BLUE CROSS AND BLUE SHIELD OF LOUISIANA
BUSINESS RULES FOR INSTITUTIONAL CLAIMS
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I. Introduction

This document complements the HIPAA 837 Implementation Guide for Institutional Claims (004010X096) and is designed to be used in conjunction with the Blue Cross and Blue Shield of Louisiana (BCBSLA) Institutional Claims Companion Guide. This document is for informational purposes only and is not intended to replace the Implementation Guide.

The information provided here offers specific details on BCBSLA institutional claims completion. The detailed criteria can be useful in developing validation edits for BCBSLA claims. Once a claim reaches the BCBSLA processing system, more extensive editing is performed.

If a transaction does not meet the minimum specifications outlined in this guide, then BCBSLA may not be able to process those transactions. Claims that do not pass the stated criteria are subject to rejection, deletion, or a delay in processing. Additionally, claims must conform to the provisions set forth in the provider network contracts.

This is a general guide developed for the electronic submission of all institutional claims. Please be aware that some of the instructions described within this handbook may not apply to your facility. Specialized services such as home health, hospice, and maternity-related claims are referenced in separate sections.

If you have questions about this guide, please contact BCBSLA EDI Services.

Phone: 225.291.4EDI (4334) Option 2

Mailing Address: EDI Customer Operations
Attention: Clearinghouse Services
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029
II. Validation of Blue Cross Contract Numbers

*Alpha prefixes*

BCBS plans assign an individual contract number to each subscriber. The contract number uniquely identifies the specific contract.

Most contract numbers are preceded by a 3-position alpha prefix. The alpha prefix identifies the Plan or national account to which the member belongs. The alpha prefix is the key element used to identify and correctly route electronic or hard copy claims to the appropriate processing area or Blue Cross plan.

See the example of a BCBSLA card below. The Member number and alpha prefix are circled.

![Example of a BCBSLA Card]

**Identifying Contracts**

Blue Cross and Blue Shield of Louisiana (BCBSLA) contracts:

- Begin with alpha prefix “XU?”
- Followed by 8 to 10 positions
- If the contract has 8 positions, the 7th position can be numeric or alpha (If alpha will be A, B, N, V or X and the last position will be 1)
- If the contract number has 9 positions the 10th position will be 1-9 or C.
- Example: XUL1234567891  XUB123456X1

Out-of-area and National account prefixes

- Begin with any alpha prefix other than XU
- Can be any length of characters
- Example: MBN123456789

Federal Employees Contracts (FEP)
• FEP contracts do not have an alpha prefix
• The first position of the contract number must be an 'R',
• The second thru ninth will be numeric
• The tenth position must be zero (0).
III. Institutional Claims Business Rules
BCBSLA will accept all valid 837 transactions, but the table below depicts the data elements that will facilitate prompt and accurate claims processing for BCBSLA institutional claims.

