Florida Blue Medicare Health Plan

HIPAA Transaction Standard Companion Guide

For Availity®1 Health Information Network Users

Refers to the Technical Report Type Three (TR3) Based on ASC X12 Version 005010X222A1

837 P – Health Care Claim Professional

Companion Guide Version Number: 2.0

900-4668-1223

Disclosure Statement

The Florida Blue Medicare HIPAA Transaction Standard Companion Guide for EDI Transactions Technical Reports, Type three (3) (TR3) provides guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12-TR3s require transmitters and receivers to make certain determinations /elections (e.g., whether, or to what extent, situational data elements apply) this Companion Guide documents those determinations, elections, assumptions or data issues that are permitted to be specific to Florida Blue Medicare business processes when implementing the HIPAA ASC X12 5010 TR3s.

This Companion Guide does **not** replace or cover all segments specified in the HIPAA ASC X12 TR3s. It does not attempt to amend any of the requirements of the TR3s or impose any additional obligations on trading partners of Florida Blue Medicare that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on Florida Blue Medicare specific codes relevant to Florida Blue Medicare business processes, rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA ASC X12 TR3s, their structure and content.

This Companion Guide provides supplemental information that exists between Florida Blue Medicare and its trading partners. Trading partners should refer to their trading partner agreement for guidelines pertaining to Availity LLC, legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on Florida Blue Medicare business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this Companion Guide is intended to amend, revoke, contradict or otherwise alter the terms and conditions of your applicable trading partner agreement. If there is an inconsistency between the terms of this Companion Guide and the terms of your applicable trading partner agreement, the terms of the trading partner agreement will govern. If there is an inconsistency between the terms of this Companion Guide and any terms of the TR3, the relevant TR3 will govern with respect to HIPAA edits and this Companion Guide will govern with respect to business edits.

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Version Change Log

Date	Description	Page
12-03-19	Document Creation	NA
02-16-2021	Format Changes	Multiple
01-23-2023	Added section 1.4 Additional information as a result of CMS audit feedback	8-9
06-01-2023	Section 1.4 verbiage modification - (version 1.2)	8-9
12/15/2023	Update to section 1.4 Florida Blue Scheduled Downtown	8
12/15/2023	Update to Table of Contents	4

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Florida Blue Medicare Health Plan Companion Guide ANSI 837 P Health Care Professional Claim

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1   INTRODUCTION

What is HIPAA 5010?

The Health Insurance Portability and Accountability Act (HIPAA) requires the health care industry in the United States to comply with the electronic data interchange (EDI) standards as established by the Secretary of Health and Human Services. The ASC X12 005010X222A1 is the established standard for Health Care Professional Claims (837 P).

What is NPI?

The National Provider Identifier (NPI) is required wherever you identify a provider or provider organization in any standard covered HIPAA-AS electronic transaction. The NPI must be valid and it must be registered with Florida Blue Medicare.

If you are a provider or provider organization who needs to obtain an NPI, please access the National Plan and Provider Enumeration System (NPPES) at National Plan & Provider Enumeration System. To register your NPI with Florida Blue, please access our NPI Notification Form at availity.com.

What is a Taxonomy code, and is it required for Florida Blue Medicare?

Taxonomy codes are administrative codes that identify the provider type and area of specialization for health care providers. Each taxonomy code is a unique ten character alpha-numeric code that enables providers to identify their specialty. Taxonomy codes are assigned at both the individual and organizational provider levels.

Taxonomy codes have three distinct levels: Level I is provider type, Level II is classification, and Level III is the area of specialization. A complete list of taxonomy codes can be found on the National Uniform Claim Committee website at nucc.org.

Taxonomy codes are required by Florida Blue Medicare under specific circumstances. Taxonomy is one of several data elements used by Florida Blue Medicare to help determine the appropriate provider record for processing. In cases where the NPI is shared by multiple provider entities, specialties or locations, the taxonomy becomes a critical data element.

For example:

ABC Hospital, Urgent Care, Lab and Physician PA Group all share the same NPI. In this case, the taxonomy becomes critical to ensure appropriate processing and fee schedule assignment.

1.1 Scope

This 837 Companion Guide was created for Florida Blue Medicare trading partners to supplement the 837 TR3. It describes the data content, business rules, and

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characteristics of the 837 transaction. If you submit your transactions through Availity, please also refer to the Availity EDI guide availity.com.

1.2 Overview

The Technical Report Type three (3) Guide (TR3) for the 837 P Health Care Professional Claim transactions specifies in detail the required formats. It contains requirements for the use of specific segments and specific data elements within segments, and was written for all health care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to send HIPAA-compliant files to Florida Blue Medicare via your vendor.

1.2 References

- TR3 Guides for ASC X12 005010X222A1 Health Care Professional Claim (837 P) and all other HIPAA standard transactions are available electronically at the Washington Publishing website wpc-edi.com
- For more information, including an online demonstration, please visit availity.com or call 800-282-4548.
- CAQH CORE Operating Rules Phase II caqh.org/CORE_operat_rules.php.

1.4 Additional Information

Florida Blue Scheduled Downtime

2024 UNIX patching schedule and Release schedule

AIX-LUNIX MONTHLY PATCHING OVERVIEW	2024 JAN	2024 FEB	2024 MAR	2024 APR	2024 MAY	2024 JUN	2024 JULY	2024 AUG	2024 SEPT	2024 OCT	2024 NOV	2024 DEC
Production Environment Patching (1 day, Sunday Maintenance window)	01/21	02/25	03/24	04/28	05/19	06/23	07/28	08/25	09/22	10/13	11/10	12/15

Enterprise Release Schedule:

Release Month	Feb 10	Apr 12	May 18 FEP	Jun 22	July 27 FEP ONLY	Aug 24	Sep 21	Oct 12 FEP ONLY	Oct 18	Nov 16	Dec 14	Jan 1,2025 FEP ONLY
Production Milestone	Sat-Sun Imp	Fri-Sat Imp	Sat-Sun Imp	Sat-Sun Imp	Sat-Sun Imp	Sat-Sun Imp	Sat-Sun Imp	Sat-Sun Imp	Fri-Sat Imp	Sat-Sun Imp	Sat-Sun Imp	Mon - Tues Imp
Implemen-tation	02/10-02/11	04/12-04/13	05/18-05/19	06/22-06/23	07/27-07/28	08/24-08/25	09/21-09/22	10/12-10/13	10/18-10/19	11/16-11/17	12/14-12/15	01/01-01/02

Any additional planned maintenance or unscheduled outages will be posted on the Status page as well as on News and Announcements at www.Availity.com.

