



BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

ERROR / REJECT MESSAGE REFERENCE MANUAL FOR

Electronic Submission of Institutional Claims 837I

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BC = BLUE CROSS CM = COMMERCIAL MD = MEDICAID

ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
'Duplicate Claim' NNNNNNNN on 99/99/99'	Exact claim has been transmitted within the past 180 days	BC, MD A. Check prior claims transmission for the following to validate true duplicate claim: <ul style="list-style-type: none"> • Provider Number • Type Claim • Type Bill • HIC/ID Number • Sex Code • Relationship Code • Statement Covers Period • Patient First Name • Patient Date
'Does Not Balance'	Total dollar amount in the charge records does not match total charges record.	The sum of all charge (Revenue code) Records must = total charges. You may have to check with your software vendor to correct this.
'Interim Bill Invalid'	This split bill cannot be filed electronically.	BC A. Split bills can only be submitted if requested in writing by Blue Cross.

ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
001	Eligibility Verification	<p>BC</p> <p>A. "CONTRACT ID NOT FOUND" indicates subscriber identification number is invalid OR claim was submitted as Blue Cross when it should have been submitted as State of MS or vice versa.</p> <p>B. "PATIENT NOT LISTED" indicates either the patient date of birth and /or patient relationship to insured is invalid OR the patient was not covered on this policy at the time of service.</p> <p>C. Enhanced edit for FEP members: There must be an exact match to the first five characters of the patient first and last names. There must be exact match to the date of birth, sex and relationship.</p> <p>D. "PATIENT POLICY NOT ACTIVE" indicates the claim date of service falls before the policy became active or after termination of policy.</p> <p>MD, CM</p> <p>E. Not edited.</p>
001	Provider ZIP Code	Must be valid
001	Provider State Abbreviation	Must be valid
001	Provider Name	Must be present. This is the name that will show on the verification report as 'Transmitted By.'
001	Provider Street Address	Must be present
001	Provider City	Must be present
002	Eligibility Verification	<p>BC</p> <p>A. Program no longer administered by BCBSMS. Please send the claim to the appropriate program administrator.</p>
003	BENEFIT PLAN NOT ACTIVE	<p>BC</p> <p>Benefit Plan not active. Membership requirements as defined in the member's contract have not yet been met for this benefit plan.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
004	Type of Bill	<p>BC, CM, MD A. All 3 digits must be numeric.</p> <p>BC B. The TYPE CLAIM INDICATOR must agree with the TYPE OF BILL. C. If TYPE OF BILL is inpatient, an accommodation REVENUE CODE must be present. D. If TYPE OF BILL is outpatient, an Accommodation REVENUE CODE must NOT be present.</p> <p>CM E. For Payor 14164 (Wellcare), type bill cannot be 131X, 141X or 83X.</p> <p>MD F. TYPE OF BILL '132' and '133' is not valid.</p>
005	Federal Tax Number	<p>BC, MD A. Not edited.</p> <p>CM B. Must be entered.</p>
005	Federal Tax Sub-ID	Not edited, but may be required for Champus claims.
006	Statement covers period	<p>BC, CM, MD A. Both dates must be in CCYYMMDD format. B. The FROM DATE must be less than or equal to the THRU DATE.</p> <p>BC C. If claim is inpatient, the FROM and THRU DATE difference must equal the sum of the COVERED and NONCOVERED days.</p> <p>MD D. The FROM YEAR must equal the THRU Year (charges for overlapping fiscal years must be split billed). For split bills, the patient status must be '30' with a '23' – occurrence code with the corresponding thru date. E. The THRU DATE cannot be over one year from current date unless an original ICN is entered.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
007	Covered Days	BC, CM A. COVERED DAYS must be valid. BC B. The sum of the COVERED DAYS and NON-COVERED DAYS must equal the sum of the accommodation revenue code UNITS OF SERVICE . MD C. Must equal the number of days represented by the billing period. The THRU DATE is counted only IF occurrence code 'C3' is present and patient status is 30.
008	Non-covered Days	BC, CM A. NON-COVERED DAYS must be valid and may be blanks or zeroes. MD B. NON-COVERED DAYS must be valid
009	Co-Insurance Days	Not edited.
010	Lifetime Reserve Days	Not edited.
012	Patient Last Name	The PATIENT LAST NAME must be in correct position and all alphabetic characters.
012	Patient Middle Initial	The MIDDLE INITIAL must be in the correct position and all alphabetic characters.
012	Patient First Name	The PATIENT FIRST NAME must be in the correct position and all alphabetic characters.
013	Patient State	The 2-digit alphabetic STATE CODE must be valid.
013	Patient Street Address	The PATIENT STREET ADDRESS must be present and in correct position.
013	Patient City	The PATIENT CITY must be present and in correct position.
013	Patient Zip Code	The ZIP CODE must be valid and numeric.
013	Patient Zip Code Extension	Not edited.
014	Patient Birth Date	The PATIENT BIRTH DATE must be in YYYYMMDD format (Year-Month-Day).
015	Patient Sex	The PATIENT SEX must be M or F <ul style="list-style-type: none"> • M = Male • F = Female
016	Patient Marital Status	Not edited.