<table>
<thead>
<tr>
<th>UB92 Form Locator</th>
<th>Field Name</th>
<th>192 NSF Reference</th>
<th>837I Reference and Page No.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name</td>
<td>Record 10 Field</td>
<td>2010AA / NM103 p 77</td>
<td>Must be the name of the provider who rendered services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Address</td>
<td>Record 10 Field</td>
<td>2010AA /</td>
<td>N301, p 79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 -16</td>
<td>N401 p 80</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N402 p 81</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N403 p 81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient Control Number</td>
<td>Record 20 Field</td>
<td>2300 / CLM01 p 158</td>
<td>Must be the number or code that is used by your facility to retrieve or post records.</td>
</tr>
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<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A maximum of 20 positions will be stored and returned by BCBSLA on the 835 ERA. A maximum of 15 positions will be returned on the paper payment register.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Type Bill Position 1-2</td>
<td>Record 40 Field</td>
<td>2300 / CLM05 -1</td>
<td>This is a three-position code that indicates the type of facility, the bill classification and the frequency. For inpatient and outpatient claims, choose one digit from</td>
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<td>UB92 Form Locator</td>
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</tr>
<tr>
<td>Position 3</td>
<td>4 Position 1-2</td>
<td>p 159</td>
<td></td>
<td>each category below:</td>
</tr>
<tr>
<td></td>
<td>Record 40 Field 4 Position 3</td>
<td>2300 / CLM05 -3 p 160</td>
<td></td>
<td>First Digit – Type of Facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Hospital (inpatient or outpatient)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Skilled Nursing Facility</td>
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<td></td>
<td></td>
<td>3 = Home Health</td>
</tr>
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<td></td>
<td></td>
<td>8 = Special Facility - Hospital (outpatient)</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Second Digit – Bill Classification (Other than Special Facilities)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Outpatient</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>4 = Other (outpatient)</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Second Digit – (Special Facilities Only)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Hospice (non-hospital based)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Hospice (hospital based)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Ambulatory Surgery Center</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Third Digit – Frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 = Admit thru discharge</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>2 = Interim (first claim)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Interim (continuing claim)*</td>
</tr>
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<td></td>
<td></td>
<td>4 = Interim (last claim)*</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>5 = Late-charges-only claim</td>
</tr>
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<td></td>
<td></td>
<td>6 = Adjustment of prior claim</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>*Member providers cannot submit interim billings for inpatient services. If 3rd position is 2 or 3 (Interim), the discharge status must equal 30.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If 3rd position is 1 or 4, discharge status field cannot equal 30.</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Fed Tax No.</td>
<td>Record 10 Field 4, 5</td>
<td>2010AA / NM109 p 78</td>
<td>Must be the federal tax identification number for the facility where the services were rendered.</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers Period From-Through</td>
<td>Record 20 Field 19, 20</td>
<td>2300 / DTP03 p 168</td>
<td>Must be the beginning and ending date of the period covered by this bill. The FROM date must be a valid date on or prior to the current date. The THROUGH date must be a valid date equal to or after the Covered From Date.</td>
</tr>
<tr>
<td>7</td>
<td>Covered Days</td>
<td>Record 30 Field 20</td>
<td>2300 / QTY01 &amp; 02/CA p 306</td>
<td>For inpatient claims only. Must be the total number of covered days. The number of covered days must equal the sum of all units indicated for the accommodation revenue codes 110 - 219. For maternity claims where newborn charges are combined with mother’s bill, covered days must not include units for nursery accommodation. (nursery accommodation will be revenue 17X) If the discharge status is 30 (type bill 112 or 113), then the sum of covered days indicated for accommodation revenue codes must be equal to the covered thru date minus the covered from date plus 1. Example 010102 thru 010902 units would be 9 days.</td>
</tr>
<tr>
<td>8</td>
<td>Non-covered</td>
<td>Record</td>
<td>2300 / QTY01 &amp;</td>
<td>The non-covered days field must be used when</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
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<td>-------</td>
</tr>
<tr>
<td>Days</td>
<td>30 Field 21</td>
<td>02 / NA p 307</td>
<td>revenue code 180 – 189 (Leave of Absence) is present and must be equal to the units indicated for revenue codes 180 - 189. This field is not required for outpatient claims.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Coinsurance Days</td>
<td>Not used by BCBSLA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Lifetime Reserve Days</td>
<td>Not used by BCBSLA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient Name</td>
<td>2010BA / NM103, 104, 105 p 109</td>
<td>Must be the patient’s last and first name. Middle initial can be reported, if available. Do not use titles or nicknames. When filing for a newborn, the infant’s given name must be used. Patient’s first name cannot be BABY, BABYBOY, BABYBOY1, BABYBOY2, BABYBOY2, BABYBOY3, BABYBOY4, BABYGIRL, BABYGIRL1, BABYGIRL2, BABYGIRL3, BABYGIRL4, BABY1, BABY2, BABY3, BABY4, GIRL, BOY, BOY1, BOY2, BOY3, BOY4, GIRL1, GIRL2, GIRL3, GIRL4, INFANT, TWIN, NEWBORN, NEWBO, INFANT1, INFANT2, INFANT3, INFANT4, BABY BOY1, BABY BOY2, BABY BOY3, BABY BOY4, BABY GIRL1, BABY GIRL2, BABY GIRL3, BABY GIRL4, BAB1, BAB2, BAB3, BAB4, UNKNOWN, or TRIPLET.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Patient</td>
<td>2010BA / N301 &amp;</td>
<td>Must be the patient’s address, city, state and ZIP.</td>
<td></td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
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<tr>
<td></td>
<td>Address</td>
<td>12, 13, 14, 15, 16</td>
<td>N302 N401, N402, N403 P 112</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2010CA / N301, N302, p 148, N401, N402, N403, p 149</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Patient Birth date</td>
<td>Record 20 Field 8</td>
<td>2010BA / DMG02 p 116</td>
<td>Must be the patient’s date of birth. Must be a valid date on or before the “Covered From Date”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2010CA / DMG02 p 152</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Sex</td>
<td>Record 20 Field 7</td>
<td>2010BA / DMG03 p 116</td>
<td>Must be the code indicating the patient’s sex. F, M and U are valid codes, however in order for BCBSLA to complete processing, F or M must be reported.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2010Ca / DMG03 p 152</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Marital Status</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Admission Date</td>
<td>Record 20: Field 17</td>
<td>2300 / DTP03 p 170</td>
<td>Must be completed only on inpatient claims. Must be the date the patient was admitted to the</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
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</tr>
<tr>
<td></td>
<td>18</td>
<td>Admission Hour</td>
<td>Record 20: Field 18</td>
<td>2300 / DTP03 p 170 Must be reported on all inpatient claims. 837I format requires 4 position hour and minute of admission (hhmm).</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Admission Type</td>
<td>Record 20: Field 10</td>
<td>2300 / CL101 p 171 Required on inpatient claims.</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Source of Admission</td>
<td>Record 20: Field 11</td>
<td>2300 / CL102 p 172 Required on inpatient claims. When admission type equals 4 (Newborn), then source of admission codes that apply to newborns must be used. (1 thru 4.)</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Discharge Hour</td>
<td>Record 20: Field 22</td>
<td>2300 / DTP01 / 096 p 165 2300 / DTP03 / p 166 Required on inpatient claims with the 3rd position of bill type equal to 1 or 4.</td>
</tr>
</tbody>
</table>
|                   | 22               | Patient Status    | Record 20: Field 21        | 2300 / CL103 p 172 Required for all inpatient claims. If ‘Discharge Status’ is 30, the 3rd position of ‘Type Bill’ must be 2 or 3. If the 3rd position of the type bill is 2 or 3, the ‘Discharge
<table>
<thead>
<tr>
<th>UB92 Form Locator</th>
<th>Field Name</th>
<th>192 NSF Reference</th>
<th>837I Reference and Page No.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Status must be 30.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>‘Discharge Status’ cannot be 30 if the 3rd position of ‘Type Bill’ is 1 or 4.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>If ‘Discharge Status’ is 31 or 32, there must be a number of days shown in the non-covered days field and no accommodation days charged for the leave days.</td>
</tr>
<tr>
<td>23</td>
<td>Medical Record Number</td>
<td>Record 20: Field 25</td>
<td>2300 / REF02 p 200</td>
<td>If present, should be the number used to retrieve this patient’s medical records.</td>
</tr>
<tr>
<td>24 – 30</td>
<td>Condition Codes</td>
<td>Record 41: Fields 4 - 13</td>
<td>2300 / HI01 thru HI12 p 291 – 298</td>
<td>BCBSLA will accept all valid condition codes. For adjudication, only the following codes are needed:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>02- Condition is employment related</td>
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<tr>
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<td></td>
<td></td>
<td>31- Patient is a student age 18-24 attending college (full-time)</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td>BCBSLA accepts all valid occurrence codes.</td>
</tr>
<tr>
<td>32 – 35</td>
<td>Occurrence Code and Date</td>
<td>Record 40: Fields 8, 10, 12, 14, 16, 18, 20, 22, 24, 26</td>
<td>2300 / HI01 – HI12 p 268 – 278</td>
<td>BCBSLA accepts all valid occurrence codes; however, only the following codes will be used in claims adjudication:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Code Description</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01  Auto accident</td>
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<td></td>
<td></td>
<td>02  Auto accident/no-fault insurance involved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>03  Accident/tort liability</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>04  Accident/employment</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
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<td></td>
<td></td>
<td>2300 / HI01 – HI12 p 268 - 278</td>
<td></td>
</tr>
</tbody>
</table>
| Record 40: Fields 9, 11, 13, 15, 17, 19, 21, 23, 25, 27 |            |                   | | 05  Accident/other than above  
| | | | 11  Onset of symptoms  
| | | | 25  Benefits terminated by primary insurer  
| | | | 40  Scheduled date of admission (outpatient)  
| | | | 41  Date of first test for pre-admission testing (outpatient)  |

Occurrence codes cannot be duplicated.

