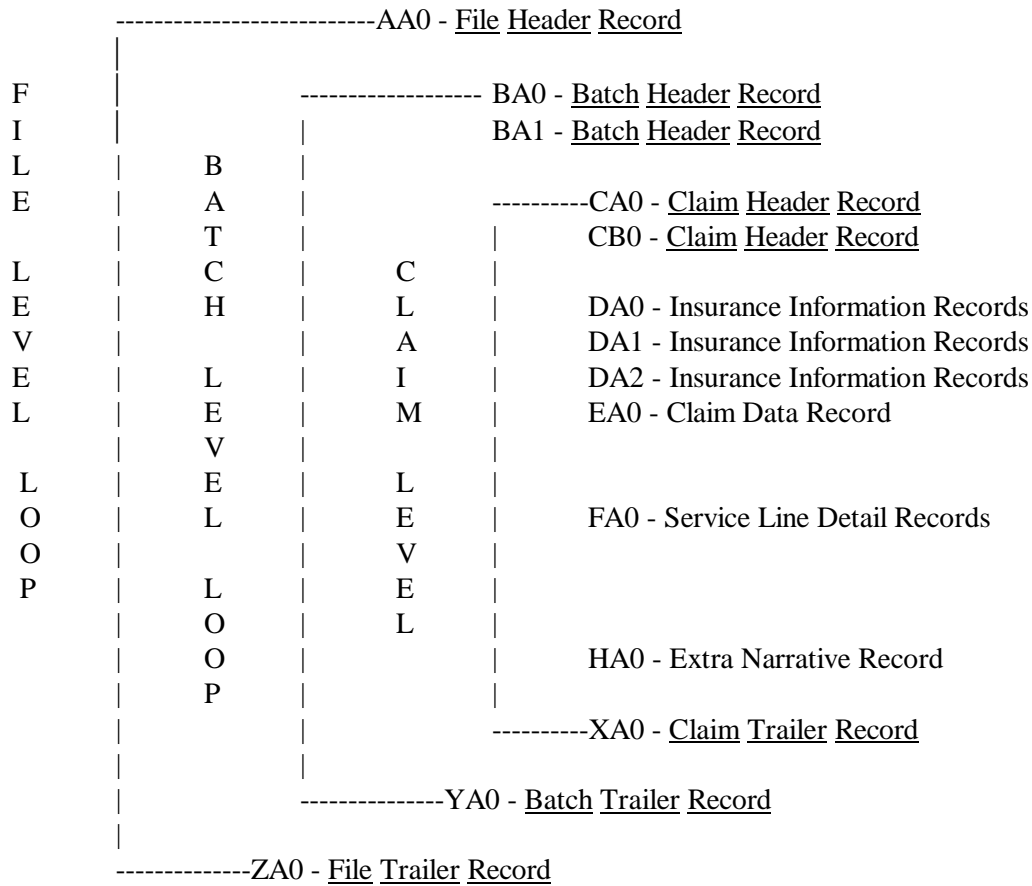


## SECTION 8 - BLUE SHIELD, HMO BLUE AND HBI

<u>TITLE</u>	<u>PAGE</u>
FILE LAYOUT - GRAPHIC ILLUSTRATION	8.2
RECORD OCCURRENCE CHART	8.3
NSF FIELD REQUIREMENTS	8.4
FIELD DEFINITIONS	8.6
GENERAL INFORMATION	8.19
DIAGNOSIS CODE REQUIREMENTS	8.19
EMC BILLING LIMITATIONS	8.19
CLAIMS REQUIRING SUPPORTING DOCUMENTATION	8.19
SPECIFIC CLAIM TYPE REQUIREMENTS	8.19
ANESTHESIA CLAIMS	8.19
BLUE SHIELD - SECONDARY	8.20
NOT OTHERWISE CLASSIFIED (NOC) PROCEDURE CODES	8.20
BLUE SHIELD TEST DATA	8.21
BLUE SHIELD - ANSI IMPLEMENTATION GUIDELINES	8.22

