Florida Blue Medicare Health Plan

HIPAA Transaction Standard Companion Guide

For Availity® Health Information Network Users

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

837I – Health Care Claim Institutional

Companion Guide Version Number: 2.0

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Disclosure Statement

The Florida Blue Medicare (Blue Cross and Blue Shield of Florida, Inc.) 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®1 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

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12/15/2023	**Update to section 1.4 Florida Blue Scheduled Downtown**	**7**
12/15/2023	**Update to Table of Contents**	**4**

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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 Technical Reports Type three (3) Guides (TR3s) for the ANSI 837 I Health Care Claim Institutional transaction 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 via your vendor The ASC X12 005010X222A1 is the established standard for Health Care Institutional Claims (837I).

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 Medicare, please access our NPI Notification 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 characteristics of the 837 I

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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 Health Care Institutional 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.

1.3 References

- TR3 Guides for ASC X12 005010X222A1 Health Care Institutional Claim (837I) 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.

Notes

- **New Year's Day** – Monday, January 2, 2023, will be recognized as a holiday since New Year's Day 2023 is on a Sunday.
- **Christmas 2023** - Christmas Day 2023 is on a Monday. Tuesday, December 26, 2023, will be recognized as a holiday since Christmas Eve 2023 is on a Sunday.

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

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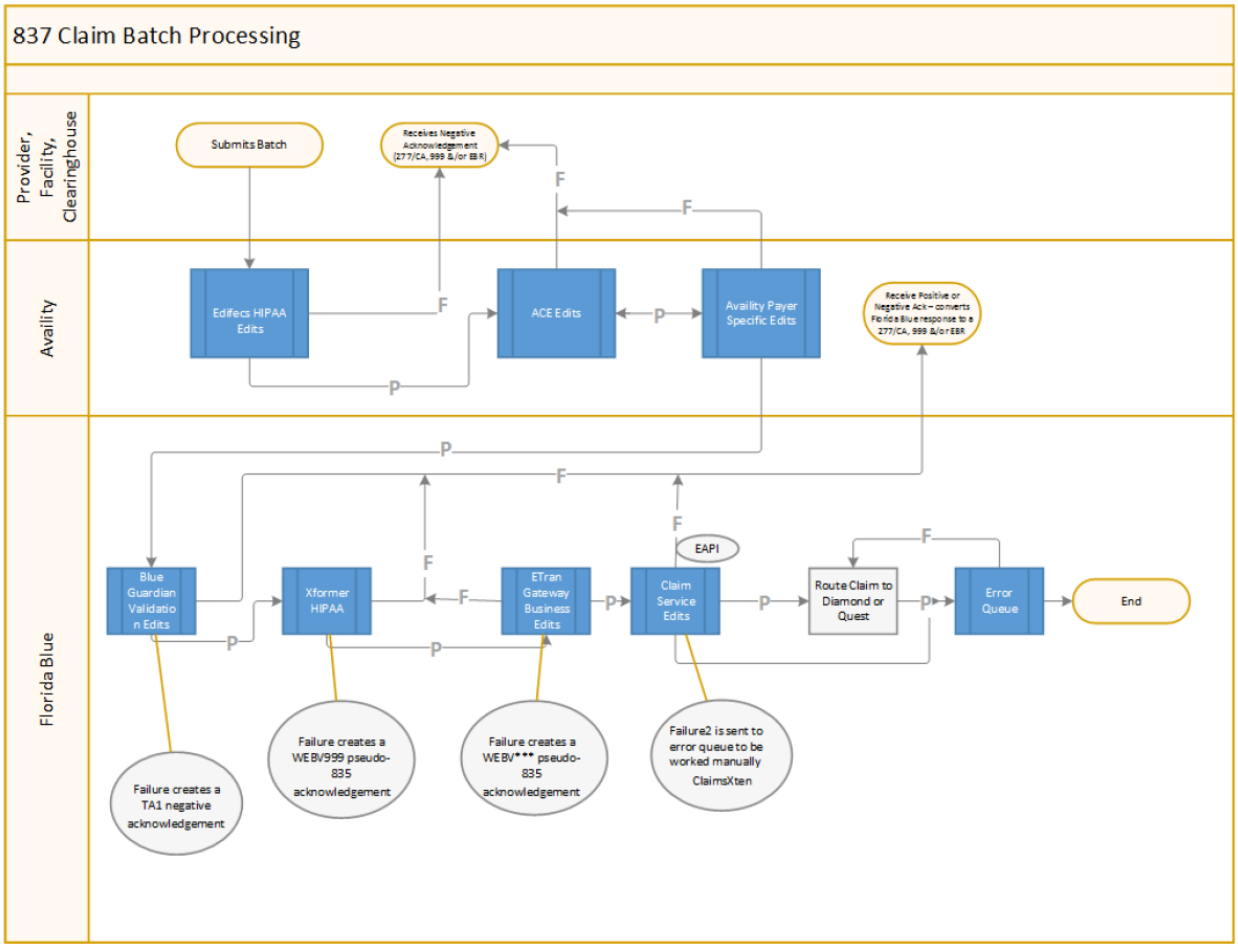
vendor prior to testing.