Occurrence codes 01 – 05 is required when an accident diagnosis code is present in the principal or first other diagnosis field.

Accident diagnosis codes are: 800 through 995.9 (excluding 995.3) V15.5, V15.6, V15.85, V71.3 - V71.6, 525.11 - 692.71, 692.76 - 692.77, 692.82, 733.10 to 733.19, 733.93-733.95.

If revenue code 450 is present, occurrence code 01 – 05 OR 11 must be present.

The occurrence date is the date that corresponds with the preceding occurrence code. Occurrence date must be present if an occurrence code is reported.

If occurrence code 01-05, 11 OR 41 is used, the occurrence date must be equal to or prior to the covered from date.

If occurrence code 40 is present, the date cannot be prior to or equal to the covered from or thru date.
<table>
<thead>
<tr>
<th>UB92 Form Locator</th>
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<th>837I Reference and Page No.</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **36** | Occurrence Span Code and Dates | Record 40: Field 22, 25 | 2300 / HI01 – 1 thru HI12 - 4 p 257 - 266 | Allowed on outpatient claims only.  
BCBSLA will accept all valid occurrence span codes.  
Only Span Code 72 will be used for adjudication.  
Span code 72 is required if outpatient type bill and one or more of the following revenue codes are present on claim:  
33X, 420, 430, 440, 820, 821, 830, 831, 840, 841, 850, 90X  
If occurrence span code is present, then the occurrence span dates must be present and a valid date on or prior to current date.  
In the “From” field, enter the first date the patient was treated for this condition. In the “Through” field, enter the last date the patient was treated for this condition. |
| **37** | Internal Control Number | Record 31: Field 14 | 2300 / REF01 F8  
2300 / REF02 p 192 | Must be present if 3\textsuperscript{RD} position of type bill is 5 or 6 (adjustments)  
Must be the 7\textsuperscript{th} position claim number found on the BCBSLA payment register or the paid/rejected screens on iLinkBlue.  
Cannot be present if 3\textsuperscript{RD} position of type bill is NOT 5 or 6. |
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<tr>
<td>38</td>
<td>NA</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>39 – 41</td>
<td>Value Codes and Amounts</td>
<td>Record 41: Field 16 - 39</td>
<td>2300 / HI01 – HI12 p 281 - 288</td>
<td>BCBSLA accepts all valid value codes; however, only the following codes will be used for claims adjudication:</td>
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<td>42</td>
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<td></td>
<td>42 Revenue Code</td>
<td>2400 / SV201 p 446</td>
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<td>A revenue code must be present on each line before revenue code 001.</td>
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<td>All 3position revenue codes must be preceded by a zero (0).</td>
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<td>Do not include revenue code 001 representing total charges. Total claim charge is reported in Loop 2400 CLM02.</td>
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<td>Revenue codes can be duplicated on an inpatient claim only if the rates differ.</td>
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<td>Revenue codes can be duplicated on an outpatient claim only if the HCPCS or line item service dates are different.</td>
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<td>071 revenue code must be present on all inpatient claims.</td>
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<td></td>
<td>071 revenue code must be present on outpatient claims if surgery CPT4 code is present or if diagnosis codes V641-V643 are present on claim.</td>
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<td>If type bill is inpatient (X1X) then accommodation revenue code(s) must be present: 110-119, 120-129, 130-139, 140-149, 150-159, 160-169, 200-219, 170-174, 179, 190-194, OR 199</td>
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<td>UB92 Form Locator</td>
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<td>When ambulance HCPCS A0428, A0429, A0427 A0425 are present, then one of the following valid ambulance revenue codes must be present 540 – 545 or 549</td>
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<td>On newborn ‘sick’ baby claims, the following nursery revenue codes can be billed. 170, 171, 172, 173, 174, OR 179</td>
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<td>No other accommodation revenue codes are allowed. Professional revenue codes 960-964, 969, 970-979, 981-989 must be filed on a 1500 or 837P claim</td>
</tr>
<tr>
<td>43</td>
<td>Description</td>
<td></td>
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<td>N/A</td>
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<tr>
<td>44</td>
<td>HCPCS/Rates</td>
<td>Record 50: Field 6, 11, 12, 13</td>
<td>Rate 2400 / SV206 p 449</td>
<td>Rates: Must be at least 3 numeric positions.</td>
</tr>
<tr>
<td></td>
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<td>Record 60: Field 6, 15, 16</td>
<td></td>
<td>The following revenue codes require rates: 071, 100-101, 111-117, 119 120-127, 129 130-137, 139 140-147, 149 150-157, 159 710-173, 174, 179 190-194, 199 200-204, 206-209 210-214, 219, 381, 382.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record 61: Field 6, 15, 16</td>
<td></td>
<td>Rates multiplied by units must equal charges. Must be the appropriate CPT4 or HCPCS code that describes the service rendered. Must be a valid and</td>
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Blue Cross and Blue Shield of Louisiana
837I Business Rules Guide

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<thead>
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<th>Field Name</th>
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<td>Field 7, 8, 15, 16</td>
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<td>Service Date</td>
<td>Record 61: Fields</td>
<td>2400 / DTP02 / D8</td>
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<td>13, 15, 16</td>
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<td>2400 / DTP03</td>
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<td>46</td>
<td>Units of</td>
<td>Record 50:</td>
<td>2400 / SV205</td>
<td>Inpatient Billing:</td>
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<td>Service</td>
<td>Fields 7, 12, 13</td>
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<td>Record 60: 9, 15, 16</td>
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<td>Record 61: Fields 9, 15, 16</td>
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<td>Record 61: Fields 9, 15, 16</td>
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<td>Record 50:</td>
<td>2400 / SV203</td>
<td>A charge must be present for each revenue code</td>
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</tbody>
</table>

The following revenue codes require units when the second position of type bill is “1”: 071, 100-101, 110-189, 200-204, 206-209, 210-214, 219, 380-382, 389

**Outpatient Billing:**
The following revenue codes require units when the second position of type bill is “3”: 300-309, 310-319, 320-329, 330-339, 340-349, 350-359, 381-389, 400-409, 420, 430, 440, 610-619, 820, 830, 831, 840, 841, 850, 851, 900, 901, 902, 903, 909

The sum of units indicated for accommodation revenue codes (110-169, 200 – 219) and leave of absence revenue codes (180 – 189) must equal the number of covered days.