# FILE LAYOUT - GRAPHIC ILLUSTRATION



## RECORD OCCURRENCE CHART

AA0 & ZA0	A submission may contain multiple files. The total record count for the file cannot exceed 9,999,999 records.
BA0 & YA0	A file may contain up to 9,999 batches. All batches within the file must be for the same payor.
CA0 & XA0	A batch may contain 9,999,999 claims. All claims within the batch must be for the same provider number.
DA0	There must be one DA0 record per claim and there cannot be more than three DA0 records per claim.
DA1, DA2,	None to three occurrences per claim.
EA0	One per claim is required.
FA0	One per claim is required. Cannot exceed 9 per claim.
HA0	None to 9 per claim.
BA1, CA1, CB0, DA3,EA1, EA2, FB0, FB1, FB2, FB3, FD0, FE0, GA0,GC0, GD0 GD1,GE0, GP0, GU0,GX0, GX1, GX2	These records are not utilized/recognized by Blue Shield.

**NSF FIELD REQUIREMENTS  
BLUE SHIELD, HMO BLUE AND HBI**

FIELD	RECORDS											
	A	B	C	D	D	D	E	F	H	X	Y	Z
	A 0	A 0	A 0	A 0	A 1	A 2	A 0	A 0	A 0	A 0	A 0	A 0
01.0	R	R	R	R	C	R	R	R	R	R	R	R
02.0	R			R	R	R		R	R		R	R
03.0		R	R	R	R	R					R	
04.0	R		R	R		C	R					R
05.0	R	R	R	R			R	R	C		R	
06.0				R		C		C				R
07.0				R		C	R	R				R
08.0			R	R		C		R				R
09.0			R	C				R			R	R
10.0				C				C		R	R	
11.0			C					C			R	
12.0										R		
13.0			C					R				
14.0		R	C	C	C			R				
15.0	R		C									
16.0				R								
17.0	R			R								
18.0	R			R				R				
19.0	R			R				C				
20.0	R			R								
21.0	R							R				
22.0	R											
23.0								C				

**NSF FIELD REQUIREMENTS  
BLUE SHIELD, HMO BLUE AND HBI**

FIELD	RECORDS											
	A A 0	B A 0	C A 0	D A 0	D A 1	D A 2	E A 0	F A 0	H A 0	X A 0	Y A 0	Z A 0
24.0							C					
25.0							C					
26.0												
27.0												
28.0							C					
29.0							C					
30.0												
31.0												
32.0							R					
33.0							C					
34.0							C					
35.0							C					
36.0							R					
37.0 THRU 94												

## FIELD DEFINITIONS

### **AA0-02.0 SUBMITTER IDENTIFIER**

Submitter ID's are assigned by Texas Health Information Network (THIN). THIN will only use the first six positions. Must be identical to the submitter identifier in file trailer (ZA0-02.0) and must match the Login ID used to access rEDI-link Blue. Contact the EDI Helpline for the correct submitter identification number.

*FILE REJECT - MESSAGE 121*

### **AA0-04.0 SUBMISSION TYPE**

Indicate the input medium or method used to transmit the data.

### **AA0-05.0 SUBMISSION NUMBER**

Must be six digit alpha-numeric value for each submission. No embedded blanks or special characters are allowed. Duplicate file IDs for a submitter (AA0-02.0) submitted within six months will be rejected.

*FILE REJECT - MESSAGE 107, 112*

### **AA0-15.0 CREATION DATE**

Indicate the date the file was created.

### **AA0-17.0 RECEIVER IDENTIFICATION**

Must equal "84980" for Blue Shield and HMO Blue. Must equal receiver identification in file trailer (ZA0-04.0).

*FILE REJECT - MESSAGE 124*

### **AA0-18.0 RECEIVER TYPE CODE**

Must equal "G" for Blue Shield and HMO Blue.

*FILE REJECT - MESSAGE 123*

### **AA0-19.0 VERSION CODE - NATIONAL**

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice.

*FILE REJECT - MESSAGE 113*

### **AA0-20.0 VERSION CODE - LOCAL**

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice. Must match National Version Code (AA0-19.0).