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
017	Admission Date	<p>A. If CLAIM is inpatient the ADMISSION DATE must be present in YYMMDD format (Year-Month-Day).</p> <p>B. The ADMISSION DATE must be less than or equal to the first date of statement covers period.</p>
018	Admission Hour	<p>BC, CM, MD</p> <p>A. The ADMISSION HOUR must be valid.</p> <p>CM</p> <p>B. Required for payor 68241 (Prudential).</p> <p>C. For payor 23222 (U.S. Healthcare), admission hour must be entered on outpatient claims if revenue codes 450 or 459 are used.</p>
019	Admission Type	<p>BC, CM, MD</p> <p>A. If CLAIM is inpatient, the ADMISSION TYPE may not be blank or zero.</p> <p>CM</p> <p>B. For PAYOR ID =95959 (PacifiCare), and OUTPATIENT claims, admission type must = 1-4 or 9.</p> <p>C. For PAYOR ID = 87043 (First Health Strategies, and OUTPATIENT claims, admission type must – 0-4 or 9.</p>
020	Admission Source	<p>BC, CM, MD</p> <p>A. If CLAIM is inpatient, the ADMISSION SOURCE may not be blank or zero.</p> <p>MD</p> <p>B. Valid codes for newborns (Admit source 4):</p> <ul style="list-style-type: none"> • Normal birth • Premature birth • Sick baby • Extramural birth • 9 – Information not available
021	Discharge Hour	A valid 2-digit DISCHARGE HOUR must be present on inpatient claims.
022	Patient Status	<p>BC, CM, MD</p> <p>A. If CLAIM is inpatient, PATIENT STATUS may not be blanks or zeroes.</p> <p>MD</p> <p>B. For Type Bill 112 or 113 must have PATIENT STATUS of 30 and occurrence codes C3 with statement through date and 42 with actual discharge date</p>
023	Medical Record Number	Not edited.
024 – 031	Condition Codes	Must be valid condition code.

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
032	Occurrence Code and Date	<p>BC, CM, MD</p> <p>A. The 2-digit OCCURRENCE CODE must be valid and numeric.</p> <p>B. The 6-digit OCCURRENCE DATE must in YYMMDD format.</p> <p>BC</p> <p>C. If occurrence code 24 is present, there must be non-covered charges or allowed amount equal to deductible amount and no prior payment</p> <p>D. If occurrence code 25 is present, non covered charges must equal total charges.</p> <p>BC, CM</p> <p>E. If an accident diagnosis code in the range of 80000-99499 is used, an accident related occurrence code and date must be entered.</p> <p>CM</p> <p>F. If type admission is '1' or '2,' occurrence code 01-06 or 11 must be entered.</p> <p>G. If PAYOR ID = 68241 (Prudential), and ACCIDENT HOUR = 00-23 or 99, then OCCURRENCE CODE 01-06 is required.</p> <p>MD</p> <p>H. If Bill Type is 112 and patient status is 30, OCCURRENCE CODE C3 must be entered and '42' OCCURRENCE CODE with actual discharge date must not be entered.</p>
033 – 035	Occurrence Code and Date	Same as error message 32
036	Occurrence Span and Date	If used, the 2-digit OCCURRENCE SPAN CODE must be valid and numeric.
037	Internal Control Number (ICN) Document Control Number (DCN)	<p>BC, CM</p> <p>A. Not edited.</p> <p>MD</p> <p>B. Must be present if STATEMENT THRU DATE is greater than one year from current date.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION									
039 A – C	Value Code and Amount	<p>BC, MD, CM</p> <p>A. If used, the 2-position VALUE CODE must be valid.</p> <p>BC, MD</p> <p>B. If an accident diagnosis code in the range of 80000-99499 is used, an accident hour must be entered with a VALUE CODE of 45.</p> <p>0059 6926 69270 69271 69273 69276 thru 69279 800 thru 96199 800 thru 99499 963 thru 9931 9933 thru 99499</p> <table border="0"> <tr> <td>V015</td> <td>V155</td> <td>V156</td> </tr> <tr> <td>V664</td> <td>V674</td> <td>V713</td> </tr> <tr> <td>V714</td> <td>V716</td> <td>V825</td> </tr> </table> <p>C. If REVENUE CODE is 380, 381 or 382 then VALUE CODES 37 and 39 with the corresponding units must be entered. Number of pints cannot be > 6.</p> <p>CM</p> <p>D. The CODE AND AMOUNT must be numeric.</p> <p>E. VALUE CODES of '01' or '02' must be entered for INPATIENT claims. 01 – semi-private, 02 – no semi-private.</p> <p>F. If blood revenue codes are used, VALUE CODE 37 and 39 or 38 must be entered.</p> <p>G. If an accident diagnosis code is entered, a VALUE CODE of 45 (accident hour) must be entered.</p> <p>BC</p> <p>H. When Blue Cross is secondary to any payer other than Medicare, report the deductible amount with an A1 VALUE CODE (deductible amount) and any Primary Paid Amount in Prior Pay.</p> <p>I. When Blue Cross out of area is secondary, report VALUE CODES that apply:</p> <p>A1 – primary deductible A2 – primary coinsurance A3 – primary paid A4 – primary allowed A5 – Non covered charges</p>	V015	V155	V156	V664	V674	V713	V714	V716	V825
V015	V155	V156									
V664	V674	V713									
V714	V716	V825									