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Holiday Schedule

Our company observes the following holidays for 2024:

1. New Year's Day - Monday, January 1
2. Martin Luther King Jr. Day - Monday, January 15
3. Memorial Day - Monday, May 27
4. Juneteenth - Wednesday, June 19
5. Independence Day - Thursday, July 4
6. Labor Day - Monday, September 2
7. Thanksgiving Holiday - Thursday, November 28 & Friday, November 29
8. Christmas Holiday -Tuesday, December 24 & Wednesday, December 25

If a holiday falls on a day when our company doesn't operate, we will observe that holiday on the closest business day. For example, if a holiday falls on a Sunday, the following Monday will be observed as a holiday.

2 GETTING STARTED

2.1 Working with Florida Blue Medicare

Availity optimizes information exchange between multiple health care stakeholders through a single, secure network. The Availity Health Information Network encompasses administrative, financial, and clinical services, supporting both real-time and batch EDI via the web and through business to business (B2B) integration. For more information, including an online demonstration, please visit availity.com or call 800-282-4548.

2.2 Trading Partner Registration

In order to register, you will need:

- Basic information about your practice, including your Federal Tax ID and National Provider Identifier.
- Someone with the legal authority (typically an owner or senior partner) to sign agreements for your organization.
- An office manager or other employee who can oversee the Availity implementation and maintain User IDs and access.

2.3 Certification and Testing Overview

All trading partners and clearing houses should be certified via Availity. It is recommended that the trading partner obtain HIPAA Certification from an approved testing and certification third party vendor prior to testing.

3 TESTING WITH FLORIDA BLUE MEDICARE AND AVAILITY

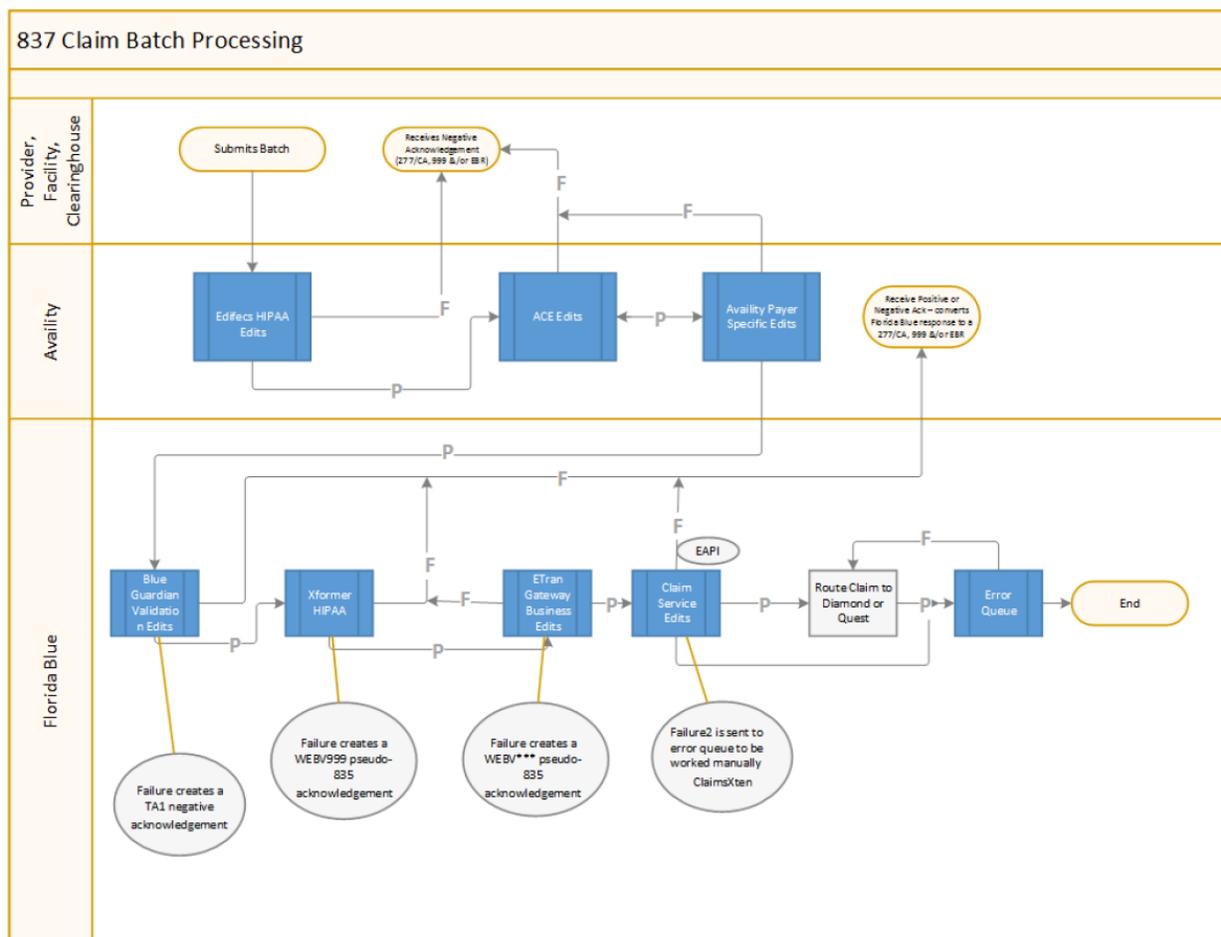[1]Availity, LLC, is a multi-payer joint venture company. For more information or to register, visit availity.com.