EXCEPTION: When combining charges for mothers and newborn baby’s claims, the units for the accommodation revenue codes for the mother must equal to the covered days. For additional instruction on maternity-related claims, see the Maternity Claims section.

Units for Louisiana Mandated Service Charge (Revenue 071) on inpatient claims must equal covered days. Units for Louisiana Mandated Service Charge on outpatient surgical claims must equal 1.

Units multiplied by the rate must equal the charges.
<table>
<thead>
<tr>
<th><strong>UB92 Form Locator</strong></th>
<th><strong>Field Name</strong></th>
<th><strong>192 NSF Reference</strong></th>
<th><strong>837I Reference and Page No.</strong></th>
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<tr>
<td><strong>Charges</strong></td>
<td></td>
<td>Fields 8, 11, 12, 13</td>
<td>p 448</td>
<td>indicated unless multiple surgical procedures are performed. Total charges cannot be greater than $999,999.99. Do not include revenue code 001 representing total charges. Total claim charge is reported in Loop 2400 CLM02.</td>
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<td>Record 60: 10, 15, 16</td>
<td>2300 / CLM02 p 159</td>
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<td>Record 61: Fields 10, 15, 16</td>
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<td>Record 90: Field 13</td>
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<td><strong>48</strong> Non-covered Charges</td>
<td>Record 50: Field 9, 11, 12, 13</td>
<td>2400 / SV207 p 449</td>
<td>Must indicate the non covered charges when a portion of a patient’s stay is non-approved.</td>
<td></td>
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<tr>
<td><strong>50</strong> Payer</td>
<td></td>
<td>Record 30: Field 8b</td>
<td>2010BC / NM103 p 127</td>
<td>Payor name must be present and should equal ‘Blue Cross.’ Data element 2010BC NM109 must equal 53120.</td>
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<td>Record 30: Field 9</td>
<td>2010BC / NM109 p 128</td>
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<tr>
<td><strong>51</strong> Provider Number</td>
<td>Record 10:Field 9</td>
<td>2010BC / REF02 p 133</td>
<td>Enter 5-digit provider number assigned by BCBSLA for the unit of your facility where services were rendered.</td>
<td></td>
</tr>
<tr>
<td><strong>52</strong> Release of Information</td>
<td>Record 30: Field 16</td>
<td>2300 / CLM09 p 161</td>
<td>Indicates that you have signed written authority to release medical or billing information for purposes of claiming insurance benefits.</td>
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<tr>
<td>53</td>
<td>Assignment of Benefits</td>
<td>Record 30: Field 17</td>
<td>2300 / CLM08 p 160</td>
<td>Enter one of the following codes to indicate who will receive payment for the claim: Y - Assignment/payment to provider N - Assignment/payment to subscriber</td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments</td>
<td></td>
<td>2320 / AMT02 p 371</td>
<td>Must be the total amount paid by the primary insurer when BCBSLA is secondary. Refer to the 837I Implementation Guide for complete details on submitting claims with BCBSLA as the secondary payor</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
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<td>Not used by BCBSLA</td>
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<td>57</td>
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<tr>
<td>58</td>
<td>Insured's Name</td>
<td>Record 30: Field 12, 13, 14</td>
<td>2010BA / NM103, 104, 105 p 109</td>
<td>Must be the member’s name exactly as it appears on the BCBS identification card.</td>
</tr>
<tr>
<td>59</td>
<td>Patient's Relationship to Insured</td>
<td>Record 30: Field 18</td>
<td>2000B / SBR02 p 103 2000C / PAT01 p 142</td>
<td>Must be the 2-digit code indicating the patient’s relationship to insured.</td>
</tr>
<tr>
<td>60</td>
<td>Certificate –</td>
<td>Record 30:</td>
<td>2010BA / NM108</td>
<td>Enter the subscriber’s identification number exactly as it appears on the identification card including the 3-</td>
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<table>
<thead>
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<tr>
<td></td>
<td>SSN – HIC – Identification Number</td>
<td>Field 7</td>
<td>(MI) 2010BA / NM109 p 110</td>
<td>position alpha prefix.</td>
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<td>2010CA / NM108 (MI)</td>
<td><strong>Blue Cross and Blue Shield of Louisiana contracts</strong></td>
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<td>2010CA / NM109 p 147</td>
<td>All BCBSLA contract numbers will be a total of 11 or 13 positions</td>
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<td>2330A / NM109 p 403</td>
<td>(including the 3 position alpha prefix).</td>
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<td>When the prefix is present, the first two positions must be XU.</td>
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<td>Third position will be alpha (A-Z).</td>
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<td>Remaining member number will be 8 or 10 positions</td>
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<td>• If the contract has 8 positions, the 7th position can be numeric</td>
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<td>or alpha (If alpha, will be A, B, N, V or X and the last position</td>
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<td>must be 1).</td>
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<td>• If the contract number has 10 positions, the first nine will be</td>
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<td>numeric and the 10th position can be 1-9 or C.</td>
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<td>• Example: XUL1234567891</td>
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<td></td>
<td>XUB123456X1</td>
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<td><strong>Out-of-Area contracts</strong> (also known as Blue Card, ITS, out-of-state</td>
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<td>National, NASCO). These contracts will begin with an alpha prefix</td>
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<td>other than XU. A valid 3-position alpha prefix must be present.</td>
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<td>EXAMPLE: YAA1234567890</td>
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<td><strong>Federal contracts:</strong></td>
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<th><strong>Notes</strong></th>
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<tr>
<td><strong>61</strong></td>
<td>Insured's Group Name</td>
<td>Record 30: Field 11</td>
<td>2000B / SBR04 p 103 2320 / SBR04 p 363</td>
<td>If contract is federal, the 1\textsuperscript{st} position must be ‘R.’ The 2\textsuperscript{nd} thru 9\textsuperscript{th} positions must be numeric. If a tenth, position must be (zero) 0. EXAMPLE: R034567810</td>
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<tr>
<td><strong>62</strong></td>
<td>Insurance Group Number</td>
<td>Record 30: Field 10</td>
<td>2000B / SBR03 p 103 2320 / SBR03 p 363</td>
<td>To meet HIPAA requirements, a group name or group number must be present. BCBSLA does not require group names for processing. If group name is not available, you may type “none.”</td>
</tr>
<tr>
<td><strong>63</strong></td>
<td>Treatment Authorization Code</td>
<td>Record 40: Field 5</td>
<td>2300 / REF01 (G1) 2300 / REF02 p 199</td>
<td>Enter the BCBSLA pre-certification number when available.</td>
</tr>
<tr>
<td><strong>64</strong></td>
<td>Employment Status Code of Insured</td>
<td></td>
<td>N/A</td>
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<tr>
<td><strong>65</strong></td>
<td>Employer Name</td>
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<tr>
<td><strong>66</strong></td>
<td>Employer Location</td>
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<td>N/A</td>
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</tr>
<tr>
<td><strong>67</strong></td>
<td>Principal Diagnosis</td>
<td>Record 70: Field 4</td>
<td>2300 / HI01-1 (BK) and HI01-2</td>
<td>All diagnosis codes must be current and valid ICD-9 codes for the “Covered Thru Date” of claim.</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
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<tr>
<td>68 – 75</td>
<td>Other Diagnosis</td>
<td>Record 70: Field 5 thru 12</td>
<td>p 228</td>
<td>ICD-9 diagnosis codes cannot be duplicated.</td>
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<td>The principal diagnosis code must be present on all claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The first position should contain &quot;V&quot; or a numeric character.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The second and third positions must be numeric with no punctuation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fourth and fifth positions must be numeric or blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If the sex is “M,” the first two positions cannot be 62 or 63.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If the sex is “F,” the first two positions cannot be 60.</td>
</tr>
<tr>
<td>76</td>
<td>Admitting Diagnosis</td>
<td>Record 70: Field 25</td>
<td>2300 / HI01 – 1(BF) and HI01 – 2 thru HI12 p 232</td>
<td>The 837I version 4010 allows up to 24 ‘Other Diagnosis’ codes. BCBSLA’s adjudication system will recognize the Principal Diagnosis and first 8 ‘Other Diagnosis’ codes reported.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other diagnosis codes must be numeric or begin with “E” or “V.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If diagnosis code 905X is present (late effect of fracture), the date of accident reported with occurrence code 01 – 05 must be prior to the covered date.</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Admit diagnosis must be present on inpatient claims.</td>
</tr>
<tr>
<td><strong>77</strong></td>
<td>E-code Diagnosis</td>
<td>Record 70: Field 26</td>
<td>2300 / HI03 – 1 (BN) HI03 – 2 P 229</td>
<td>Not used by BCBSLA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>78</strong></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>79</strong></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>80 and 81</strong></td>
<td>Principal Procedure Code and Date</td>
<td>Record 70: Field 13 and 14</td>
<td>2300 HI01 – 1 (BR) HI01 – 2 P 242 Date HI01 - 3</td>
<td>The 837I version 4010 allows one principal procedure code and up to 24 “Other” procedure codes. BCBSLA’s adjudication system will recognize the principal procedure and the first 5 “Other” procedure codes reported. All procedure codes must be current and valid ICD-9 codes. Principal procedure must be present on inpatient claims containing surgical revenue codes (revenues 36X, 370, 379, 710) unless a diagnosis code from the range V64.1 – V64.3 is present. For each procedure code reported, a valid date must be present and must be within the covered From and Thru date range.</td>
</tr>
<tr>
<td></td>
<td>Other Procedure Codes and Date</td>
<td>Record 70: Field 15 thru 24</td>
<td>2300 HI01- 1 (BQ) HI01 – 2 Thru HI12 – 3</td>
<td></td>
</tr>
<tr>
<td><strong>82</strong></td>
<td>Attending Physician ID and Name</td>
<td>Record 80: Field 5, 9</td>
<td>2310A REF01 (1A) REF02 P 322 2310A NM103 –</td>
<td>To meet HIPAA requirements, the attending physician ID and name must be present. However, BCBSLA does not require attending physician information for claim adjudication.</td>
</tr>
<tr>
<td>UB92 Form Locator</td>
<td>Field Name</td>
<td>192 NSF Reference</td>
<td>837I Reference and Page No.</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>83</td>
<td>Other Physician ID and Name</td>
<td>Record 80: Field 6, 11</td>
<td>2310B REF01 (1A) REF02 P 333</td>
<td>To meet HIPAA requirements, the ‘Other’ physician ID and name must be present. However, BCBSLA does not require attending physician information for claim adjudication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2310B NM103 NM105 P 328</td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>Remarks</td>
<td>Record 90: Field 4</td>
<td>2300 NTE01 (ADD) NTE02 P 208</td>
<td>The ‘Remarks’ field must be completed if the 3rd position of type bill is ‘5’ or ‘6’. If the third digit of a revenue code is “9” or if revenue codes 920 or 940 are present enter a description and the charge in remarks. If occurrence code 01 - 03 or 04 is present, but no accident diagnosis (525.11, 692.71, 692.76, 692.77, 692.82 733.93 to 733.95 and 733.10 to 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6, V15.85, V71.3-V71.6) or a diagnosis code beginning with an “E” other than E903-E9049, E9300-E9499 or E9500-E959 is present in principal diagnosis or diagnosis 1, then enter type of accident and date and time of accident in remarks field. The “Remarks” field cannot contain information unless required. If you feel the information entered should be accepted, please call 225.291.4334 for a determination on edit change.</td>
</tr>
</tbody>
</table>