3 TESTING WITH FLORIDA BLUE MEDICARE AND AVAILITY

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

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5.1 EDI Customer Service

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

- availity.com
- floridaBlue.com

6 CONTROL SEGMENTS/ENVELOPES

837 I - Health Care Institutional 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** – If submitting directly to FL Blue is the Florida Blue Medicare Tax ID, 592015694. If submitting through Availity, 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 Guides ASC X12 005010X223A2 will be used for processing.
Req #	**Loop ID – Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
G3	**Acknowledgments –** **Florida Blue Medicare acknowledgements are created to communicate the status of files or claims. 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 Institutional Claim must be a valid calendar date in the appropriate format based on the respective HIPAA-AS TR3 qualifier. Failure to do so may cause processing delays or rejection.
G6	**Batch Transaction Processing**			Generally, Availity and Florida Blue Medicare Gateways accept transmissions 24 hours a day, seven (7) days a week
G7	**Multiple Transmissions**	All Segments		Any errors detected in a transaction set will result in the entire transaction set being rejected.

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G8	**All Transactions – B2B / EDI**			Florida Blue Medicare requires that -(dashes) be removed from all Tax IDs, SSNs and Zip codes.
G9	**All Transactions**			Health Care Institutional Claims submitted with multiple patient events will be split into separate transactions and returned one at a time.
Req #	**Loop ID – Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
G10	**All Transactions**			Florida Blue Medicare requires that no special characters be submitted in any text fields.

Enveloping Information – 837 Institutional 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 the 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 1 in the field.
Req #	**Loop ID – Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
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.
E11	**Functional Group Header Functional Identifier Code**	GS01	*Appendix C (C.7)*	HC– Health Care Claim - Institutional Florida Blue Medicare requires submission of the above value in this field.

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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.
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 Institutional Claim Submission, all others may cause rejection.
E14	**Implementation Convention Reference**	ST03	*67*	Must contain 005010X223A2.

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 corrected 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 Submitter Identifier**	NM109	72	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**	PER 02	74	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 (PER) Segment.
B3	**1000B – Receiver Name Last Name or Organization Name**	NM103	77	FBM01 The above value is required in this field.
B4	**1000B – Receiver Name Receiver Primary Identification Number**	NM109	77	831056418 The above value is required in this field.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B5	**2000A – Billing Provider Specialty Information**	PVR03	80	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 and descriptors are located at nucc.org.
B6	**2000C — Patient Hierarchical Level**	PAT01	133	Florida Blue Medicare does not accept ANSI 837 I transactions which have the PAT01 segment equal to 39 (organ donor). Organ donor claims should be submitted on a UB04 with the appropriate supporting documentation.
B7	**2010AA – Billing Provider Postal Code**	N4	88	Florida Blue Medicare requires submission of a valid nine digit postal zip code.