Blue Cross and Blue Shield of Florida, Inc., is an Independent Licensee of the Blue Cross and Blue Shield Association.

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Florida Blue Medicare recommends that trading partners contact Florida Blue Medicare
to obtain a testing schedule and or notify Florida Blue Medicare of potential testing
opportunities prior to implementing any foreseen transaction impacts to the business
flow of both Florida Blue Medicare and /or the trading partner.

4   CONNECTIVITY/COMMUNICATIONS WITH FLORIDA BLUE MEDICARE AND AVAILITY

4.1 Process Map

4.2 Passwords

If a password change is necessary, please contact Availity at 800-282-4548 or
availity.com.

5   CONTACT INFORMATION

5.1 EDI Customer Service

For EDI customer service related to Florida Blue Medicare, please visit availity.com or call

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800-282-4548.

5.2 EDI Technical Assistance

For support of EDI transactions through Availity, please visit availity.com or call 800-282-4548.

5.3 Provider Service Number

For provider services, please contact Florida Blue Medicare at 800-727-2227. For faster service, please have your Availity transaction ID available.

5.4 Applicable websites/email

- availity.com
- floridablue.com

6 CONTROL SEGMENTS/ENVELOPES

ANSI 837 P - Health Care Professional Claim:

The purpose of this section is to delineate specific data requirements where multiple valid values are presented within the 5010 TR3.

- Interchange control header (ISA06) Interchange Sender ID (Mailbox ID) – is individually assigned to each trading partner.
- Interchange control header (ISA08) Interchange Receiver ID – If submitting directly to Florida Blue use the Florida Blue Medicare Tax ID, 592015694. If submitting through Availity, use 030240928 (+ six (6) spaces). Reference the Availity EDI guide at availity.com.
- Interchange control header (ISA15) Usage Indicator – defines whether the transaction is a test (T) or production (P).
- Functional Group Header (GS02) Application Sender's code – is individually assigned to each trading partner.

Global Information

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Req #	Loop ID – Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
G1	**All Transactions for Availity Users only**			Florida Blue Medicare requires a trading partner agreement to be on file with Availity indicating all electronic transactions the trading partner intends to send or receive.
G2	**All Segments**			Only loops, segments, and data elements valid for the 837 HIPAA-AS TR3 Guide ASC X12 005010X222A1 will be used for processing.
G3	**Acknowledgements –** **Florida Blue Medicare acknowledgements are created to communicate the status of transactions. It is imperative that they be retrieved on a daily basis. One file could result in multiple acknowledgements.** **ANSI X12:** **- TA1 – Interchange Acknowledgement** **- 999 – Functional Acknowledgement**			TA1 is available immediately after depositing file 999 is available immediately after depositing file. Files and/or claims that do not pass edits are indicated on these acknowledgements and must be corrected and resubmitted. Availity Users: Availity will forward Florida Blue Medicare acknowledgements to the submitter. Please refer to the Availity EDI Guide at availity.com.
G4	**Negative Values**			Submission of any negative values in the 837 transaction is not allowed.
G5	**Date fields**			All dates submitted on an incoming 837 Health Care Professional Claim must be a valid calendar date in the appropriate format based on the respective TR3 qualifier. Failure to do so may cause processing delays or claims being returned as a provider correctable error. These must be corrected and resubmitted electronically.
G6	**Batch Transaction Processing**			Generally, Availity and Florida Blue Medicare Gateways accept transmissions 24 hours a day, seven (7) days a week.

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Req #	Loop ID – Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
G7	All transactions – B2B / EDI			Florida Blue Medicare requires that - (dashes) be removed from all Tax IDs, SSNs and Zip codes.
G8	All transactions			Florida Blue Medicare requires that no special characters be submitted in any text fields.

Enveloping Information – 837 Professional Claim Submission

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
E1	**Interchange Control Header Authorization Information Qualifier**	ISA01	*Appendix C (C.4)*	Florida Blue Medicare requires 00 in this field.
E2	**Interchange Control Header Authorization Information**	ISA02	*Appendix C (C.4)*	Florida Blue Medicare requires 10 spaces in this field.
E3	**Interchange Control Header Security Information Qualifier**	ISA03	*Appendix C (C.4)*	Florida Blue Medicare requires 00 in this field.
E4	**Interchange Control Header Security Information**	ISA04	*Appendix C (C.4*	Florida Blue Medicare requires 10 spaces in this field.
E5	**Interchange Control Header Interchange ID Qualifier**	ISA05	*Appendix C (C.4)*	Florida Blue Medicare requires 01 in this field.
E6	**Interchange Control Header Interchange Sender ID**	ISA06	*Appendix C (C.4)*	Florida Blue Medicare requires submission of your individually assigned Florida Blue Medicare sender mailbox number in this field.
E7	**Interchange Control Header Interchange ID Qualifier**	ISA07	*Appendix C (C.5)*	Florida Blue Medicare requires ZZ in this field.
E8	**Interchange Control Header Interchange Receiver ID**	ISA08	*Appendix C (C.5)*	Florida Blue Medicare will only accept the submission of Florida Blue Medicare Tax ID number 592015694 in this field.
E9	**Interchange Control Header Acknowledgement Requested**	ISA14	*Appendix C (C.6)*	The TA1 will not be provided without a code value of one (1) in the field.
E10	**Interchange Control Header Functional Group Header/Functional Group Trailer**	GS - GE ISA - IEA	*Appendix C (C.7)*	Florida Blue Medicare will only process one transaction type per GS-GE (functional group). However, we will process multiple ST's within one (1) GS-GE group as long as they are all the same transaction type.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
E11	**Functional Group Header Functional Identifier Code**	GS01	*Appendix C (C.7)*	HC – Health Care Claim - Professional Florida Blue Medicare requires submission of the above value in this field.
E12	**Functional Group Header Application Sender's Code**	GS02	Appendix C (C.7)	Florida Blue Medicare requires the submission of the Florida Blue Medicare assigned Sender Code in this field.