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
039 A – C (continued)	Value Code and Amount	<p>J. On Medicare Advantage Outpatient claims where an Ambulance REVENUE CODE (054x) is present, VALUECODE A0 must be included along with a zip code in the AMOUNT field</p> <p>K. On Medicare Advantage Outpatient claims with an ESRD REVENUE CODE (0821, 0831, 0841, 0851, 0880, or 0881) the following VALUE CODES and corresponding AMOUNTS are required:</p> <p>A8 with the patient's height in the amount field.</p> <p>A9 with the patient's weight in the amount field.</p> <p>61 with a valid CBSA code in the amount field.</p> <p>L. On Medicare Advantage Outpatient claims with Home Health REVENUE CODE (0023) VALUE CODE of 61 is required with a valid CBSA code in the AMOUNT field.</p>
039 B – D	Value Code and Amount	Same as 39A
040 A – C	Value Code and Amount	Same as 39A
040 B – D	Value Code and Amount	Same as 39A
041 A – C	Value Code and Amount	Same as 39A
041 B – D	Value Code and Amount	Same as 39A
042	Revenue Code	<p>BC, MD</p> <p>A. The 4-digit REVENUE CODE must be valid and numeric.</p> <p>BC</p> <p>B. REVENUE CODE must be valid for the provider.</p> <p>C. REVENUE CODE must fall within the revenue code effective/cancel dates.</p> <p>CM</p> <p>D. The 4-digit REVENUE CODE must be valid and numeric. See Appendix A for valid REVENUE CODES.</p> <p>E. For Payor 06118 (MD Health Plan), for type claim '131', revenue code 450-459 cannot be used.</p> <p>MD</p> <p>F. REVENUE CODES must be in ascending numeric sequence except for the final entry which must be '001'.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
		<p>G. REVENUE CODES 964, and 976-978 will be allowed with covered charges. Other 96X, 97X, 98X and 99X will be allowed with non-covered charges only.</p> <p>H. If TYPE OF BILL is '13X', REVENUE CODES 82X, 83X, 84X and 85X are invalid for ESC submission and must be submitted hard copy.</p> <p>I. If TYPE OF BILL is '11X', one or more of the following accommodation REVENUE CODES are required:</p> <ul style="list-style-type: none"> • 10X – 17X • 20X – 21X <p>J. If TYPE OF BILL is '13X', the above accommodation REVENUE CODES may not be entered.</p> <p>K. Revenue code '540' is invalid.</p>
043	Disease Specific Pharmacy	<p>If the procedure code falls in the DSP list (see list below), and the DOS from date is on or after 1/1/09, then the NDC must be present and valid, and the metric qty must be present</p> <p>'90281' '90283' '90284' '90378' 'C9003' 'J0129' 'J0135' 'J0180' 'J0205' 'J0215' 'J0256' 'J0364' 'J0585' 'J0587' 'J1325' 'J1438' 'J1458' 'J1459' 'J1460' 'J1470' 'J1480' 'J1490' 'J1500' 'J1510' 'J1520' 'J1530' 'J1540' 'J1550' 'J1560' 'J1561' 'J1562' 'J1566' 'J1568' 'J1569' 'J1572' 'J1595' 'J1743' 'J1745' 'J1785' 'J1825' 'J1830' 'J1931' 'J2170' 'J2323' 'J2357' 'J2503' 'J2504' 'J2778' 'J2941' 'J3285' 'J7186' 'J7187' 'J7189' 'J7190' 'J7192' 'J7193' 'J7194' 'J7195' 'J7198' 'J7311' 'J9212' 'J9213' 'J9214' 'J9216' 'J9310' 'Q3025' 'Q3026' 'Q4080' 'Q4096' 'Q4097' 'S0145' 'S0146' 'S0162'.</p>

ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
044	HCPCS Code	<p>BC</p> <p>A. HCPCS Code must fall within HCPC procedure effective/cancel dates.</p> <p>B. See Appendix B for a list of revenue codes requiring HCPCS codes if filed on an outpatient claim:</p> <p>MD</p> <p>C. If TYPE OF BILL is '131X' and REVENUE CODE is 30X or 31X, HCPCS CODES are required.</p> <p>D. If REVENUE CODE is 964 or 976 – 979, a HCPCS CODE is required.</p>
044	Unit Charges / Rates	<p>BC, CM, MD</p> <p>A. Unit charges must be numeric.</p> <p>MD</p> <p>B. There must be an entry in this column if REVENUE CODE is 10X – 17X, 20X – 21X or 38X.</p>
045	Date of Service	<p>BC</p> <p>A. Must be entered for all REVENUE CODES.</p> <p>CM, MD</p> <p>B. Not edited.</p>
046	Units of Service	<p>BC, MD</p> <p>A. If REVENUE CODES in the ranges of 110-119, 120-129, 150-159, 200-219, 331-334, 380-388, 510-529, 800-809, or 912 are used, UNITS OF SERVICE must be entered for each REVENUE CODE.</p> <p>BC</p> <p>B. Units exceeds maximum for HCPCS.</p> <p>C. For REVENUE CODE '912', if the STATEMENT COVERS FROM and STATEMENT COVERS THRU dates are different, then UNITS OF SERVICE must be greater than 1.</p> <p>D. The sum of the units for accommodation REVENUE CODES must equal COVERED DAYS.</p> <p>CM</p> <p>E. See Appendix A for REVENUE CODES requiring UNITS.</p> <p>MD</p> <p>F. If TYPE OF BILL is '13X' and REVENUE CODE is 29X-38X, 41X-45X, 51X-53X, and 80X UNITS OF SERVICE are required.</p>