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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 Contact Name Billing Provider Contact Name**	PER02	92	Required in the first iteration of the billing provider Contact Information Segment.
B10	**2010AB – Pay to Provider Postal Code**	N4	98	Florida Blue Medicare requires submission of a valid nine digit postal zip code.
B11	**2010BA – Subscriber Name Subscriber First Name**	NM104	113	Required when NM102 = 1 (Person) and the person has a First Name.
B12	**2010BA – Subscriber Name Identification Code Qualifier**	NM108	113	Florida Blue Medicare requires MI in NM108
B13	**Subscriber Primary Identifier**	NM109	114	Florida Blue Medicare requires submission of the ID number in NM109 exactly as it appears on the member's ID card. Do not use any embedded spaces or the claim could be returned as a provider correctable error and must be corrected and resubmitted
B14	**2010BA – Subscriber Gender Code**	DMG03	119	Florida Blue Medicare requires submission of the Subscriber's Gender Code.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B15	**2010BB – Payer Name Payer Name**	NM103	123	Florida Blue Medicare Florida Blue Medicare requires submission of above value in this field.
B16	**2010BB – Payer Name Qualifier**	NM108	123	PI – Payer Identification
B17	**Payer ID**	NM109	123	FBM01 - Florida Blue Medicare Plan Code ID Florida Blue Medicare requires submission of above value in this field.
B18	**2010CA – Patient First Name**	NM104	136	Florida Blue Medicare requires submission of the Patient's First Name.
B19	**2010CA – Patient's Gender Code**	DMG03	141	Florida Blue Medicare requires submission of the Patient's Gender Code.
B20	**Coordination of Benefits (COB) Balancing**	2300	143	Total Claim Charge Amount and Service Line Charges must balance. CLM02 must be equal to sum of the service line charge amounts (sum of the SV102's).

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B21	**2300 – Claim Information / 2400 – Service Line Number Monetary Amount Line Item Charge Amount**	CLM02 SV203	145 427	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)
B22	**2300 – Claim Information Claim Frequency Type Code**	CLM05-3	145	Florida Blue Medicare will accept only the following codes: Zero (0) = Non- Payment/Zero One (1) = Admit Through Discharge Claim Two (2) = Interim – First Claim Three (3) = Interim – Continuing Claim Four (4) = Interim – Last Claim Five (5) = Late Charge(s) Only 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).
B23	**2300 – Claim Supplemental Information Paperwork Claim Note**	PWK NTE	154 178	At this time, Florida Blue Medicare will not be utilizing information in these segments for electronic claim processing.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B24	**2300 – Claim Information Health Care Diagnosis Code**	HI	184-304	Florida Blue Medicare requires that you do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.
B25	**2300 – HI - VALUE INFORMATION Value code of A0 2300 HIxx-2 where HIxx-1 = BE segment.**	HI	284-293	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) Institutional. If the zip code is not in the Plan's service area, the claim must be rejected.
B26	**2300 – Claim Information Health Care Diagnosis Code**	HI	184-304	Clinical trial number (loop 2300, REF02) 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).

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B27	**2310A – Attending Provider Specialty Information**	PRV03	322	Taxonomy code is one of several data elements used by Florida Blue Medicare to help determine the appropriate provider record for processing. Please include taxonomy code when submitting attending provider information. Taxonomy codes can be located at nucc.org.
B28	**2310D – Rendering Provider NPI Rendering Provider Identifier**	NM109	336	When a rendering provider is submitted, Florida Blue Medicare requires the rendering provider's NPI be submitted for all claims. Invalid or missing NPI will result in claims being returned as a provider correctable error and must be corrected and electronically resubmitted.
B29	**2310C – Service Facility Location Postal code**	N4	345	Florida Blue Medicare requires submission of a valid none digit postal zip code.
B30	**Coordination of Benefits (COB) Balancing**	2320	354	Total Claim Charge Amount and sum of service lines must balance. (CLM02) must be equal to sum of the service line charge amounts (sum of the SV102's).
B31	**2320 – Other Subscriber Information Claim Filing Indicator Code**	SBR09	356-357	In Loop 2320, if SBR09=MA the Medicare Report Number should be reported in Loop 2330B REF. Note: SBR09=MB is not allowed for the BCBSF Systems.
Req #	**Loop ID - Segment Description & Element Name**	**TR3 Data Element**	**TR3 Page(s)**	**Plan Requirement**
B32	**2330B – Other Payer Name**	REF01 REF02	384	In Loop 2320, if SBR09=MA; then the Medicare Report Number needs to be reported in Loop 2330B, in the following REF segment configuration: • REF01=F8 • REF02=Medicare Report Number=Medicare ICN Note: SBR09=MB is not allowed for the BCBSF Systems.
B33	**2400 – Service Line Number Assigned Number**	LX01	423	For Institutional claims Florida Blue Medicare will only allow and process 450 service lines per claim. Claims greater than 450 service lines will be returned as a provider correctable error.
B34	**2400 – Service Line Number Product/Service ID Qualifier**	SV202-1	425	HC Florida Blue Medicare requires submission of above value in this field as only HCPCS Procedure codes are accepted by Florida Blue Medicare at this time.

