 Loop 2320) • Quantity (CAS04 Loop 2320) • COB Payer Paid Amount AMT02 Loop 2320 where AMT01 = D)

837 Professional Claims/Encounters Data Elements, continued

Claim Section	Data Elements
Service Line Data (can be repeated up to 50 instances per claim	• Product/Service ID (SV101-2 Loop 2400) • Procedure Modifiers (SV101-3 to SV101-6 Loop 2400) • Line-Item Charge (SV102 Loop 2400) • Date of Service (DTP03 Loop 2400) • Adjustment Group Code (CAS01 Loop 2320) • Drug Identification (National Drug Code LIN03 Loop 2410) • Drug Quantity (CTP04 Loop 2410) • Unit of Measure (CTP05-1 Loop 2410) • Rendering Provider Last Name or Organization Name (NM103 Loop 2420A) • Rendering Provider First Name (NM104 Loop 2420A) • Rendering Provider Middle Name or Initial (NM105 Loop 2420A) • Rendering Provider NPI (NM109 Loop 2420A) • Rendering Provider Taxonomy Code (PRV03 Loop 2420A) • Line Adjudication – Other Primary Identifier (SVD01 Loop 2430) • Line Adjudication - Adjustment Reason Code (CAS02 Loop 2320) • Line Adjudication – Service/Service ID (Procedure Code SVD03-2 Loop 2430) • Line Adjudication – Procedure Modifier (SVD03-3 to SVD03-6 Loop 2430) • Paid Service Unit Count (SVD05 Loop 2430) • Bundled/Unable Line # (SVD06 Loop 2430)

837 Institutional Claims/Encounters Data Elements

Claim Section	Data Elements
Billing Provider Data	• Taxonomy Code (PRV03 Loop 2000A) • Provider Last /Organization Name (NM103 Loop 2010AA) • NPI (NM109 Loop 2010AA) • Tax ID (REF02 Loop 2010A REF01 = "EI" or "SY") • Address 1 (N301 Loop 2010AA) • Address 2 (N302 Loop 2010AA) • City (N401 Loop 2010AA) • State or Province Code (N402 Loop 2010AA) • Postal Code (N403 Loop 2010AA) • Country Code (N404 Loop 2010AA) • Country Subdivision Code (N407 Loop 2010AA)
Patient Data	• Subscriber ID (NM109 Loop 2010BA) • Patient Last Name (NM103 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient First Name (NM104 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient Middle Name or Initial (NM105 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent) • Patient Date of Birth (DMG02 Loop 2010BA is patient is subscriber/ Loop 2010CA if patient is a dependent)
Claim Level Data	• Claim Frequency Type Code (CLM05-3 Loop 2300) • Total Charge Amount (CLM02 Loop 2300) • Admission Type Code (CL01 Loop 2300) • Admission Source Code (CL02 Loop 2300) • Patient Status Code (CL03 Loop 2300)
Other Subscriber Information (can be repeated up to 5 instances)	• Adjustment Group Code (CAS01 Loop 2320) • Adjustment Reason Code (CAS02 Loop 2320) • Amount (CAS03 Loop 2320) • Quantity (CAS04 Loop 2320) • COB Payer Paid Amount AMT02 Loop 2320 where AMT01 = D)

837 Institutional Claims/Encounters Data Elements, continued

Claim Section	Data Elements
Service Line Data (can be repeated up to 999 instances per claim)	• Product/Service ID (SV201 Loop 2400) • Line-Item Charge (SV203 Loop 2400) • Date of Service (DTP03 Loop 2400 DTP01 can equal "472" or "434") • If NDC is submitted, National Drug Code (LIN03 Loop 2410) • If NDC is submitted, Drug Quantity (CTP04 Loop 2410) • If NDC is submitted, Unit of Measure (CTP05-1 Loop 2410) Line Adjudication – Other Primary Identifier (SVD01 Loop 2430) • Line Adjudication – Service Line Paid Amount (SV02 Loop 2430) • Line Adjudication – Service/Service ID (Procedure Code SVD03-2 Loop 2430) • Line Adjudication – Procedure Modifier(s) (SVD03-3 to SVD03-6) Loop 2430) • Paid Service Unit Count (SVD05 Loop 2430) • Bundled/Unable Line # (SVD06 Loop 2430)

Child Health and Disability Program (CHDP) and Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Submission

All Medi-Cal Trading Partners/Providers should submit CHDP electronically using National Standard HIPPA 837 Formats. Please refer to the DHCS website for further information on converting local codes to CPT 4 National Codes.

- Use the CRC segment ("Conditions Indicator") in the 2300 loop to indicate if an EPSDT referral was given for diagnostic or corrective treatment. The CRC segment should indicate the referral only, not the actual diagnostic or corrective treatment. The CRC referenced diagnostic or corrective treatment should be included on a separate submission.
- In the 2400 loop (service level), use a "Y" in field SV111 ("Yes/No Condition Response Code") if there was an EPSDT involvement in the service.
- EPSDT Diagnostic or corrective treatments will be submitted differently:
  - Identify the EPSDT Supplemental Services by reporting the "EP" procedure modifier with the appropriate CPT code(s) for services rendered.