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| E13 | **Functional Group Header Application Receiver's Code** | GS03 | *Appendix C (C.7)* | 592015694 Florida Blue Medicare requires the submission of the above value in this field for 837 Professional Claim Submission, all others may cause rejection. |
| E14 | **Implementation Convention Reference** | ST03 | *70* | Must contain 005010X222A1. |

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Trading partners and providers failure to abide by these requirements will result in provider correctable errors and must be and resubmitted.

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B1	**1000A – Submitter Primary Identification Number** **Identification Code**	NM109	75	Florida Blue Medicare requires the submission of the Florida Blue Medicare assigned Sender Code in this data element.
B2	**1000A – Submitter EDI Contact Information** **Submitter Contact Name**	PER02	77	Required when the contact name is different than the name contained in the Submitter Name segment of this loop and it is the first iteration of the Submitter EDI Contact Information Segment.
B3	**1000B – Receiver Name** **Organization Name**	NM103	80	FBM01 The above value is required in this field.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B4	**1000B – Receiver Name** **Receiver Primary Identification Number**	NM109	80	831056418 The above value is required in this field.
B5	**2000B – Subscriber Hierarchical Level** **Claim Filing Indicator Code**	SBR09	118	BL The above value is required in this field.

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B6	**2000A – Billing Provider Taxonomy**	PRV03	83	Taxonomy codes are required by Florida Blue Medicare under specific circumstances. Taxonomy is one of several data elements used by Florida Blue Medicare to help determine the appropriate provider record for processing. In cases where the NPI is shared by multiple provider entities, specialties or locations, the taxonomy becomes a critical data element. For example. ABC hospital, Urgent Care, Lab and Physician PA group all share the same NPI. In this case the taxonomy becomes critical to ensure appropriate processing and fee schedule assignment. Taxonomy codes can be located at nucc.org.
B7	**2000C — Patient Hierarchical Level**	PAT01	144	Florida Blue Medicare does not accept ANSI 837 P transactions which have the PAT01 segment equal to 39 (organ donor). Organ donor claims should be submitted on a HCFA-1500 with the appropriate supporting documentation.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B8	**2010AA – Billing Provider NPI** **Reference Identification code**	NM109	90	Florida Blue Medicare requires the billing providers' NPI. Invalid or missing NPI will result in claims being returned as a provider correctable error. These must be corrected and resubmitted electronically.
B9	**2010AA – Billing Provider Zip Code**	N403	92	A valid full nine digit zip code is required.

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B10	2010AB – Pay-to Provider Zip Code	N403	104	A valid full nine digit zip code is required.
B11	2010BA – Subscriber Name Identification Code Qualifier	NM108	122	Florida Blue Medicare requires MI in NM108
B12	2010BA – Subscriber Name Subscriber Primary Identifier	NM109	123	Florida Blue Medicare requires submission of the ID number in NM109 exactly as it appears on the member's ID card, including any applicable prefix or suffix Do not use any embedded spaces or the claim could be returned as a provider correctable error and must be corrected and resubmitted.
B13	2010BA – Subscriber Gender Code	DMG03	128	Florida Blue Medicare requires submission of the Subscriber's Gender Code in this field
B14	2010BB – Payer Name Payer Name	NM103	134	Florida Blue Medicare
B15	2010BB – Payer Name Payer Identification Qualifier	NM108	134	PI – Payer Identification
B16	2010BB – Payer Name Payer Identifier	NM109	134	FBM01 Florida Blue Medicare Payer Identifier
Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B17	2010CA – Patient First Name	NM104	148	Patient's First Name is required in this field.
B18	2010CA – Patient's Gender Code	DMG03	153	Patient's Gender Code is required in this field

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B19	2300 – Claim Information / 2400 – Service Line Number Monetary Amount Line Item Charge Amount	CLM02 SV102	159 354	The total claim charge amount must equal the sum of all submitted line items. Failure to do so will result in claims being returned as a provider correctable error and must be corrected and electronically resubmitted. Note: If the whole dollar amounts are sent in monetary elements, do not include the decimal or trailing zero (e.g., $30 = 30). When indicating the dollars & cents, the decimal must be indicated (e.g., $30.12 = 30.12).
B20	2400 – Service Units/Days	SV104	355	The submission of valid Units of Service for all claim lines are required.
B21	2300 – Claim Information Claim Frequency Type Code	CLM05-3	159	Only the following codes will be accepted: Zero (0) =Non-Payment/Zero One (1) =Admit Through Discharge Claim Seven (7) = Replacement Of Prior Claim Eight (8) = Void/Cancel Of Prior Claim Note: When submitting the corrected claim, the original Reference Number (ICN/DCN) also known as the Original Claim Number is required to be sent in loop 2300 REF. (REF01= F8 qualifier for Original Reference Number, REF02 = Original Claim Number).
B22	2300 – Claim Information Health Care Diagnosis Code	HI	226	Do not transmit a decimal point in the diagnosis code. The decimal point is assumed.
Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B23	2300 – Claim Information Demonstration Project Identifier	REF02	226	Clinical trial number (loop 2300, REF02 – REF01=P4) is required when V707 (ICD-9) or Z00.6 (ICD-10) is in diagnosis position 1 or 2 (loop 2300, HI01-2 or HI02-2).
B24	2310B – Rendering Provider NPI Rendering Provider Identifier	NM109	264	When Rendering Provider is submitted, the rendering provider's NPI is required on all claims. Invalid or missing NPI will result in claims being returned as a provider correctable error and must be corrected and resubmitted.