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B35	**2400 – Service Line Number Line Item Charge Amount**	SV203	427	The total claim charge amount must equal the sum of all submitted line items. Otherwise will result in claims being returned as provider correctable error and must be corrected and electronically resubmitted. Note: If the whole dollar amounts are submitted, do not include a decimal or trailing zero (E.g. $30 = 30). When indicating the dollars & cents, the decimal must be indicated (E.g. $30.12 = 30.12).
B36	**2400 – Service Line Number National Drug Code (NDC)**	LIN03	451	NDC Format must be eleven numeric digits in 5-4-2 format. Other characters or formats are not allowed.
B37	**2400 – Service Unit Count**	SV2 05	428	Florida Blue Medicare requires submission of Service Unit Count.

I. Florida Blue Medicare NPI TR3 Matrices - Attributes Requirements

Florida Blue Medicare NPI Attributes Requirements																								
	NPI						Taxonomy						EIN (Tax ID)						Zip + 4 Digit					
Claims	Institutional			Professional			Institutional			Professional			Institutional			Professional			Institutional			Professional		
PROVIDER TYPES	IG	BC	A	IG	BC	A	IG	BC	A	IG	BC	A	IG	BC	A	IG	BC	A	IG	BC	A	IG	BC	A
Billing Provider	R	R	R	R	R	R	S	R	R	S	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Pay To																			S	R	R	S	R	R
Rendering Provider	S	S	S	S	S	S				S	R	R												
Referring Provider	S	S		S	S*	S																		
Ordering Provider				S	S*	S																		
Supervising Provider				S	R	R																		
Servicing Facility	S	S	S	S	S	S													R	R	R	R	R	R
Attending	S	R	R				S	R	R															
Operating	S	R	R																					
Other Operating Physician	S	R																						
Purchase Service Provider				S	S																			
Legend:																								
R - Required																								
S - Situational																								
Blank - Not Available																								
IG - Implementation Guide																								
BC - Blue Cross																								
A - Availity																								

*Important Note: For Ancillary Providers, see Billing Requirements pg. 18 and 19

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II. NPI TR3 Matrices - Attributes Technical Location Information

837 Professional	NPI					Taxonomy					Zip + 4 Digit				
PROVIDER TYPE	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 – N/A
IG - Implementation Guide
BC - Blue Cross

*Important Note: For Ancillary Providers, see Billing Requirements pg. 18 and 19

Helpful Tips: How to Avoid Provider Identification Errors for Claims involving National Provider Identifier (NPI) and Tax ID number.

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.

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

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).

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

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 Two (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. Additional HIPAA 5010 reference information can be found on our website at *www.floridablue.com* under the Provider tab and by selecting Get Ready for 5010.