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IV. Special Billing Requirements

Home Health Claims

1. Revenue code 261 must have one of the following valid modifiers present:

BP, BU, BR, LL, NU, QR, RR, UE, NR

2. The revenue codes accepted by BCBSLA from participating home health agencies are shown in the following table. The appropriate HCPCS or CPT code must be included when billing revenue codes with double asterisks (**).

<table>
<thead>
<tr>
<th>Accepted Revenue Codes</th>
<th>HCPCS/CPT Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>258**</td>
<td>J0000 thru J9999</td>
</tr>
<tr>
<td>261**</td>
<td>E0781 thru E0784</td>
</tr>
<tr>
<td>264 **</td>
<td>A4230 thru A4232</td>
</tr>
<tr>
<td>271 **</td>
<td>A4206 thru A6406</td>
</tr>
<tr>
<td>272 **</td>
<td>A4206 thru A6406</td>
</tr>
<tr>
<td>274 **</td>
<td>L0000 thru L4999, L5000 thru L9999</td>
</tr>
<tr>
<td>291 **</td>
<td>E0100 thru E1406</td>
</tr>
<tr>
<td>292 **</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
</tr>
<tr>
<td>293 **</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
</tr>
<tr>
<td>294 **</td>
<td>E0100 thru E1406, E1700 thru E1830</td>
</tr>
<tr>
<td>300 thru 319 **</td>
<td>80002 thru 89399, 36415, G0001,</td>
</tr>
<tr>
<td></td>
<td>G0058 thru G0060</td>
</tr>
<tr>
<td>421, 424, 431, 434, 441, 444, 550, 551, 552, 559, 561, 571</td>
<td></td>
</tr>
<tr>
<td>600 **</td>
<td>E0424 thru E0480 E0500, E0600, E0601</td>
</tr>
<tr>
<td></td>
<td>E0550 thru E0585</td>
</tr>
<tr>
<td></td>
<td>E1353 thru E1406</td>
</tr>
<tr>
<td>900 thru 999</td>
<td></td>
</tr>
</tbody>
</table>

**HCPCS/CPT4 codes must be present when one of these revenue codes is reported.
Maternity Claims

Mother and Baby Discharged on the Same Date

Member providers must submit combined billings for mothers and newborns who are discharged on the same date.