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Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B25	2310B – Rendering Provider Taxonomy	PRV03	265	Taxonomy codes are required under specific circumstances. Taxonomy is one of several data elements used to help determine the appropriate provider record for processing. Taxonomy codes can be located at nucc.org.
B26	2310C – Service Facility Zip Code	N403	273	A valid full nine digit zip code is required when a service facility is submitted.
B27	2310E – Ambulance Pick-up Location ZIP Code	N403	288	Plans must validate the point of pickup zip code for air ambulance service on claims with dates of service beginning April 19, 2015. Validation is based on the following CMS guidelines for air ambulance claims: For electronic claims, validate the origin information (zip code of the point of pick-up), as sent in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional. If the zip code is not in the Plan's service area, the claim must be rejected.
B28	2320 – Other Subscriber Information Claim Filing Indicator Code	SBR09	298	In Loop 2320, if SBR09=MB the Medicare Report Number should be reported in Loop 2330B REF. Note: SBR09=MA is not allowed
B29	2320 – Outpatient Adjudication Information	MOA	310	This information is requested to facilitate claims processing.
B30	2330B – Other Payer Name	NM108	321	PI qualifier is required in this field.

Req #	Loop ID - Segment Description & Element Name	TR3 Data Element	TR3 Page(s)	Plan Requirement
B31	2330B – Other Payer Claim Control Number	REF01 REF02	331	In Loop 2320, if SBR09=MB the Medicare Report Number should be reported in Loop 2330B, in the following REF segment configuration: • REF01=F8 • REF02=Medicare Report Number=Medicare ICN Note: SBR09=MA is not allowed

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B32	2400 – Service Line Number Product/Service ID Qualifier	SV101-1	352	HC We require the submission of above value in this field as only HCPCS Procedure codes are accepted at this time.
B33	2400 – Professional Service Procedure Modifier(s)	SV101-3 SV101-4 SV101-5 SV101-6	353	Please submit the appropriate modifiers in priority order.
B34	2410 – Drug Identification Drug Identification	LIN03	424	National Drug Code (NDC) NDC Code Format (11-digits using 5-4-2 format [i.e., five-digits, followed by four-digits, followed by two-digits]. Do not include any hyphens or spaces (e.g., 01234567891). DME Providers must submit NDC and quantity Note: Refer to Specialty Pharmacy Billing Section VII.C.
B35	2410 – Drug Identification Drug Quantity	CTP04	426	DME Providers must submit NDC and quantity Note: Refer to Specialty Pharmacy Billing Section VII.C.
B36	2420C – Service Facility Zip Code	N403	445	A valid full nine digit zip code is required when a service facility is submitted.

Billing Requirements for Ancillary Providers

If ancillary providers have a Florida Blue Medicare provider agreement that does not require the registration of employed health care providers, then only the billing provider information should be populated on the claim. If the Florida Blue Medicare provider agreement requires registration of employed health care providers, then the rendering and billing NPI should be billed appropriately on claims.

Important Note: When billing Referring Physician Information, the referring physician's NPI is always required for Florida Blue Medicare.

1. **The following is a sample of necessary provider billing information required on the 837 P:**
   - Ancillary provider with registered employed health care providers
     - Rendering provider NPI (loop 2310B & 2420A)
     - Billing provider NPI (loop 2010AA)

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- Ancillary provider with no registered employed health care providers:
  - Rendering provider NPI – Blank
  - Billing provider NPI (loop 2010AA)

Appropriately Billing Provider IDs

This information provides the technical details for the 837 P Loops for the NPI, Tax ID
and Taxonomy Codes.

a) **Billing Provider:**
  - **National Provider ID (NPI)** in Loop 2010AA, Segment NM1, Elements NM101
    = 85, NM108=XX and NM109=NPI (example:
    NM1*85*1*PROVIDERLASTNAME*PROVIDERFIRSTNAME****XX*12345678
    90~)
  - **Federal Tax ID** in Loop 2010AA, Segment REF, Elements REF01=EI and
    REF02 = Tax ID (example: REF*EI*123456789~)
  - **Taxonomy** in Loop 2000A, Segment PRV, Elements PRV01 = BI, PRV02 =
    PXC, PRV03 = Provider Taxonomy

b) **Referring Provider:**
  - **Claim Level** - Referring/Ordering Provider in Loop 2310A, Segment NM1,
    Elements NM101 = DN, NM108 = XX and NM109 = NPI
    (example:NM1✻DN✻1✻WELBY✻MARCUS✻W✻✻JR✻XX✻1234567891~)
  - **Service Line** - Referring Provider in Loop 2420F, Segment NM1, Elements
    NM101 = DN, NM108 = XX, NM109 = NPI
    (example:NM1✻DN✻1✻WELBY✻MARCUS✻W✻✻JR✻XX✻1234567891~)

c) **Rendering Provider:**
  - **Claim Level** - Rendering Provider in Loop 2310B, Segment NM1, Elements
    NM101 = 82, NM108 = XX and NM109 = NPI
    (example:NM1✻82✻1✻DOE✻JANE✻C✻✻✻XX✻1234567804~)
  - **Service Line** - Rendering Provider in Loop 2420A, Segment NM1, Elements
    NM101 = 82, NM108 = XX and NM109 = NPI (example:
    NM1✻82✻1✻DOE✻JANE✻C✻✻✻XX✻1234567804~)

d) **Ordering Provider:**
  - **Service Line** - Ordering Provider in Loop 2420E, Segment NM1, Elements
    NM101 = DN, NM108 = XX, NM109 = NPI (example:
    NM1✻DK✻1✻RICHARDSON✻TRENT✻✻✻✻XX✻1234567891~)

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HCPCS Information

This information provides the technical details for the 837 P Loops for the HCPCS code and HCPCS units.