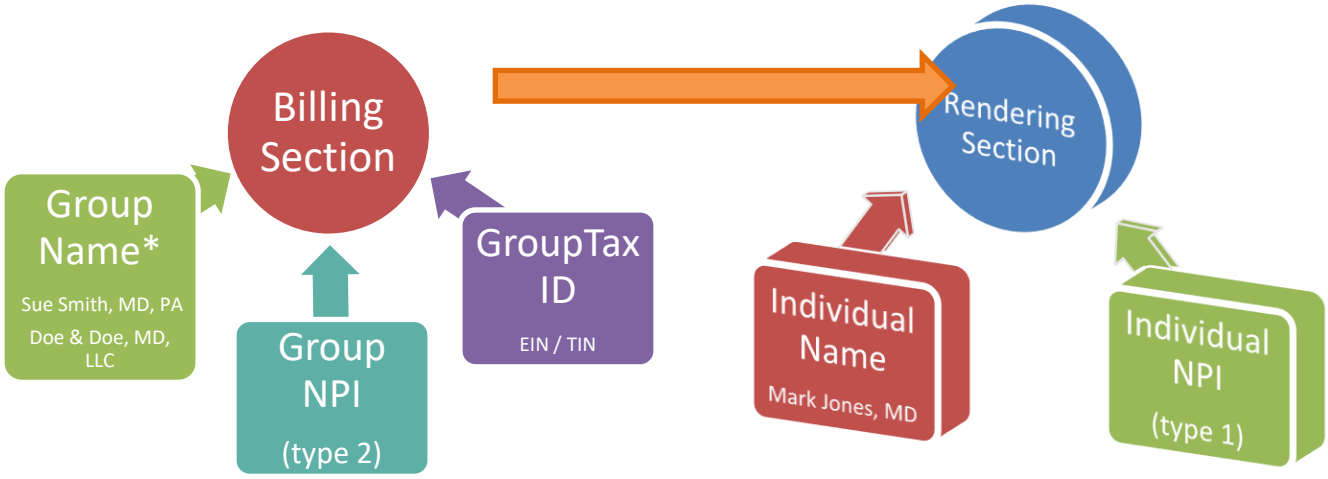
A. Billing as a Group Provider – OPTION One (1)

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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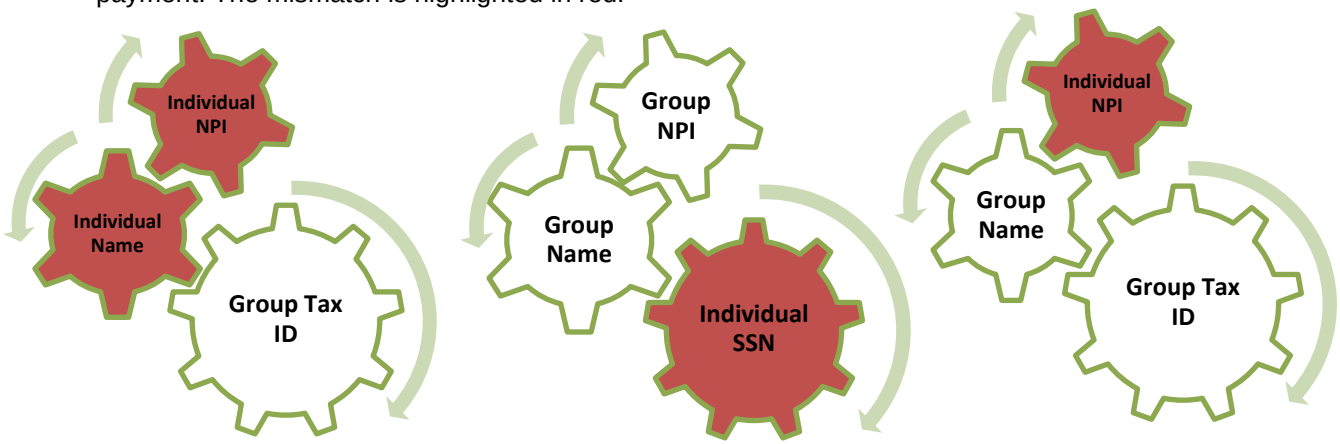
Incorrect Entries (THE MISMATCH):