1. Nursery revenue codes (170-174, 179, 113, 123, 133, 143, 153) must be equal to or less than the units shown for the mother’s accommodation codes (110-119, 120-129, 130-139, 140-149, 150-159, 160-169, 200-219.)

2. If delivery of twins, the units indicated for nursery revenue codes can be up to double the amount of units indicated for the mother’s accommodation. However, the diagnosis of 651.01 or V27.2 must be in the principal diagnosis or the first diagnosis field.

3. If delivery of triplets, the units indicated for nursery revenue codes can be up to triple the amount of units indicated for the mother’s accommodation. However, the diagnosis code of 651.10, 651.11 or 651.13 must be in the principal diagnosis or the first diagnosis field.

4. If delivery of quadruplets, the units indicated for nursery revenue codes can be up to four times the amount of units indicated for the mother’s accommodation. However, the diagnosis codes of 651.20, 651.21, or 651.23 must be in the principal diagnosis or first diagnosis field.

Mother and Baby Discharged on Different Dates

If the mother and baby are not discharged on the same day, their charges cannot be combined on one claim. You must bill one claim for the baby and one claim for the mother.
Hospice Claims

For Regular contracts

- All hospice services for regular BCBSLA contracts should be coded as a professional (837P) claim.

For Federal contracts

- Hospice claims for FEP contracts must be coded as institutional and require “Life Expectancy” information. Life expectancy information must be indicated in the 837I as follows:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Element</th>
<th>Page #</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>NTE02</td>
<td>247</td>
<td>Example “Six months life expectancy”</td>
</tr>
</tbody>
</table>

For out-of-state and NASCO contracts

- All hospice services for out-of-state and NASCO contracts should be coded as an institutional (837I) claim.
Pathology Reports for Cancer Contracts

Cancer contracts can be identified by the assigned Group Number C0005. If submitting a Pathology report for a cancer contract, this information should be available in the following 837I element:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Element</th>
<th>Page #</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>NTE01</td>
<td>206</td>
<td>NTE01 must be present</td>
</tr>
<tr>
<td>2300</td>
<td>NTE02</td>
<td>2</td>
<td>NTE02 should contain the following:</td>
</tr>
</tbody>
</table>

- Date of Pathology Report, Operative Note, Radiology Report, or any other supporting documentation.
- Diagnosis

If space is available, include the following: Diagnosis Location (left, right, both sides), Referring Physicians Name and Metastatic Condition.
Case Management Claims

If you have a case that has been negotiated through the BCBSLA Case Management Department, you will receive a letter with a Contract Code (reference number.) The Contract Code must be present to ensure that the claim is routed to the appropriate department and processed accurately.

Indicate the Contract Code as follows in the 837I format:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Element</th>
<th>Page #</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>CN101</td>
<td>176</td>
<td>CN101 = 09</td>
</tr>
<tr>
<td>2300</td>
<td>CN104</td>
<td>176</td>
<td>CN104 = Contract Code as assigned by BCBSLA</td>
</tr>
</tbody>
</table>
V. Reports Generated from Clearinghouse

The BCBSLA Clearinghouse provides a series of reports to assist in the tracking and monitoring of transactions. Clearinghouse reports are a critical part of the electronic submission process.

The Trading Partner is responsible for monitoring all reports to ensure that all transactions were received and accepted for processing by BCBSLA. In addition, the Trading Partner is required to take corrective action when necessary. All questions regarding reports should be directed to EDI Customer Operations at: 225-291- (4334) option 2.

We recommend that you maintain a copy of these reports for at least 60 days.

Summary of Reports Generated from Clearinghouse:

1. Communication Reports
   a. TA1 Interchange Acknowledgement (all X12 transactions)

2. Functional Acknowledgement Report
   a. 997 (all X12 transactions)
   b. BCCLREDI X12 Error Report (only for X12 transactions with errors)

3. Claims Submission Validation Reports
   a. Accepted/Not Accepted  (for all Claims transactions only)

4. Activity Log
   The Activity Log is available from the submitter’s mailbox. The log lists files/reports that were sent and received. Each listing provides the file/report name, date and time of the transmission, protocol used and the size of the file. See Exhibit F for an example of an Activity Log.

5. BCTPERR Report
   This report is generated anytime the submitter ID within the transaction does not match the mailbox or the Test/Production indicator does not match the file. See Exhibit G for an example of a BCTPERR Report.
Communication Reports

Communication Reports are an immediate acknowledgement of successful communication and receipt of transmitted files. They are the first step in the reconciliation process. They are not an indication that the transmitted files were accepted for processing. The Trading Partner is responsible for monitoring the reports and ensuring that all transactions submitted were received by the BCBSLA Clearinghouse.

If you do not receive a communication report, we did not receive the transmission and the transmission will need to be resent. You may refer to the Activity Log that is available from your mailbox to review the status of previous submissions.

TA1 Interchange Acknowledgement
The TA1 provides the status of an X12 interchange header and trailer. Positive TA1 acknowledgements will not be utilized by BCBSLA. Trading Partners will automatically receive a negative TA1 for files that cannot be processed or submitted for HIPAA validation. See Exhibit A on the following page for an example of a negative TA1.
Example of TA1 Interchange Acknowledgement Report (all X12 transactions)

Exhibit A: Negative (Rejected) TA1 Report

ISA*00* 00* ZZ*BCBSLA001 ZZ*T0001098
*030625*1320*U*00401*000000067*0*T*:
TA1*000019998*030602*0913*R*009~
IEA*0*000000067~
Functional Acknowledgment Reports

997
The 997 report is available for all X12 transactions and indicates the validity of a standard transaction. Trading Partners will be able to pull this report the next time they connect to the BCBSLA Clearinghouse. If the 997 contains a rejected status, in many cases the trading partner will receive a BCCLREDI X12 Error Report (see below) with detailed error descriptions. However, a 997 that rejected due to errors in the "Control Structure" will only create the 997 Reject. A BCCLREDI X12 Error Report WILL NOT be generated on this X12 transaction with Control Structure errors.