## FIELD DEFINITIONS

### **AA0-21.0 TEST/PRODUCTION INDICATOR**

All files are handled as production unless:

- This field contains “TEST”,
- The provider has not completed and returned all the necessary EDI Enrollment and Agreement forms.
- The submitter is not flagged as production in the BCBSTX submitter file.

### **AA0-22.0 PASSWORD**

Required for all submissions. The password is assigned by THIN. Must be six digit alpha-numeric. Contact the EDI Helpline for verification of the password.

*FILE REJECT - MESSAGE 122*

### **BA0-03.0 BATCH TYPE**

Batch type “100”.

*BATCH REJECT - MESSAGE 201*

### **BA0-05.0 BATCH IDENTIFICATION**

Must be six digit alpha-numeric value for each batch ID. No embedded blanks or special characters are allowed. Duplicate batch IDs for a billing provider (BA0-14.0) submitted within six months will be rejected.

*BATCH REJECT - MESSAGE 205, 212*

### **BA0-14.0 PROVIDER BLUE SHIELD NUMBER**

Must be six digit Blue Shield PIN or Group Number.

*BATCH REJECT - MESSAGE 241*

### **CA0-03.0 PATIENT CONTROL NUMBER**

Blue Shield will carry the first ten positions of this field into the claims processing system and return it on the remittance.

### **CA0-04.0 PATIENT LAST NAME**

Must be entered even if the same as the insured.

*BATCH REJECT - MESSAGE 4BB*

## FIELD DEFINITIONS

- CA0-05.0 PATIENT FIRST NAME**  
Must be entered even if the same as the insured.  
This must be the newborn's legal name. It must not be BABY, BOY, GIRL, TWIN, NWBR, CHILD, NBBOY, INF or NBGIRL.
- BATCH REJECT - MESSAGE 4BB, 4BC*
- CA0-08.0 PATIENT DATE OF BIRTH**  
Must be the patient's date of birth.
- BATCH REJECT - MESSAGE 4BK*
- CA0-09.0 PATIENT'S SEX**  
Valid values are M or F.
- BATCH REJECT - MESSAGE 4BH*
- CA0-11.0 PATIENT ADDRESS - 1**  
This field is required if DA2 Record is not given.
- BATCH REJECT - MESSAGE 4BQ*
- CA0-13.0 PATIENT CITY**  
This field is required if DA2 Record is not given.
- BATCH REJECT - MESSAGE 4BR*
- CA0-14.0 PATIENT STATE**  
This field is required if DA2 Record is not given.
- BATCH REJECT - MESSAGE 4BS*
- CA0-15.0 PATIENT ZIP CODE**  
This field is required if DA2 Record is not given.
- BATCH REJECT - MESSAGE 4BT*

## FIELD DEFINITIONS

### **DA0-03.0 PATIENT CONTROL NO**

Blue Shield will carry the first twelve positions of this field into the claims processing system and return it on the remittance.

### **DA0-04.0 CLAIM FILING INDICATOR**

Indicate whether or not this record is being provided to obtain payment from the indicated payor or for informational purpose. Valid values are:

P = payment is being requested of this payor

I = payment is not being requested of this payor

### **DA0-05.0 SOURCE OF PAYMENT**

If DA0-04.0 = "P", then DA0-05.0 must = G.

If DA0-04.0 = "I", then DA0-05.0 may = any of the following values:

A = Self Pay

B = Workers Compensation

C = Medicare

D = Medicaid

E = Other Federal Program

F = Commercial Insurance Company

H = Champus

I = HMO

J = Federal Employee's Program (FEP)

K = Central Certification

L = Self Administered

M = Family or Friends

N = Managed Care - Non-HMO

P = Blue Cross

T = Title V

V = Veterans Administration Plan (VA)

Z = Other (Medigap)

*CLAIM REJECT - MESSAGES 302, 303, 304, 309*

## FIELD DEFINITIONS

**DA0-06.0 INSURANCE TYPE CODE**

If DA0-05.0 = "G, DA0-06.0 must =  
GP = Group Policy  
IP = Individual Policy

**DA0-07.0 PAYOR ORGANIZATION IDENTIFICATION**

The value is 84980.