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 (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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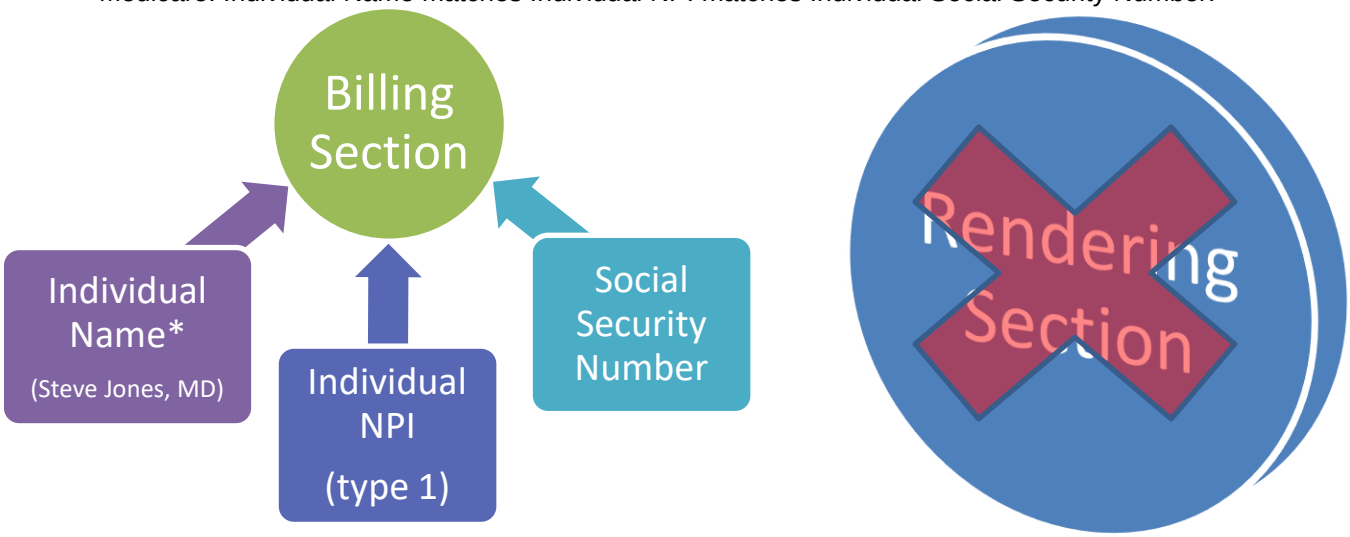
Billing as an Individual Provider – OPTION0 Two (2)

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**.**

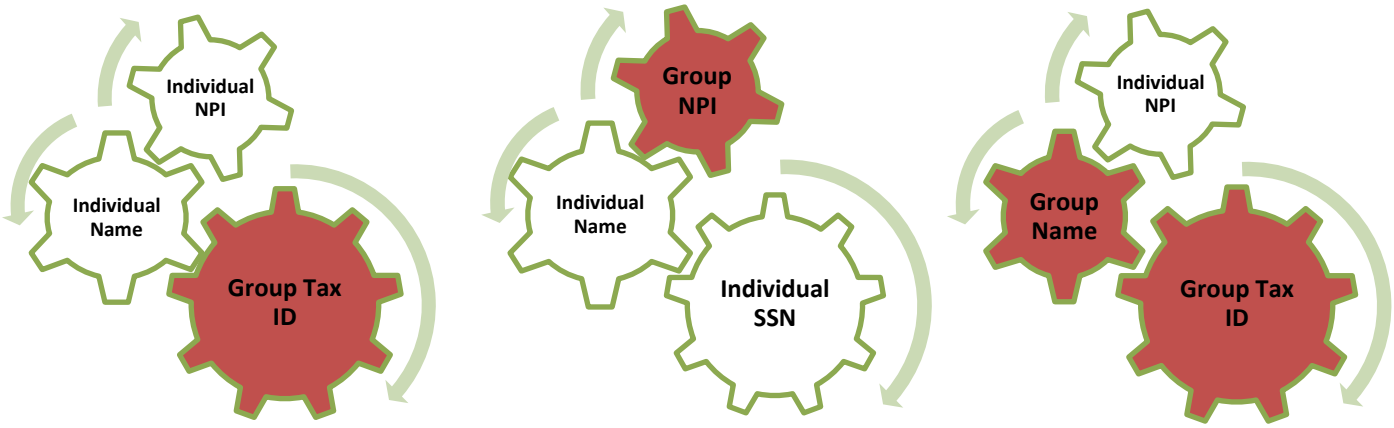
Correct Entry (THE MATCH):

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 (5), and then option two (2). If you would like to register a

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different Tax ID number, please complete the Provider Information Update Form available on availity.com (sections 1 and 6.). A completed IRS confirmation letter must be included.

Tips for Sending Coordination of Benefits Information on Electronic Claims

837 Institutional Health Care 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 would normally be primary, claims from VA/DOD facilities, Medicare Crossover claims.
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 zero (0).