On rejected 997’s the trading partner must make the corrections and retransmit the file. See Exhibits B and C for examples of accepted and rejected 997 reports.

BCCLREDI X12 Error Report
The X12 Error Report indicates the validity of files submitted in the 837 format. Files that do not meet standard HIPAA compliancy will be rejected. The report will include the data contained in your file as well as specific error information. You may need to refer to the appropriate 837 Implementation Guide for assistance with this report.

See Exhibit D for an example of the X12 report.
Examples of the 997 Functional Acknowledgement Reports

Exhibit B: Accepted 997 Acknowledgement

ISA*00*  *00* *ZZ*BCBSLA001  *ZZ*T0001098  *030618*0844*U*00401*000000049*0*T*:~
GS*FA*BCBSLA001*T0001098*20030618*0844*24*X*004010X096A1~
ST*997*0001~
AK1*HC*17999~
AK2*837*00017999~
AK5*A~
AK9*A*1*1*1~
SE*6*0001~
GE*1*24~
IEA*1*000000049~.

Exhibit C: Rejected 997 Acknowledgement

ISA*00*  *00* *ZZ*BCBSLA001  *ZZ*T0001098  *030603*1527*U*00401*000000007*0*T*:~
GS*FA*BCBSLA001*T0001098*20030603*1527*4*X*004010X096A1~
ST*997*0001~
AK1*HC*17557~
AK2*837*00017557~
AK3*SV2*2527*2400*8~
AK4*3*782*6~
AK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*4~
IEA*1*000000007~

NOTE: If the 997 contains a rejected status, in many cases the trading partner will receive a BCCLREDI X12 Error Report with detailed error descriptions. However, a 997 that rejected due to errors in the "Control Structure" will only create the 997 Reject. An X12 Error Report **WILL NOT** be generated on this X12 transaction.
Exhibit D: Example of the BCCLREDI X12 Error Report for an Institutional Claim

ISA*00* *00* *ZZ*0001000 *ZZ*BCBSLA001 *030602*0900*U*00401*000017557*1*T*:
GS*HC*T0001000*BCBSLA001*20030602*090025*17557*X*004010X096A1
ST*837*00017557
BHT*0019*00*00017557*20030602*090025*CH
REF*87*004010X096A1
NM1*41*2*BCBSLA*****46*T0001000
PER*JC*JIM DOE*TE*1234567890
NM1*40*2*BLUE CROSS*****46*BCBSLA001
HL*1***20*1
NM1*85*2*GENERAL HOSP*****24*123456789
N3*PO BOX 123456
N4*TOWN*GA*303842872
REF*1A*12345
REF*1C*123456
REF*1D*12345678
REF*1H*123456789
REF*G2*123456789
HL*2*1*22*0
SBR*P*18*0005*****BL
NM1*IL*1*PATIENT*GREGORY*A***MI*123456789
N3*12345 MAIN
N4*TOWN*MS*395030000
DMG*DK*19470217*M
NM1*PR*2*BLUE CROSS TRADITIONAL*****PI*999990228
N3*PO BOX 23071
N4*TOWN*MS*392253071
CLM*12345678*5028.8***13:A:1*Y**Y*********Y
DTP*434*RD*20020614-20020614
DTP*435*DT*200206141200
CLI*2*2
REF*D9*00017557
REF*G1*21066311
REF*EA*000000755690
HI*BK:1712
HI*BH:11:D8:20020614*BH:A1:D8:19470217
NM1*71*1*DOE*SCOTT*A***24*123456789
PRV*AT*ZZ*203BG0000Y
[H 2310A PRV 127 37 3 0 2000B.2300.2310A.PRV.PRV03 (null) H52003Attending Provider Specialty Code not found in Taxonomy Code Table]
REF*1G*G12345
REF*1G*G12345
LX*1
SV2*0352*HC:71260*1710*UN*1
DTP*472*D8*20020614
LX*2
SV2*0352*HC:74170*1552.5*UN*1
DTP*472*D8*20020614
LX*3
SV2*0352*HC:72193*1417*UN*1
DTP*472*D8*20020614
LX*4
SV2*0636*HC:A4646*349.3*UN*2
DTP*472*D8*20020614
SE*2982*00017557
GE*1*17557
IEA*1*000017557
***********************
Claims Submission Validation Reports

Accepted/Not Accepted Reports
The disposition of institutional claims is detailed on the Accepted/Not Accepted Reports. This report provides detailed information on the claims that have been accepted or not accepted by BCBSLA for processing. All claims received are validated with a comprehensive set of business logic edits. The Trading Partner is responsible for reviewing these reports and taking corrective action when necessary. We recommend you maintain these reports for at least 60 days.

This process evaluates the submission at the claims level.

- Accepted claims are moved into the BCBSLA internal claims system for adjudication.
- Not Accepted claims are rejected. These claims do not enter the processing system and must be corrected and retransmitted electronically for processing.

All claim transactions received Monday through Friday (except holidays) prior to 3 p.m. (CST) will be processed in our daily processing cycle. Accepted/Not Accepted Reports are available the following day by 9 a.m.

See Exhibit E for an example of the Accepted/Not Accepted Report
Exhibit E: Example of Accepted/Not Accepted Report for Institutional Claims

![Table showing examples of accepted and not accepted claims.](image)

See Appendix A for details on resolving the errors in the Error Description field.