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047	Total Charges by Revenue Code	<p>BC, MD, CM A. Must be numeric and not equal to zero.</p> <p>BC, MD, CM B. If a unit charge is required, units of service times unit charges must equal total charges by REVENUE CODE.</p> <p>BC C. A revenue code charge cannot exceed \$99,999.99 A revenue code may be entered multiple times to report the charges.</p>
048	Non-covered Charges Invalid HCPCS / Diagnosis Code	<p>MD A. Must be numeric.</p> <p>BC, CM B. Vaccine covered by Federal Government and should not be billed to BCBSMS. Only the administration component should be billed (and any procedures performed during the visit as applicable.)</p>
050 A B C	Payor Identification <ul style="list-style-type: none"> • A = Primary • B = Secondary • C = Tertiary 	<p>BC</p> <p>A. PAYER A, B or C MUST CONTAIN THE WORDS 'Blue Cross XXX' (where XXX is Plan Code) Note: Plan Code may always be 230 and the appropriate plan code will be assigned at Blue Cross.</p> <p>B. Plan Code must be valid.</p> <p>C. For State of Mississippi employees and teachers, the PAYOR NAME must be 'STATE OF MS'</p> <p>D. If a primary payer is list, there MUST be either a deductible, coinsurance or prior payer amount or a 24 occurrence code.</p>

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050 A B C	Payor Name	<p>CM</p> <p>A. Commercial claims must have valid PAYOR ID information required about payer.</p> <p>B. PAYER ID code must be entered only if PAYER NAME is entered.</p> <p>C. For every PAYER ID, there must be a PAYER NAME.</p> <p>D. PAYER A, B, OR C must be valid payor according to the NEIC Payor List.</p> <p>E. For Cigna/Equicor (payor 62944), group numbers 57800, 70600, 70602, 70605, 70607, 70609, 70610, 70611, 70612, 70613, and 70614 cannot be electronic.</p> <p>F. For Guardian (payor 64246):</p> <ul style="list-style-type: none"> • The group number must be 4 to 6 positions. • The group number must be numeric. • The group number may <u>not</u> = 000000, 111111, 099999, 999999 or 999990. <p>G. For New York Life (payor 66915), the group number must be:</p> <ul style="list-style-type: none"> • 5 or 6 characters • Position 1 must = 0-9 or A-Z • Positions 2-4 must = 0-9 • Positions 5-6 must = 0-9 or spaces <p>H. For Prudential (payor 68241), <u>neither</u> the Payor Name <u>nor</u> the Group Name may = "AARP," "A.A.R.P.," or "A A R P" – these claims cannot be electronic.</p> <p>MD</p> <p>I. Payer A, B or C must contain the word 'MEDICAID.'</p> <p>J. 'MEDICAID' cannot be listed as Primary if a Secondary or Tertiary Payer is listed.</p>
051	Blue Cross Blue Shield Provider Number / NPI	<p>BC</p> <p>A. NPI or W-9 information has not been established in our system and/or does not match existing provider identifier information in our system. Please contact the BCBSMS Provider Administration department at 601-664-4618 to establish and/or verify your NPI and W-9 information.</p> <p>CM, MD</p> <p>B. Not edited.</p>
051	Medicaid Provider Number	<p>BC, CM</p> <p>A. Not edited.</p> <p>MD</p> <p>B. Must be an approved ESC submitter.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
052 A B C	Release of Information Certification Indicator	Indicator must = Y, N, or R <ul style="list-style-type: none"> • Y = Yes • N = No • R = Restricted
053 A B C	Assignment of Benefits Certification Indicator	Indicator must = Y or N <ul style="list-style-type: none"> • Y = Yes • N = No
054 A B C	Prior Payment	BC, CM <ul style="list-style-type: none"> A. Blue Cross records show that this is a secondary policy, therefore there must be a primary paid amount, amount applied to deductible or a primary denied reason. MD <ul style="list-style-type: none"> B. Must be numeric.
055 A B C	Estimated Amount Due	Not edited.
056	Other Insurance Information Required (Paid, Allowed, Denied Reason, etc.)	BC <ul style="list-style-type: none"> A. When records indicate other insurance coverage is primary on Federal Employee members, primary insurance information must be filed on the claim.
058 A B C	Insured's Last Name	BC, CM, MD <ul style="list-style-type: none"> B. Must be in correct position. C. Must be all alphabetic characters Note: Last name should not be followed by a comma. BC, MD, CM <ul style="list-style-type: none"> D. For each payer listed INSURED'S LAST NAME must be coded.
058 A B C	Insured's First Name	BC, CM, MD <ul style="list-style-type: none"> A. Must be in correct position. B. Must be all alphabetic characters. BC, MD, CM <ul style="list-style-type: none"> C. For each PAYOR listed INSURED'S FIRST NAME must be coded.
059 A B C	Patient's Relationship to Insured	BC, CM, MD <ul style="list-style-type: none"> A. The PATIENT'S RELATIONSHIP CODE must be numeric. BC, MD, CM <ul style="list-style-type: none"> B. For each PAYOR listed, PATIENT'S RELATIONSHIP must be coded.