**DA0-08.0 PAYOR CLAIM OFFICE NUMBER**

The three digit alpha prefix found in front of the subscriber ID on the ID card, is entered in this field. FEP claims will not have an alpha prefix entered. HMO Blue claims will always have ZGA entered.

BATCH REJECT - MESSAGE 4B3

**DA0-09.0 PAYOR NAME**

When Blue Shield is secondary, the primary payor name must be given.

**DA0-10.0 GROUP NUMBER**

Entered when field DA0-08.0 equals ZGA. The group number must be five, six or seven digit numeric as listed on the subscribers ID card. This field is left justified, blank filled. If DA0-08.0 is other than ZGA, the group number is not required.

*CLAIM REJECT - MESSAGE 4B1*

**DA0-14.0 PRIOR AUTH NO**

Enter the referral or the pre-certification number.

**DA0-16.0 PAT SIGNATURE SOURCE**

Valid values: C - Signed HCFA - 1500 claim form on file.  
S = Signed signature authorization form for Block 12 on file.  
M = Signed signature authorization form for Block 13 on file.  
B = Signed signature authorization form or forms for both Block 12 and Block 13 are on file.  
P = Signature generated by provider because the patient was not physically present for services.

**DA0-17.0 PATIENT RELATIONSHIP TO INSURED**

The only valid values are:  
01 - Self  
02 - Spouse  
03 - Dependent  
16 - Sponsored Dependent

*CLAIM REJECT - MESSAGE 4BJ*

## FIELD DEFINITIONS

### **DA0-18.0 INSURED IDENTIFICATION NUMBER**

Must be the insureds subscriber ID number as listed on the ID card. The following criteria should be used to validate this field.

If DA0-08.0 is ZGA, this field will be 9 or 11 numerics.

If the subscriber ID begins with "R", then 8 numerics will following the "R".

If DA0-08.0 is other than ZGA, the subscriber ID can be any alpha-numeric length.

*CLAIM REJECT - MESSAGE 4B2*

### **DA0-19.0 INSURED'S LAST NAME**

Enter the last name of the insured even if the same as the patient.

*CLAIM REJECT - MESSAGE 4BA*

### **DA0-20.0 INSURED'S FIRST NAME**

Enter the first name of the insured even if the same as the patient.

*CLAIM REJECT - MESSAGE 4BA*

### **DA1-14.0 PAYOR AMOUNT PAID**

Must be submitted on DA1 record, sequence 01 when Blue Shield is the secondary payor. Reflects the total amount paid by the primary payor.

### **DA2-03.0 PATIENT CONTROL NO**

Blue Shield will carry the first twelve positions of this field into the claims processing system and return it on the remittance.

### **DA2-04.0 INSURED ADDRESS 1**

Enter the insured's street address. If the record is sent but this field is blank, the claim will be rejected.

*CLAIM REJECT - MESSAGE 4BD*

### **DA2-06.0 INSURED CITY**

Enter the insured's city. If the record sent but the field is blank, the claim will be rejected.

*CLAIM REJECT - MESSAGE 4BE*

### **DA2-07.0 INSURED STATE**

Enter the insured's state. If the record is sent but the field is blank, the claim will be rejected.

*CLAIM REJECT - MESSAGE 4BF*

## FIELD DEFINITIONS

**DA2-08.0 INSURED'S ZIP CODE**

Enter the insured's zip code. If the record is sent but the field is blank, the claim will reject.

*CLAIM REJECT - MESSAGE 4BG*

**EA0-04.0 EMPLOYMENT RELATED INDICATOR**

Must not be blank. Valid values are N or Y.

*CLAIM REJECT - MESSAGE 4BL*

**EA0-05.0 ACCIDENT INDICATOR**

Must not be blank. If condition is not an accident, enter N.

When the diagnosis is accident related one of the following is required.

A for auto

O for other

*CLAIM REJECT - MESSAGE 4BM*

**EA0-07.0 ACCIDENT/SYMPTOM DATE**

Date is to be one of the following:

If one of the following diagnosis codes, enter the LMP date.