- HCPCS code in Loop 2400, Segment SV1, Element SV101= HCPCS Code
- HCPCS units in Loop 2400, Segment SV1, Element SV104= HCPCS Units

NDC

Qualifier and NDC Code

This information provides the technical details for the 837 P Loops for the NDC Qualifier and NDC Code.

- Bill the NDC qualifier (N4) and NDC Code (11-digits using 5-4-2 format [i.e., five-digits, followed by four-digits, followed by two-digits]). Do not include any hyphens or spaces (e.g., 01234567891).
- NDC Qualifier in Loop 2410, Segment LIN, Element LIN02 = N4
- NDC Code in Loop 2410, Segment LIN, Element LIN03 = 11 digit NDC Code (e.g., LIN**N4*01234567891)

NDC Quantity

- Bill the NDC Quantity using a metric decimal quantity administered to the patient as defined in the NCPDP Billing Unit Standard. The quantity of each submitted NDC must be a numeric value greater than zero. Decimal quantities must be submitted if applicable. Do not include any spaces (e.g., 10.25).
- The 2410 Loop requires all three CTP segments. The segments are NDC Unit Price, NDC Quantity and Composite of Measure.
- NDC Unit Price in Loop 2410, Segment CTP03, Element = Dollar Amount (0.00 is acceptable)
- NDC Quantity in Loop 2410, Segment CTP04, Element = (Maximum length of 15 with implied decimal)
- Composite unit of measure in Loop 2410, Segment CTP05, Element = (e.g., UN, ML, GR, F2)

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NPI Requirements – Technical

837 Professional PROVIDER TYPE	NPI					Taxonomy					Zip + 4 Digit				
	IG	BC	Loop	Segment	Data Element	IG	BC	Loop	Segment	Data Element	IG	BC	Loop	Segment	Data Element
Billing Provider	R	R	2010AA	NM1	09	S	R	2000A	PRV	03	S	R	2010AA	N4	03
Pay To Provider											S	S	2010AB	N4	03
Rendering Provider	S	S	2310B 2420A	NM1	09	S	S	2310B 2420A	PRV	03					
Referring Provider	S	S*	2310A 2420F	NM1	09										
Ordering Provider	S	S*	2420E	NM1	09										
Supervising Provider	S	R	2310D 2420D	NM1	09										
Purchase Service Provider	S	S	2420B	NM1	09										
Service Facility	S	S	2310C 2420C	NM1	09						S	R	2310C 2420C	N4	03

Legend:
R - Required
S - Situational
Blank - Not Available
IG - Implementation Guide
BC - Blue Cross

*Important Note: For Ancillary Providers, see Billing Requirements pg.

Helpful Tips

How to Avoid Provider Identification Errors

Below are reminders to help you reduce the number of WEBV040 and WEBV042 claims errors displayed when claim data (or information) does not match information registered with Florida Blue Medicare.

A. **Billing Provider Section**
This section is used to provide information regarding the billing provider for services rendered. It should match the name written on the check or electronic funds transfer from Florida Blue Medicare.

i. **OPTION One (1)**: If you are registered as a group provider (PA, LLC, etc.) with Florida Blue Medicare and you want to bill as a group provider, enter the appropriate group name, Tax ID number and the group NPI (type 2).

1. **THE MATCH**: Group Name matches Group NPI matches Group Tax ID.

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      ii. **OPTION Two (2):** If you are registered as an individual provider with Florida Blue Medicare and you are billing as an individual provider, please enter your name, Social Security Number and your individual NPI (type 1).

            1. **THE MATCH:** Individual Name matches Individual NPI matches Individual Social Security Number

B. Rendering Provider Section

This section is used to provide information regarding who performed the services. It is the provider who actually sees the patient.

      iii. OPTION One (1): If you billed as an organization (PA, LLC, etc.) list the name of the rendering individual provider and the rendering individual NPI.

      iv. OPTION Teo (2): If you billed as an individual, do not list a rendering provider. This would be redundant as the billing individual would be the same as the rendering individual. Submitting redundant information can cause a different provider correctable error.

Below is an example to assist you in understanding the appropriate entry of billing and rendering provider information to reduce the number of returned claims.

C. Billing as a Group Provider – OPTION One (1)

If you are billing as a group provider, (PA, LLC, etc.), the NPI must be the Group NPI (type 2) along with the appropriate Tax ID number for the group.

Please note that the Billing Section is for the entity BILLING for the services. The Rendering Provider Section is for the provider who PERFORMED the services.

Correct Entry (THE MATCH):