Loop ID	Reference Designator	837P Expected Value
2300 CRC - EPSDT Referral	CRC01 Code Qualifier	ZZ = Mutually Defined EPSDT Screening referral information
	CRC02 Certification Condition Code Applies Indicator	Y = If EPSDT referral given. If no EPSDT referral was given, do not populate
	CRC03 CRC04* CRC05* Condition Indicator *Use CRC04 and CRC05 when a second and third condition code is necessary	AV = Available-Not Used. Patient refused referral. NU = Not Used If CRC02 = N, then NU must be used in CRC03 S2 = Under Treatment ST = New Services Requested
2400 SV1	SV111 EPSDT Indicator	Y = indicates EPSDT involvement
	SV101-03, 04, 05 or 06 Procedure Modifier	EP = Modifier to identify EPSDT Supplemental Services

Physician Administered Drug (PAD) Submissions – 340B

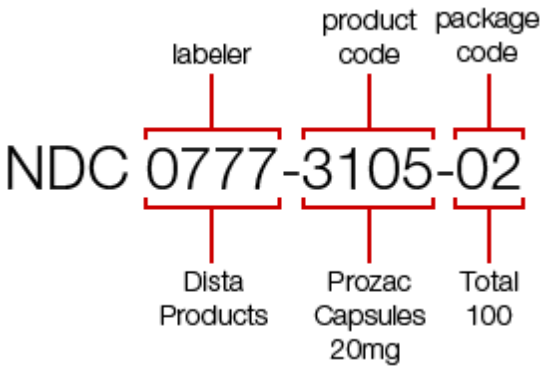
For the Medi-Cal line of business, services that include the use of 340B physician administered drugs should be reported accurately with the proper procedure code, **National Drug Code**, drug unit, and drug quantity to Blue Shield Promise.

National Drug Code (NDC)

What is a National Drug Code (NDC)?

The NDC, or National Drug Code, is a unique 10-digit, 3-segment number. It is a universal product identifier for human drugs in the United States. The code is present on all nonprescription (OTC) and prescription medication packages and inserts in the US. The 3 segments of the NDC identify the labeler, the product, and the commercial package size. The first set of numbers in the NDC identifies the labeler (manufacturer, repackager, or distributer). The second set of numbers is the product code, which identifies the specific strength, dosage form (i.e, capsule, tablet, liquid) and formulation of a drug for a specific manufacturer. Finally, the third set is the package code, which identifies package sizes and types. The labeler code is assigned by the FDA, while the product and package code are assigned by the labeler.

Example NDC



For example, the NDC for a 100-count bottle of Prozac 20 mg is 0777-3105-02. The first segment of numbers identifies the labeler. In this case, the labeler code "00777" is for Dista Products Company, the labeler of Prozac. The second segment, the product code, identifies the specific strength, dosage form (i.e, capsule, tablet, liquid) and formulation of a drug for a specific manufacturer. In our case, "3105" identifies that this dosage form is a capsule. The third segment is the package code, and it identifies package sizes and types. The package code "02" for this bottle of Prozac identifies that 100 capsules are in the bottle.

National Drug Code (NDC) Conversion Table, continued

Converting NDCs from 10-digits to 11 digits.

Proper billing of a National Drug Code (NDC) requires an 11-digit number in a 5-4-2 format. If a drug's NDC does not follow this format, then zeroes must be inserted at the beginning of the appropriate section of the number, as shown in the table below.

NOTE: Do not use hyphens when entering the actual data in your claim.

Converting NDCs from 10-digits to 11-digits					
10- Digit Format on Package	10- Digit Format on Example	11- Digit Format	11- Digit Format Example	Actual 10-Digit NDC Example	11- Digit Conversion Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99	0002-7597-01	00002-7597-01
5-3-2	99999-999-99	5-4-2	99999-0999-99	50242-040-62	50242-0040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-09	60575-4112-1	60575-4112-01

Present on Admission (POA)

For Inpatient claims or encounters, the Present on Admission indicator must be properly reported for all diagnosis codes. The POA is in loop 2300 segment HI01-09; the 01 incrementally increases for each additional diagnosis reported. As indicated below, report "Y" for Present at the time of inpatient admission, "N" for Not present at the time of inpatient admission, "U" if the documentation is insufficient to determine if the condition was present on admission, "W" if the provider was unable to clinically determine if the condition was present on admission and do not populate if the POA does not apply.

Loop / Segment	Value	Description
2300 HI01-09	Y	Present at time of inpatient admission
	N	Not present at the time of inpatient admission
	U	Insufficient documentation to determine of condition present on admission
	W	Provider unable to clinically determine of condition present on admission