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060 A B C	HIC/Contract/Identification Number	<p>BC, CM, MD</p> <p>A. Must be left justified with no embedded blanks, spaces or special characters.</p> <p>BC</p> <p>B. Basic Blue Cross = 9 numeric positions followed by 'M'. (If number has an alpha prefix, please include).</p> <p>C. Federal Employee (FEP) = 'R' prefix followed by 8 numeric positions.</p> <p>D. Blue Card Program (out-of-state Blue Cross) = Up to 15 alpha/numeric positions.</p> <p>E. For State of MS claims, the ID number is the 9 numbers followed by an 'M'. There will NOT be an alpha prefix.</p> <p>CM</p> <p>F. Use the <u>Insured Employee Number</u> from the ID card exactly as it appears.</p> <p>G. If PAYOR ID = 60054 (Aetna), the ID must be 9 or 10 digits.</p> <p>H. If PAYOR ID = 62308 or 62944 (Cigna/Equicor), ID must be 9 characters.</p> <p>I. If PAYOR ID = 65978 (Metlife), ID must be 9 digits.</p> <p>J. If PAYOR ID = 68195 (Provident), ID must be 9 digits.</p> <p>K. If PAYOR ID = 71412 (Mutual of Omaha), the first 6 digits of the ID may not = 999999.</p> <p>L. If PAYOR ID = 87726 (Travelers), ID must be 9 digits, but may not = 000000000, or 999999999, or 123456789.</p> <p>M. If PAYOR ID = 69140 (Allamerica), ID must be up to 9 digits numeric and may not = all 9's, 8's, 7's, 6's, 5's, 4's, 3's, 2's, 1's, or 0's.</p> <p>N. If PAYOR ID = 06105 (Connecticare), the ID must be 9 or 11 digits.</p> <p>O. If PAYOR ID = 41099 (John Alden Life), the ID must be 9 digits.</p> <p>P. If PAYOR ID = 65935 (Mass Mutual), the ID must be 9 digits.</p> <p>Q. If the PAYOR ID = 13310 Seabury & Smith), the ID must be 9 or 10 digits.</p> <p>R. If the PAYOR ID = 38253 (Selectcare), the ID must be 9, 10, or 11 digits.</p> <p>MD</p> <p>S. Must appear <u>exactly</u> as appears on the Medicaid ID card with or without a co-pay exception code.</p>

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061 A B C	Insured's Group Name	MD Group Name must be entered.
062 A B C	Insurance Group Number	BC, MD A. Not edited. CM B. There must be a valid PAYOR ID . C. Group number must be present, except for Medicare.
063	Treatment Authorization Code	BC A. On Medicare Advantage claims for Home Health (REVENUE CODE 0023), the 18 digit Benefit Management Treatment Authorization Code is required. CM B. Required for payor 23222 (U S Healthcare) on inpatient claims. MD C. If present, must be eight (8) numeric positions.
064	Employment Status Code	Not edited.
065	Employer Name	BC, MD A. Not edited. CM B. The first 3 positions must be entered for PAYOR ID 63105 (MedNet).
066	Employer Location	Not edited.

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067	Diagnosis Code	<p>BC</p> <ul style="list-style-type: none"> A. Must be left justified with no embedded punctuation and valid according to ICD9 coding. B. Statement covers from/through dates must fall within the effective/cancel dates of the diagnosis. C. The POA indicator must be valid. Valid values are Y, N, U, W, and 1 or blank. D. For all inpatient claims (bill type 11x or 12x) claims from network providers with an admit date of 1/1/09 or after, the primary and all secondary diagnosis codes require the presence of a POA indicator and a value of 1 will not be accepted. E. Serious Reportable Event (SRE) diagnosis codes (E876.5, E876.6, and E876.7) will not be accepted on inpatient or outpatient claims from network providers with dates of service on or after 1/1/10. Under no circumstances will there be reimbursement for SREs, and the member will be held harmless for any charges relating to the SRE.
068	Other Diagnosis Code	<p>BC</p> <p>If an occurrence code of 01 to 03 is filed along with an accident date, a corresponding E diagnosis code in the defined range (E810.0 through E816.9, E8190 through E8199, E8220 through E8239, E8250 through E8259, E8263 through E8279, E8284, E8299, E929 through or E929.0) must be present in one of the diagnosis fields between two and four.</p> <p>BC, MD, CM Same as Error Message 067 a & B.</p>
069 – 075	Other Diagnosis Code	<p>BC, MD, CM Same as Error Message 067 a & B.</p>
076	Admitting Diagnosis Code	<p>BC, MD, CM A. Same as Error Message 067 A & B.</p> <p>BC B. On Medicare Advantage Inpatient claims an Admitting Diagnosis is required.</p>
077	E-Code	<p>BC, MD A. Same as Error Message 067 a & B.</p> <p>CM B. Not edited.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
080 081	Principal Procedure Code	<p>BC, CM, MD</p> <p>A. PROCEDURE CODES must be left justified with no embedded punctuation.</p> <p>B. PROCEDURE CODES must fall within the code's effective/cancel dates.</p> <p>BC</p> <p>C. The following REVENUE CODES require valid ICD9-CM procedure codes:</p> <ul style="list-style-type: none"> • 201 • 213 • 350-359 • 360-379 except 374 • 482 • 700-729 (excluding 720 & 721) • 920 • 963-964 • 975 <p>CM</p> <p>D. The following REVENUE CODES require valid ICD9-CM procedure codes:</p> <ul style="list-style-type: none"> • 201 • 213 • 360-379 • 700-729 (excluding 721) • 963-964 • 975 • Note: 'C' is on second occurrence of 'J' record. <p>MD</p> <p>E. REVENUE CODE 36X requires a valid ICD9-CM procedure code.</p> <p>F. If PROCEDURE CODE is 72.0-72.9, 73.09, 73.22, or 73.51-73.99 and covered is greater than three (3), TREATMENT AUTHORIZATION NUMBER is required.</p> <p>G. If PROCEDURE CODE is 74.0-74.2, 74.4 or 74.99 and covered is greater than five (5), TREATMENT AUTHORIZATION NUMBER is required.</p>
080 081	Principal Procedure Date	<p>BC, MD</p> <p>A. The PROCEDURE DATE must be in CCYYMMDD (Year-Month-Day) format.</p> <p>B. The PROCEDURE DATE must fall within the STATEMENT COVERS period.</p> <p>C. The PROCEDURE DATE must fall within the effective/cancel dates of the procedure.</p>
082	Attending Physician ID	<p>BC, MD</p> <p>Must be entered.</p>