This example shows how the information submitted matches data registered with Florida Blue Medicare. The Group Name matches Group NPI which matches Group Tax ID number and all match Florida Blue Medicare provider files.
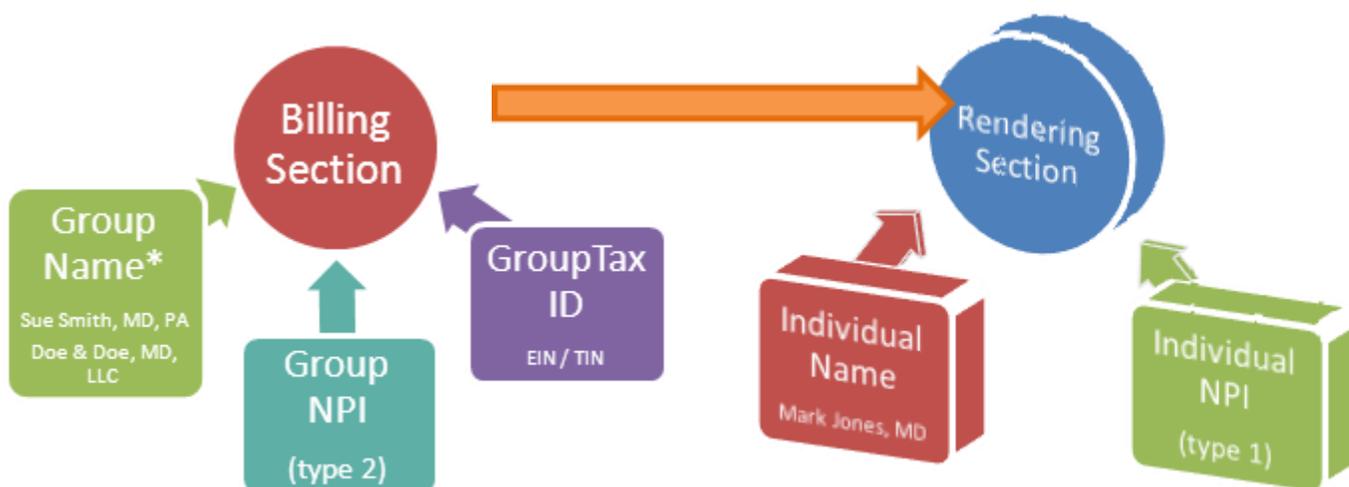
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Incorrect Entries (THE MISMATCH):

Below are examples of information that will result in a mismatch of data causing a
WEBV040 provider correctable error ultimately resulting in a delay in
payment. The mismatch is highlighted in red.

Remember: Group Name = Group NPI = Group Tax ID Number

To confirm how you are registered with Florida Blue Medicare, please call the Provider
Contact Center at 800-727-2227, select option five (5), and then option two (2). If you
would like to register a different Tax ID number, please complete the Provider
Information Update Form available on availity.com (sections one (1) and six (6). A
completed IRS confirmation letter must be included.

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D. Billing as an Individual Provider – OPTION 2

If you are billing as an individual provider, the NPI must be the individual NPI (type 1) along with the appropriate Social Security Number. Do not enter a provider at all in the rendering section when the billing and rendering provider is the same person. Submitting redundant information can cause a different provider correctable error.
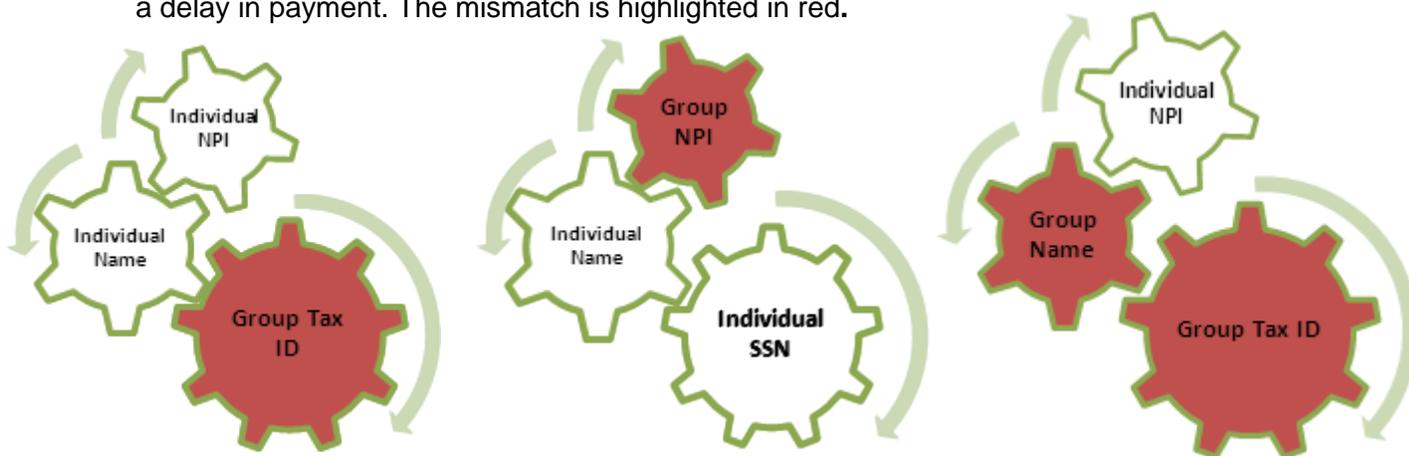
Correct Entry (THE MATCH):

This example shows how the information entered matches data registered with Florida Blue Medicare. Individual Name matches Individual NPI matches Individual Social Security Number.
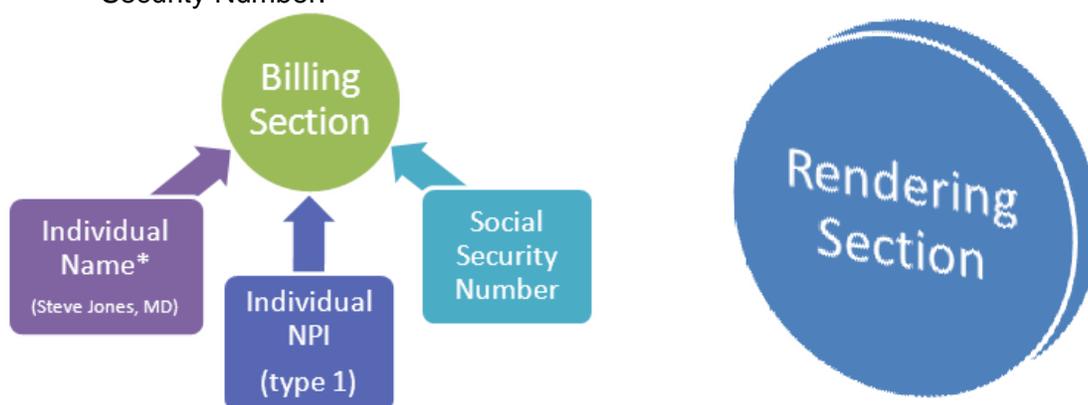
Incorrect Entries (THE MISMATCH):

Below are examples of information entered that will result in a mismatch of data causing a delay in payment. The mismatch is highlighted in red.