64000 - 64694, 64898, 65000 - 67004, 67200 - 67204, 67700, 73811, 73812, V220, V221, V222, V230, V231, V232, V233, V234, V235, V237, V238, V239, V240, V241, V242, V270, V271, V272, V273, V274, V275, V276, V277, V279, V280, V281, V282, V283, V284, V285, V288, V289, V616, V617

If one of the following diagnosis codes, enter the original accident date.

800 - 9599, 9646, 9846, 9829, 9895, 9896, 9941, 9959, 0269, 0719, 5185, 5251, 5582, 69271

If none of the above, enter the earliest date of service listed on the claim.

*CLAIM REJECT - MESSAGE 4BN*

**EA0-24.0 REFER PROV LAST NAME**

This should be the last name of the referring provider.

**EA0-25.0 REFER PROV FIRST NAME**

This should be the first name of the referring provider.

## FIELD DEFINITIONS

### **EA0-28.0**      **ADMISSION DATE 1**

This field is required when services are performed while the patient was confined in a health care facility. The admission date must not be after the condition date.

The following place of service codes require an admission date.

- 21 inpatient hospital
- 31 skilled nursing facility
- 32 nursing facility
- 33 custodial care facility
- 51 inpatient psychiatric facility
- 52 psychiatric facility partial hospitalization
- 53 community mental health center
- 54 intermediate care facility/mentally retarded
- 56 psychiatric residential treatment center

*CLAIM REJECT - MESSAGE 409, 4BP*

### **EA0-29.0**      **DISCHARGE DATE 1**

See EA0-26.0.

## FIELD DEFINITIONS

- EA0-32.0**     **DIAGNOSIS CODE-1**
- EA0-33.0**     **DIAGNOSIS CODE-2**
- EA0-34.0**     **DIAGNOSIS CODE-3**
- EA0-35.0**     **DIAGNOSIS CODE-4**

All claims require a diagnosis code. Please note that ICD-9-CM codes must be coded to the highest level of specificity, i.e., coding to the fourth or fifth digit. E and M diagnosis codes are not valid. The diagnosis must be valid for the sex of the patient.

If the claim contains a diagnosis code from each of the following categories and services are pointing to each, the services must be split. A claim can only have one condition date. Since each of these categories require a condition date the claim must be split.

### Maternity

64000 - 64694, 64898, 65000 - 67004, 67200 - 67204, 67700, 73811, 73812, V220, V221, V222, V230, V231, V232, V233, V234, V235, V237, V238, V239, V240, V241, V242, V270, V271, V272, V273, V274, V275, V276, V277, V279, V280, V281, V282, V283, V284, V285, V288, V289, V616, V617

### Accident

800 - 9599, 9646, 9846, 9829, 9895, 9896, 9941, 9959, 0269, 0719, 5185, 5251, 5582, 69271

The FEP contract requires that a claim cannot contain services for alcohol abuse, psychiatric or drug abuse along with other diagnoses. The alcohol abuse, psychiatric or drug abuse must be filed on a separate claim.

**Alcohol abuse**, (29100 - 29199, 30300 - 30399, 30500 - 30509, 79030)

**Psychiatric**, (29000 - 29099, 29300 - 29599, 30000 - 30299, 30600, V40 - V402, V403, V409, V61 -V610, V611, V612, V613, V614, V618 - V619, V620 - V624, V625, V626 - V628, V6282, V6289, V629, V654, V6540, V6549, V693, V701 - V702)

**Drug abuse** (29200 - 29299, 30400 - 30499, 30510 - 30599, 32700 - 32799, V6542)

Updated ICD-9-CM codes can be obtained from the American Hospital Association (AHA). There is no cost for an AHA member. There is a small fee for a non-member. The AHA toll-free number is 1-800-242-2626.

*CLAIM REJECT - MESSAGE 440, 441, 442, 443, 451, 452, 453*

## FIELD DEFINITIONS

### **EA0-36.0 PROV ASSIGN IND**

Valid values are: Y = Assigned  
N = Not Assigned

### **FA0-05.0 SVC FROM DATE**

The Service From Date is required on each detail line. Date cannot be a future date, must not be prior to patient's date of birth, must be not prior to condition date or prior to the hospital admit date.