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
082	Attending Physician Name	BC, MD A. Must be entered. CM B. Not edited.
083	Other Physician ID – 1	BC, MD Not edited.
083	Servicing Provider ID	CM Required for PAYOR ID 06105 (Connecticare), PAYOR ID 23742 (Community Health Plan of New Albany) and 62129 (Healthsource Tennessee).
083	Other Physician Name – 1	BC, MD Not edited.
083	Other Physician ID – 2	BC, MD Not edited.
083	Other Physician Name – 2	BC, MD Not edited.
084	Remarks	Not edited.
085	Provider Representative Signature	Not edited.
086	Date Bill Submitted	Not edited.
087	Principal diagnosis	Age/sex must be valid for diagnosis
088	Other Diagnosis Code - 1	Age/sex must be valid for diagnosis
089	Other Diagnosis Code - 2	Age/sex must be valid for diagnosis
090	Other Diagnosis Code - 3	Age/sex must be valid for diagnosis
091	Other Diagnosis Code - 4	Age/sex must be valid for diagnosis
092	Other Diagnosis Code - 5	Age/sex must be valid for diagnosis
093	Other Diagnosis Code - 6	Age/sex must be valid for diagnosis
094	Other Diagnosis Code - 7	Age/sex must be valid for diagnosis
095	Other Diagnosis Code - 8	Age/sex must be valid for diagnosis

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
096	Admitting diagnosis	Age/sex must be valid for diagnosis
097	Primary Procedure	The age and sex of the patient must be valid for the principal procedure.
098	Other Procedures	The age and sex of the patient must be valid for the other procedures.
099	No Blue Cross Liability	<p>BC</p> <p>A. If TYPE CLAIM Blue Cross inpatient or Blue Cross outpatient and Medicare is indicated as PAYER A , at least one of the following amounts must be billed:</p> <ul style="list-style-type: none"> • A room difference for REVENUE CODES 110-169. <p><i>and/or</i></p> <ul style="list-style-type: none"> • A deductible amount reported as value code or CAS segment. <p><i>and/or</i></p> <ul style="list-style-type: none"> • A co-insurance amount reported as value code or CAS segment. <p><i>and/or</i></p> <ul style="list-style-type: none"> • An occurrence code of '24' and a date indicating primary insurance denied charges as 'not a covered service.' <p><i>and/or</i></p> <ul style="list-style-type: none"> • An occurrence code of '25' and a date indicating primary insurance denied claim as 'Coverage terminated.' <p>B. If Blue Cross is indicated as the only payer, Primary Paid amount must be zeroes. When filing a corrected claim, do not show previous amount paid and do not show paid amount for professional fees when filing hospital charges.</p>
101		Duplicate claim. This claim has been previously accepted by Blue Cross & Blue Shield for processing. Use myAccessBlue to check for or inquire about claim status. If claim should have been a corrected claim, re-file with the correct bill type.
102	Does Not Balance	The sum of all charge (Revenue code) records must = total charges. You may have to check with your software vendor to correct this.
104		Frequency code '6' is not valid. Corrected claim should be '7', void should be '8'.

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
105	ORIGINAL DCN	<p>BC</p> <p>When a corrected claim is indicated, the original document control number is required. This is the same as the claim number on the voucher.</p>
106	INTERIM or FINAL BILL	<p>BC</p> <p>Interim Bills (TYPE OF BILL ending in 12, 13, or 14, or PATIENT STATUS 30) are not acceptable for this claim type.</p>
107	CORRECTED CLAIM	<p>BC</p> <p>A corrected claim must be received within 12 months of the original claim payment date.</p>
108	CORRECTED CLAIM	<p>BC</p> <p>Only one correction per original claim should be transmitted.</p>
109		Claim does not meet any DRG criteria.
110	WINDOW OF SERVICE	<p>BC</p> <p>Pre-Admission Testing / Services – All outpatient services provided within 48 hours prior to admission as an inpatient are included in the Fair Market Price for the inpatient stay and must be billed to BCBSMS as part of the inpatient claim. This provision applies only to outpatient services performed at the same (or related) facility where the patient is subsequently admitted. Does not apply to claims in which Medicare is primary.</p>
141		Invalid age.
151		Invalid sex.
197		Invalid age for grouper.
198		Invalid sex for grouper.
199		DRG is un-groupable. Check the admission date, discharge status, POA indicators, age and sex of the patient and the ICD9 procedure codes to