R =Required S=Situational	837 Fields	Business Requirement
S	**2000B SBR01**	Value cannot = P (Primary Payer)
R	**Total Claim Charge Amount**	Loop 2300 CLM02 - Must balance to the sum of all service line charge amounts reported in Loop 2400 SV203.
R	**Claim Payment Amount**	When Florida Blue Medicare is secondary, submit the primary insurer payment information to support correct processing of COB information. 2320 AMT01 = D; REQUIRED 2320 AMT02 – Sum of all Line level Payment Amount minus any Claim Level Adjustment amounts must balance to Claim level Payment Amount.
R	**Patient Responsibility**	Loop 2300 HI01-1 = BE, HI01-2 = Value Code (A1- Deductible, A2 – Coinsurance and A7 – Copay) and HI01-5 = Amount*Note: The first value code will be reported as HI01; the second will be HI02 and will continue up to 12 value codes.
R	**HEALTH CARE SERVICE LOCATION INFORMATION**	When the institutional claim is for inpatient services (loop 2300, CLM05-1=11), the number of covered days is required and is calculated starting from the admit date to the day before discharge. In Loop 2300 use the following HI segment configuration: HI01-1 = BE, HI01-2 = 80, HI01-5= number of days.
S	**Inpatient Adjudication Information**	Required when Inpatient adjudication Information is reported in the remittance advice, or used to report Medicare Remittance Remarks Codes. Refer to TR3, pages 391-397 for details.
S	**Outpatient Adjudication Information**	Required when Outpatient adjudication Information is reported in the remittance advice. Or Used to submit Medicare Remittance Remarks Codes. Refer to TR3, pages 398-401 for details.

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R =Required S=Situational	837 Fields	Business Requirement
S	Payer Claim Control Number	Loop 2330B, REF01 = F8, REF02 = Payer's Internal Claim Control Number or Original Reference Number

If billing a claim containing a trauma diagnosis, you will need to bill one or more occurrence, condition or value codes from the following code sets:

R =Required S=Situational	837 Fields	Business Requirement
S	2300	**Occurrence Codes:**

Code	Meaning	Qualifier	Segment
01	Accident/Medical Coverage	BH	HI01- 2, HI02-2, HI03 – 2, HI04 – 2, HI05 – 2, HI06 – 2, HI07 – 2, HI08 – 2, HI09 – 2, HI10 – 2,HI11 – 2, HI12 - 2
02	Accident No Fault		
03	Accident Tort		
04	Accident Work Related		
05	Accident No Medical or Liability Coverage – Other Accident		Recommend use of E or Y codes when OCC = 05
06	Crime Victim		

R =Required S=Situational	837 Fields	Business Requirement
S	2300	**Condition Codes:**

Code	Meaning	**Qualifier**	**Segment**
01	Military Service	BG	**HI01 – 2, HI02 – 2, HI03 – 2, HI04 – 2, HI05 – 2, HI06 – 2, HI07 – 2, HI08 – 2, HI09 – 2, HI10 – 2, HI11 – 2, HI12 - 2**
02	Employment Related		
03	Other Insurance Not Reflected Here		

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<table>
<tr><th>R =Required
S=Situational</th><th>837
Fields</th><th>Business Requirement</th></tr>
<tr><td>S</td><td>2300</td><td><u>Value Codes:</u>
<table>
<tr><th>Code</th><th>Meaning</th><th>Qualifier</th><th>Segment</th></tr>
<tr><td>14</td><td>No Fault</td><td>BE</td><td rowspan="2">HI01 – 2, HI02 – 2, HI03 – 2, HI04 – 2, HI05 – 2, HI06 – 2, HI07 – 2, HI08 – 2, HI09 – 2, HI10 – 2, HI11 – 2, HI12 - 2</td></tr>
<tr><td>15</td><td>Employment Related</td></tr>
</table></td></tr>
</table>

8 ACKNOWLEDGEMENTS AND/OR REPORTS

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 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

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EDI Guide located on the Availity website at availity.com.

Florida Blue Medicare processes the following ASCX12 HIPAA transactions for Institutional Claim Submission

ASC X12 837 005010X222A1	Institutional 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)

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