*CLAIM REJECT - MESSAGE 401, 402, 403, 404*

### **FA0-06.0 SVC TO DATE**

The Service To Date is not required unless billing for services performed over a range of dates. The date span of the From and To Dates must be within the same month and year. The To date must be a valid date and must not be prior to the From date.

*CLAIM REJECT - MESSAGE 337,405*

### **FA0-07.0 PLACE OF SERVICE**

The place of service is required on each detail. The valid values are:  
11, 12, 21, 22,23, 24, 25, 26, 31, 32, 33, 34, 41, 42, 51, 52, 53, 54, 55, 56, 61, 62, 65, 71, 72, 81, 99.

Refer to Exhibit 4 for definitions of each.

*CLAIM REJECT - MESSAGE 408*

### **FA0-08.0 TYPE OF SERVICE**

For Blue Shield and HMO Blue claims the field is left justified and right blank filled. Valid values are:

0, 1, 2, 3, 4, 5, 6, 7, 8, 9, A, H, I, P, R, T, V, X.

See Exhibit 1 for a definition of each.

*CLAIM REJECT - MESSAGE 460*

## FIELD DEFINITIONS

### **FA0-09.0 HCPCS PROCEDURE CODE**

This is a required field for each detail line. This must be either a CPT-4 or an alpha-numeric procedure code listed on the BCBSTX file. The type of service to procedure code is validated to the BCBSTX file. See Exhibit 2 for a listing. The procedure code must be valid for the patient's age and sex. The procedure code is also validated to the place of service.

Anesthesia services must be billed using the CPT-4 surgical procedure code. DO NOT use the CPT-4 anesthesia procedure codes.

Procedure codes that are classified as NOT OTHERWISE CLASSIFIED must have a narrative description. See also HA0-05.0 for instructions.

Of the following procedure codes only one can be billed per claim because of the hospital admit date requirement. Multiple admissions must be split.

90200, 90215, 90220, 90221, 99221, 99222, 99223

*CLAIM REJECT - MESSAGE 461, 462, 463, 464, 465, 470, 471*

### **FA0-10.0 HCPCS MODIFIER 1**

### **FA0-11.0 HCPCS MODIFIER 2**

Used to modify payment of a procedure or to assist in determining appropriate coverage. Blue Shield will allow all CPT-4 valid modifiers. See Exhibit 3 for a list of valid modifiers.

### **FA0-13.0 LINE CHARGES**

This is a required field for each detail line. Must be greater than zero.

*CLAIM REJECT - MESSAGE 407*

### **FA0-14.0 DIAGNOSIS CODE POINTER 1**

This is the only diagnosis code pointer field that is used for processing claims. Diagnosis pointer fields 2 through 4 are ignored.

*CLAIM REJECT - MESSAGE 440*

### **FA0-18.0 UNITS OF SVC**

Must be equal to or greater than 001.0. Must be equal to or less than 999.0. This field should equal 0010 when anesthesia minutes are submitted in FA0-19.0.

*CLAIM REJECT - MESSAGE 406*

## FIELD DEFINITIONS

**FA0-19.0 ANESTHESIA/OXYGEN MINUTES**

This field is required when the type of service is 7.

*CLAIM REJECT - MESSAGE 467*

**FA0-21.0 COB INDICATOR**

If values 2 or 4 are used, then Payor Name (DA0-09.0) is mapped into the processing system. Following are the valid values.

- 0 No other insurance
- 1 Texas Blue Shield
- 2 Other Commercial insurance
- 3 Medicaid
- 4 Medicare
- 5 Unknown
- 7 No Medicare "B" coverage

*CLAIM REJECT - MESSAGE 410*

**FA0-23.0 RENDERING PROVIDER ID**

Required when the billing provider is a group. Enter the six digit rendering provider number.

*CLAIM REJECT - MESSAGE 430, 431*

**FA0-24.0 REFERRING PROV ID**

Required. Enter the referring providers UPIN.

**HA0-05.0 EXTRA NARRATIVE DATA**

This field is required when the procedure code has a description of "NOT OTHERWISE CLASSIFIED". Additional documentation that is required for claims processing can be faxed or mailed. The method of submission (i.e., faxed or mailed) and the postmark or fax transmission date will be given in this field.