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
		correct.
401		E-code cannot be reason for visit.
402		Invalid procedure code.
403		Procedure and age conflict.
404		Procedure and sex conflict.
405		Service unit out of range for procedure.
406		Multiple bilateral procedures without modifier 50.
407		Inappropriate specification of bilateral procedure.
408		Invalid modifier.
409		Terminated bilateral procedure or terminated procedure with units greater than one.
410		Inconsistency between implanted device and implantation procedure.
411		Multiple medical visits on same day with same revenue code without condition code G0.
412		Transfusion or blood product exchange without specification of blood product.
413		Observation revenue code on line item with non-observation HCPCS code.
414		Partial hospitalization condition code 41 not approved for type of bill.
415		Multiple observation overlap in time.
416		Codes G0378 and G0379 are only allowed with bill type 13X.

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
417		Non-reportable for site of service.
418		G0379 only allowed with G0378.
419		Clinical trial requires diagnosis code V707 as other than primary diagnosis.
420		Use of modifier CA with more than one procedure not allowed.
421		Revenue code with maximum occurrence of 450 times.
422		CA modifier requires patient status code 20.
423		Claim lacks required device code.
424		Incorrect billing of blood and blood products. Bill 038x and a 0391 revenue code. Both rev codes should have the same HCPCS code, both should have a BL modifier and both should have the same units. You do not need to file code 36430 as rev code 0391 is for administration.
425		Units greater than one for bilateral procedure billed with modifier 50.
426		Incorrect billing of modifier FB.
427		Trauma response critical care code with revenue code 068x and CPT 99291.
428		Claim lacks allowed procedure code.
429		Incorrect billing of revenue code with HCPCS code.
441		Revenue code requires HCPCS.
451		Invalid date.
452		Revenue code requires HCPCS
453		Claim lacks required radiopharmaceutical.

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ERROR MESSAGE	DESCRIPTION	CORRECTIVE ACTION
671		Invalid diagnosis.
672		Diagnosis and age conflict.
673		Diagnosis and sex conflict.

APPENDIX A REVENUE CODE REQUIREMENTS – COMMERCIAL CLAIMS

“X” – DENOTES UNITS REQUIRED

	UNITS REQUIRED		
CODES	UNITS	INPATIENT	OUTPATIENT
10X	# DAYS	X	
11X	# DAYS	X	
13X	# DAYS	X	
14X	# DAYS	X	
15X	# DAYS	X	
16X	# DAYS	X	
17X	# DAYS	X	
18X	# DAYS	X	
20X	# DAYS	X	
21X	# DAYS	X	
22X			
23X			
24X			
25X			
26X			
27X			
28X			
29X			
30X	# TESTS		X
31X			
32X			
34X			
35X	# SCANS	X	X
36X			
37X			
38X			
39X			
40X			
41X	# TREATMENTS		X

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APPENDIX A (continued)
REVENUE CODE REQUIREMENTS – COMMERCIAL CLAIMS

CODES	UNITS REQUIRED		
	UNITS	INPATIENT	OUTPATIENT
42X	# TREATMENTS		X
43X	# TREATMENTS		X
44X	#TREATMENTS		X
45X	# VISITS		X
46X			
47X			
48X			
49X			
50X			
51X	# VISITS		X
52X	# VISITS		X
53X	# VISITS		X
54X	# MILES	X	X
55X	# VISITS	X	
56X	# VISITS	HH	HH
57X	# VISITS	HH	HH
58X	# VISITS	HH	HH
59X	# VISITS	HH	HH
60X			
61X			
63X			
64X			
65X			
66X			
70X			
71X			
72X			
72X	# DAYS	X	X
73X			
74X			

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APPENDIX A (continued)
REVENUE CODE REQUIREMENTS – COMMERCIAL CLAIMS

CODES	UNITS REQUIRED		
	UNITS	INPATIENT	OUTPATIENT
75X			
76X			
79X			
80X	# SESSIONS	X	X
81X			
82X	# SESSONS		X
83X	# SESSIONS		X
84X	# DAYS		X
85X	# DAYS		X
86X			
87X			
88X			
89X			
90X	# VISITS		X
91X	# VISITS		X
92X	# VISITS		X
94X	# VISITS		X
96X			
97X			
98X			
99X			