REMEMBER: Individual Name = Individual NPI = Individual Social Security Number

To confirm how you are registered with Florida Blue Medicare, please call the Provider Contact Center at 800-727-2227, select option five (5), and then option two (2). If you would like to register a different Tax ID number, please complete the Provider Information Update Form available on availity.com (sections one (1) and six (6). A

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completed IRS confirmation letter must be included.

Sending Coordination of Benefits Information on Electronic Claims

When Florida Blue Medicare is the secondary carrier, file the claim to Florida Blue
Medicare on the member's behalf only after the primary insurance has completed
processing. When Florida Blue Medicare shows another health plan is primary and there
is no primary carrier payment or denial information, the claim will be returned for
correction. EXCEPTIONS: Claims submitted with a GY modifier where Medicare (Fee for
Service) would otherwise be primary, claims from VA/DOD facilities, Medicare Crossover
claim will not be subject to these requirements.

When Florida Blue Medicare files show another health plan is primary, that information is
provided on the 271 Eligibility and Benefits query response. When the primary plan is
NOT Florida Blue Medicare, the following loops and segments will be required:

NOTE: When the charges, payment amount, deductible, coinsurance, co-pay or
adjustment is zero, the AMT or CAS segment must still be submitted. Indicate the zero
amounts as 0.

R =Required S=Situational	837 Fields	Business Requirement
S	2320 SBR01	Payer responsibility sequence may not be P Primary. The use of S or T requires other payer information in loop 2320.
S	Loop 2320 CAS 01-19, as needed	Submission of other insurance payment information requires claim adjustment group codes and associated monetary amounts. Please be sure to submit any differences between the paid and charge amounts in the CAS segments. The 837 must balance including the COB segments.
R	Loop 2320 AMT 01	When Florida Blue Medicare is secondary, submit the primary insurer payment information to support correct processing of COB information. AMT01 = D; REQUIRED, then the AMT02 is the Payer Paid Amount.
R	Loop 2430 CAS segments Loop 2430 SVD02	When Medicare (Fee for Service) is primary and Florida Blue Medicare is secondary, a line level adjustment reason code and payment amount which must balance back to charge are required.

The following information corresponds to Box 10 on the CMS/HCFA1500 Claim form indicating
the accident type as Employment Related, Auto or Other. External Cause of Injury Codes or

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External Cause of Morbidity Codes, while not required, can speed up processing of claims and reduce requests for information. These codes are especially important when billing OA as the accident type. External Injury Codes or Cause of Morbidity Codes should be billed in the diagnoses field but should NEVER be billed as the primary diagnosis.

R =Required S=Situational	837 Fields	Business Requirement
R	2300, CLM11-1, CLM11-2, CLM11-3	If billing a claim containing a trauma diagnosis (800.00-999.9 in 9 and any E code) you will need to bill one or more values in loop segment 2300, CLM11-1, CLM11-2, and or CLM11-3 indicating If the injury was Employment, No Fault Auto or Other Accident. Claims billed without one of these codes will be returned for correction. | Value	Means
---	---
EM	Employment Related
AA	No Fault Auto
OA	Other Accident	

8 ACKNOWLEDGEMENTS AND/OR REPORTS

The purpose of this section is to outline the Florida Blue Medicare processes for handling the initial processing of incoming files and electronic acknowledgment generation.

TA1 Interchange Acknowledgement Transaction

All X12 file submissions are pre-screened upon receipt to determine if the interchange control header (ISA) or interchange control trailer (IEA) segments are readable. If errors are found, a TA1 response transaction will be sent to notify the trading partner that the file could not be processed provided the file contains a code value of one (1) in the ISA14. No TA1 response transaction will be sent for error-free files.

Once Florida Blue Medicare determines that the file is readable, validation is performed on the ISA and IEA loop information. If these segments have a non-standard structure, the file will receive a full file reject and the TA1 response transaction will be sent to the trading partner, provided the file contains a code value of one (1) in the ISA14.

999 Functional Acknowledgement Transactions

If the file submission passes the ISA/IEA pre-screening above, it is then checked for ASC X12 syntax and HIPAA compliance errors. When the compliance check is complete, a 999 will be sent to the trading partner informing them if the file has been

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accepted or rejected. If multiple transaction sets (ST-SE) are sent within a functional group (GS-GE), the entire functional group (GS-GE) will be rejected when an ASC X12 or HIPAA compliance error is found.

If the file submission passes the ISA/IEA pre-screening above, it is then checked for ASC X12 syntax and HIPAA compliance errors. When the compliance check is complete, a 999 will be sent to the trading partner informing them if the file has been accepted or rejected. If multiple transaction sets (ST-SE) are sent within a functional group (GS-GE), the entire functional group (GS-GE) will be rejected when an ASC X12 or HIPAA compliance error is found.

9 TRADING PARTNER AGREEMENTS

Please contact Availity for your trading partner agreement at 800-282-4548 or availity.com.

10 TRANSACTION SPECIFIC INFORMATION

10.1 ASC X12 Transactions Supported

IMPORTANT NOTE: If you submit your transactions through Availity, please refer to the Availity EDI Guide located on the Availity website at availity.com.

Florida Blue Medicare processes the following ASCX12 HIPAA transactions for professional claims submission.

ASC X12 837 005010X222A1	Professional Claim Submission
ASC X12 TA1 v005010X231A1	Response to the X12 transactions where errors are encountered in the outer envelopes (ISA/IEA and GS/GE segments)
ASC X12 999 v005010X231A1	Functional Acknowledgement - Response to the X12 transactions where structural and syntactical errors are encountered within the transaction segments itself (ST-SE segments)