*CLAIM REJECT - MESSAGE 470*

## **FIELD DEFINITIONS**

**DATE ALL DATE FIELDS**

If submitted, must be valid dates in CCYYMMDD format.

*CLAIM REJECT - MESSAGE 337, 401, 405*

**STATE ALL STATE FIELDS**

If submitted, must be valid two-digit state postal abbreviation.

*CLAIM REJECT - MESSAGE 4BF, 4BS*

**ZIP ALL ZIP CODE FIELDS**

If submitted, must be five (5) numerics or nine (9) numerics. May not contain hyphens. The first characters of the zip code must be within the range for the state according to the U. S. Postal Service.

*CLAIM REJECT - MESSAGE 4BG, 4BT*

For a complete list of reject messages, refer to Exhibit 5.

## **BLUE SHIELD - GENERAL INFORMATION**

- **DIAGNOSIS CODE REQUIREMENTS**

All claims require a diagnosis code.

Diagnosis codes in the External Causes of Injury and Poisoning range (E800 - E999) are not acceptable.

Diagnosis codes in the Morphology of Neoplasms range (M8000 - M9970) are not acceptable.

- **EMC BILLING LIMITATIONS**

There are no claim types that are not accepted in National Standard Format. If you have questions regarding specific services/claim types, please contact your EMC Marketing Representative.

- **CLAIMS REQUIRING SUPPORTING DOCUMENTATION**

Certain services require supporting documentation for correct claim processing.

Refer to FAX/MAIL EMC Documentation Appendix for a list of services and instructions.

- **SPECIFIC CLAIM TYPE REQUIREMENTS**

**ANESTHESIA CLAIMS**

Claims for anesthesia services are to be submitted using the CPT-4 surgical procedure codes (10040 - 69979) with the appropriate modifier.

- **BLUE SHIELD SECONDARY**

To submit a Blue Shield secondary claim electronically does not require the submission of the primary payor's explanation of benefits but does require the submission of three additional data elements:

Other Insurance Indicator  
Primary Payor Name  
Primary Payor Amount Paid

Submit this information in the following information in the indicated fields:

Other Insurance Indicator  
FA0 Record, Field 21.0  
Enter: 2

Primary Payor Name  
DA0 Record, Field 09.0  
Enter: The name of the Primary Insurance Carrier

Primary Payor Amount  
DA1 Record, Field 14.0  
Enter: The amount paid by the Primary Insurance Carrier

- **NOT OTHERWISE CLASSIFIED PROCEDURE CODES**

All efforts should be made to file a claim using valid specific HCPCS codes. If a specific HCPCS code cannot be used, NOC codes can be submitted electronically if these guidelines are followed.

When a NOC code is billed, the procedure description must be submitted in HA0-05.0. If NOC codes are submitted without procedure descriptions, the claim is rejected.

If sufficient documentation cannot be submitted electronically, refer to the FAX/MAIL EMC Documentation Appendix.

Procedure 99070 - Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays supplied or materials provided) are not to be filed on electronically submitted Blue Shield claims.

## **BLUE SHIELD - TEST DATA**

Section 3 of this Implementation Guide describes the testing process. We recommend that new EDI System Vendors and Submitters include the following claim situations when testing Blue Shield. Testing each of these situations, will ensure that all possible claims processing situations have been tested.

### **General Claims -**

Multiple Place of Services (11, 12, 21, 22, 32...)

Blue Shield Secondary Insurance to Commercial Narratives

Assistant Surgery

Multiple Surgery's

Solo Practice

Group Practice (with Performing Provider Id #'s)

9 Detail lines

### **Specialty Claim Types -**

Anesthesia/CRNA (with modifiers, minutes)

## **BLUE SHIELD ANSI IMPLEMENTATION GUIDELINES**

Following are guidelines / information that will assist you in implementing the ANSI X12 837 transaction set, versions 3030.2B, 3051.3B and 3051.3B.01 for Blue Shield claims.