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APPENDIX B

Revenue Codes Requiring HCPCS/CPT-4 Codes

REVENUE CODE	DESCRIPTION	HCPCS/CPT-4 REQD?
0001	TOTAL CHARGES	NO
010X	ALL-INCLUSIVE RATE	NO
011X	ROOM & BOARD – PRIVATE	NO
012X	ROOM & BOARD – SEMIPRIVATE	NO
013X	SEMIPRIVATE – THREE AND FOUR BEDS	NO
014X	PRIVATE (DELUXE)	NO
015X	ROOM & BOARD – WARD	NO
016X	OTHER ROOM & BOARD	NO
017X	NURSERY	NO
018X	LEAVE OF ABSENCE	NO
019X	SUBACUTE CARE	NO
020X	INTENSIVE CARE	NO
021X	CORONARY CARE	NO
022X	SPECIAL CHARGES	NO
023X	INCREMENTAL NURSING CHARGE RATE	NO
024X	ALL-INCLUSIVE ANCILLARY	NO
025X	PHARMACY	NO
026X	IV THERAPY	YES
0270-0273	MEDICAL/SURGICAL SUPPLIES AND DEVICES	NO
0274	PROSTHETICS AND ORTHOTICS	YES
0275-0279	MEDICAL/SURGICAL SUPPLIES AND DEVICES	NO
028X	ONCOLOGY	YES
029X	DURABLE MEDICAL EQUIPMENT	NO
030X	LABORATORY	YES
031X	LABORATORY PATHOLOGICAL	YES
032X	RADIOLOGY – DIAGNOSTIC	YES
033X	RADIOLOGY – THERAPEUTIC AND/OR CHEMOTHERAPY ADMIN	YES
034X	NUCLEAR MEDICINE	YES
035X	CT SCAN	YES
036X	OPERATING ROOM SERVICES	YES
037X	ANESTHESIA	YES
038X	BLOOD	YES
039X	BLOOD AND BLOOD COMPONENT ADMIN, PROCESSING AND STORAGE	YES
040X	OTHER IMAGING SERVICES	YES
041X	RESPIRATORY SERVICES	YES
042X	PHYSICAL THERAPY	YES
043X	OCCUPATIONAL THERAPY	YES
044X	SPEECH-LANGUAGE PATHOLOGY	YES

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APPENDIX B (continued)
Revenue Codes Requiring HCPCS/CPT-4 Codes

REVENUE CODE	DESCRIPTION	HCPCS/CPT-4 REQD?
045X	EMERGENCY ROOM	YES
046X	PULMONARY FUNCTION	YES
047X	AUDIOLOGY	YES
048X	CARDIOLOGY	YES
049X	AMBULATORY SURGICAL CARE	YES
050X	OUTPATIENT SERVICES	YES
051X	CLINIC	YES
052X	FREESTANDING CLINIC	YES
053X	OSTEOPATHIC SERVICES	YES
054X	AMBULANCE	YES
055X	SKILLED NURSING	NO
056X	MEDICAL SOCIAL SERVICES	NO
057X	HOME HEALTH AIDE	NO
058X	HOME HEALTH – OTHER VISITS	NO
059X	HOME HEALTH – UNITS OF SERVICE	NO
060X	OXYGEN (HOME HEALTH)	YES
061X	MAGNETIC RESONANCE TECHNOLOGY (MRT)	YES
0620-0621	MEDICAL/SURGICAL SUPPLIES – EXTENSION OF 027X	NO
0623	MEDICAL/SURGICAL SUPPLIES – SURGICAL DRESSINGS	YES
0624-0629	MEDICAL/SURGICAL SUPPLIES – EXTENSION OF 027X	NO
0630-0633	PHARMACY – EXTENSION OF 025X	NO
0634	PHARMACY – EPO LESS THAN 10,000 UNITS	YES
0635	PHARMACY – EPO 10,000 UNITS OR MORE	YES
0636	PHARMACY – DRUGS REQUIRING DETAILED CODING	YES
0637-0639	PHARMACY – EXTENSION OF 025X	NO
064X	HOME IV THERAPY SERVICES	NO
065X	HOSPICE SERVICES	NO
066X	RESPIRE CARE	NO
067X	OUTPATIENT SPECIAL RESIDENCE CHARGES	NO
068X	TRAUMA RESPONSE	NO
070X	CAST ROOM	YES
071X	RECOVERY ROOM	NO
0720-0721	LABOR ROOM/DELIVERY	NO
0722-0724	LABOR ROOM/DELIVERY	YES
0725-0728	LABOR ROOM/DELIVERY	NO
0729	LABOR ROOM/DELIVERY	YES
073X	EKG/ECG	YES
074X	EEG	YES
075X	GASTROINTESTINAL SERVICES	YES

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APPENDIX B (continued)
Revenue Codes Requiring HCPCS/CPT-4 Codes

REVENUE CODE	DESCRIPTION	HCPCS/CPT-4 REQD?
076X	TREATMENT OR OBSERVATION ROOM	YES
077X	PREVENTIVE CARE SERVICES	YES
078X	TELEMEDICINE	YES
079X	EXTRA-CORPOREAL SHOCK WAVE THERAPY	YES
080X	INPATIENT RENAL DIALYSIS	NO
0810	ACQUISITION OF BODY COMPONENTS	NO
0811-0814	ACQUISITION OF BODY COMPONENTS	YES
0815-0819	ACQUISITION OF BODY COMPONENTS	NO
082X	HEMODIALYSIS – OUTPATIENT OR HOME	YES
083X	PERITONEAL DIALYSIS – OUTPATIENT OR HOME	YES
084X	CAPD (DIALYSIS) – OUTPATIENT OR HOME	YES
085X	CCPD (DIALYSIS) – OUTPATIENT OR HOME	YES
088X	MISCELLANEOUS DIALYSIS	YES
090X	BEHAVIORAL HEALTH TREATMENTS/SERVICES	YES
091X	BEHAVIORAL HEALTH TREATMENTS/SERVICES – EXTENSION OF 090X	YES
092X	OTHER DIAGNOSTIC SERVICES	YES
093X	MEDICAL REHABILITATION DAY PROGRAM	NO
094X	OTHER THERAPEUTIC SERVICES	YES
095X	OTHER THERAPEUTIC SERVICES	YES
096X	PROFESSIONAL FEES	YES
097X	PROFESSIONAL FEES	YES
098X	PROFESSIONAL FEES	YES
099X	PATIENT CONVENIENCE ITEMS	NO