- You must contact our office and be set up as a trading partner prior to submitting ANSI transactions.
- A test file must be submitted and approved prior to submitting production claims.
- 837 ANSI transaction files equal to or greater than 1 Mg. will be held and processed in the nightly batch cycle. The response files will be available the next day. You will receive a message to this effect immediately, when your file is being processed in this manner.
- In addition to the 997 acknowledgment, you will receive our formatted response file which will provide you with file/batch/claim status information. Since the ANSI transaction is translated immediately into National Standard Format for editing and processing, the response file will reference NSF fields and values. You will need a copy of the Texas Health Information Network Implementation Guide to assist you in resolving any rejects you may encounter.
- We have implemented the ANSI X12 837 for Blue Shield based on the WEDI Professional Care Claim / Encounter Implementation Guide. You may obtain a copy of the guide from the following web site:

<http://www.wedi.org/wedi>

- Following are definitions for specific data elements and their requirements that are unique to Blue Cross Blue Shield of Texas:

### 0-010-ISA - INTERCHANGE CONTROL HEADER

ISA04 - Must equal the password for the submitter id in ISA06, based on the BCBSTX security table.

ISA06 - Must equal the 6 digit submitter id, based on the BCBSTX security table.

ISA08 - Must equal 'G84980'

### 1-010-BGN - BEGINNING SEGMENT

BGN02 - Only the first six bytes are acknowledged by BCBSTX. This number must be unique for each submission since duplicate file checking is performed. If the file id number matches a previously transmitted file from the same submitter, it will be rejected as a duplicate file at the time of transmission.

### 2-130-CLM - HEALTH CLAIM

CLM03 - Must equal "BL".

CLM09 - Must equal: A - Assigned or C - Not Assigned.

CLM11 - Must equal "Y".

2-135.C-DTP - ADMISSION DATE and  
2-135.D-DTP - DISCHARGE DATE

DTP06 - If 2-130-CLM06 equals: 21, 31, 32, 33, 51, 52, 53, 54, 55, or 56, these fields must reflect the admission date and if applicable, the discharge date.

2-135.F - ILLNESS DATE

DTP03 - Must contain the date of the first symptom of the illness or injury. If unknown, plug the first (oldest) date of service on the claim as the symptom date.

2-135.G - ACCIDENT DATE

DTP03 - Must contain the date of the accident if 2-130-CLM13, CLM14, or CLM15 contain "AA", "EM", or "OA".

2-135.L - LAST MENSTRUAL PERIOD DATE

DTP03 - Required for maternity related services.

2-240 - QTY - ANESTHESIA MODIFYING UNITS

This segment is not recognized by the Blue Shield system.

## 2-290 - SV1 - PROFESSIONAL SERVICE

Only the following ANSI type of service codes will be accepted for Blue Shield claims in the SV107 data element:

<b>ANSI TOS VALUE:</b>	<b>WILL CONVERT TO NSF TOS VALUE:</b>	<b>NARRATIVE DESCRIPTION:</b>
1	1	MEDICAL CARE
2	2	SURGICAL
3	3	CONSULTATION
4	4	DIAGNOSTIC X-RAY (TOTAL)
5	5	DIAGNOSTIC LAB (TOTAL)
6	6	RADIATION THERAPY
7	7	ANESTHESIA
8	8	SURGICAL ASSISTANCE
9	9	OTHER MEDICAL
10	0	BLOOD CHARGES
12	A	DURABLE MEDICAL EQUIP. PURCHASE
18	H	DURABLE MEDICAL EQUIP. RENTAL
19	V	PNEUMONIA VACCINE

To bill for the professional component only of a diagnostic x-ray or laboratory procedure, it will be necessary to submit a "26" modifier in SV109 in addition to the 4 or 5 in the SV107.

Likewise, to bill for the technical component only of a diagnostic x-ray or laboratory procedure, it will be necessary to submit a "TC" modifier in SV109 in addition to the 4 or 5 in the SV107.

\*\*\* The above values will only be converted to the appropriate National Standard Format values if ISA08 is equal to "G84980".

## 2-325-SV6 - ANESTHESIA SERVICE

SV601 - The Blue Shield system does not recognize the Anesthesia procedure codes listed in the American Medical Association's CPT manuals. The appropriate surgical procedure code should be submitted along with any applicable modifiers.