July 3, 2003
Exhibit F: Activity Log

LOG batch for remote user : T0001098

Wed May 7 08:25:11 2003
 Add with protocol=ASYNC: ID=T0001111, BID="X12Claims.in"
 ...... Added successfully, bytes=36342, batch No.=638

Wed May 7 09:37:08 2003
 Add with protocol=ASYNC: ID=T0001111, BID="X12Claims.in"
 ...... Added successfully, bytes=16334, batch No.=640

Wed May 7 09:43:23 2003
 Add with protocol=ASYNC: ID=T0001111, BID="X12Claims.in"
 ...... Failed, returned error code=1

Wed May 7 15:17:53 2003
 Extract with protocol=FTP: ID=T0001111, BID="#0000639"......
 Extracted ID=T0001111, BID="<<ACTIVITY LOG>>", bytes=653,
 batch No.=639
 ...... Successfully extracted 1 batch(es).
Exhibit G: BCTPERR Report

The BCTPERR Report will display an error message at the beginning of the file. See boxed area below:

```
ERROR >>> Mailbox ID does not match Trading Partner ID within the file Submitted
<<<ISA*00*1234567890*00*1234567890*ZZ*T0000014 *ZZ*BCBSLA001
*030601*1907*U*00401*000000032*0*7*<~
GS*HC*T0000014*RECEIVER CODE*20030601*1907*1*X*004010X098A1~
ST*837*0001~
BHT*0019*00*0001*20030601*1907*CH~
REF*87*0041111111A1~
NM1*41*2*HEALTH CLINIC &*****46*T0000011~
PER*IC*RON DAVID*TE*3333333332~
NM1*40*2*BLUE CROSS BLUE SHIELD*****46*11111~
HL*1**20*1~
PRV*PT*ZZ*203BF0100X
```

Trading Partners that receive this report must correct the Trading Partner ID and retransmit the entire file.
Appendix A: Not Accepted Error Definitions

The disposition of Institutional (hospital) claims is detailed on the Accepted Inpatient and Outpatient Claims Report and the Not Accepted Inpatient and Outpatient Claims Reports. These reports provide detailed information on the claims that have been accepted or not accepted by BCBSLA for processing. The Electronic Data Interchange Clearinghouse Services Guide details the various reports received throughout the electronic claims process.

Trading Partners are responsible for monitoring the accepted/not accepted reports to ensure that all claims submitted were received and accepted by BCBSLA, and to take corrective action when necessary. The not accepted report identifies claims with critical errors, which were not accepted for processing. All claims that appear on the Not Accepted Claims Report must be corrected and retransmitted for processing.

The Error Description field on this report contains a descriptive summary of why the claim was not accepted for processing (see example below). When possible, the Error Data field will contain the specific code/data found on the claim, which caused the error. Both fields should assist you in making corrections to the claim. This section lists the errors that appear on not accepted reports and a detailed description to assist with error resolution.

The Not Accepted Report provides the patient account number, patient’s last and first names, dates of service, total charge on claim, type of bill (TOB), error description and error data (data on claim that is incorrect).

Example of a Not Accepted Claims Report

<table>
<thead>
<tr>
<th>Error Description Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error Description Field</td>
</tr>
</tbody>
</table>

### Example of a Not Accepted Claims Report

<table>
<thead>
<tr>
<th>Error Description Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error Description Field</td>
</tr>
</tbody>
</table>

---

**July 3, 2003**

**42**
071 REVENUE CODE WITH NO SURGERY CPT4 CODE
071 revenue code can only be present if surgery CPT4 is present on claim or if a diagnosis code of V641-V643 are present on claim.

071SGY
Revenue 071 can only be present if surgery CPT4 code is present on claim or if diagnosis codes V641-V643 is present on claim.

ACCIDENT HOUR INVALID
If value code 45 is present, then a value amount must be present and equal to 0000-2300 or 9900.

ACCIDENT OCC CODE NOT FOUND
If a diagnosis code is within the accident range (525.11, 692.71,692.76, 692.77, 692.82 733.93 to 733.95 and 733.10 to 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6, V15.85, V71.3-V71.6) then an occurrence code of 01-05 must be present.
NOTE: A diagnosis code beginning with an 'E' other than E903-E9049, E9300-E9499 or E9500-E959 is also considered an accident.

ACCOM DAYS VS COV/NCOV DAYS
1. The sum of units indicated for accommodation revenue codes (110-169, 200-219) and leave of absence revenue codes (180-189), is not equal to the allowed days (covered thru date minus covered from date).
2. Check the covered from & thru dates to be sure you have the correct dates entered.
3. Check the units indicated next to accommodation and leave of absence revenue codes.
a. If units exceed the allowed minutes, identify days that exceed the allowed days with one or more of the following revenue codes: 221, 224, or 229.
b. If units are below the allowed days, all days that are below the allowed days must be identified with an accommodation or leave of absence revenue code.

ACCOM REV CODE MUST BE PRESENT
If type bill is 111, 112, 113, 114, 115, or 116 then accommodation revenue code 110-119, 120-129, 130-139, 140-149, 150-159, 160-169, 200-219, 170-174, 179, 190-194, or 199 must be present.

ADMIT DT GREATER THAN FROM DT
The Admission Date can not be greater than the Statement From Date.
ADMIT HOUR INVALID
1. Must be present on all inpatient claims and a valid Admit Hour.
2. Must be four numeric positions indicating hour and minute of admission (hhmm).

AFTER PROV. TERMINATION DATE
The BCBSLA provider number must be effective for the date of service filed on claim.

AMBREV
Revenue code 540 through 545 or 549 must be entered when one of the following HCPCS codes are present: A0425, A0427, A0428, A0429,

ASSIGNMENT OF BENEFITS INVALID
Must be Y or N to indicate if benefits are assigned.

BEFORE PROVIDER EFFECTIVE DATE
The BCBSLA provider number must be effective for the date of service filed on claim.

BLOOD FURNISHED INVALID
The units for revenue codes 380, 381 or 382 must be equal to the value amount for pints of blood furnished (value code 37.)

BLOOD REPLACED INVALID
The value amount of replaced pints of blood (value code 39.) must be equal or less than the value amount for furnished pints of blood (value code 37).

CHARGE = 0
1. If revenue code is duplicated to show multiple procedures, both codes must have a surgical CPT code. If not, a charge must be entered.
2. If a surgery revenue code is duplicated, a charge must be present by at least one of the surgery revenue codes.
3. On inpatient claims, must be present for each revenue code.

CONDITION CODE 31 VS DOB
When condition code 31 (patient full time student age 18-24), the patients date of birth subtracted from current date should be 18-24.
CONTRACT NUMBER INVALID

If Blue Cross Blue Shield of Louisiana (BCBSLA) Contract:

It must be found on the BCBSLA eligibility file and can be 8, 10, 11, or 13 positions.

If 1ST and 2ND positions are alpha:
1. The first two positions must be XU.
2. The 3RD position must be alpha (A-Z)
3. The 4TH thru 9TH positions must be numeric
4. The 10TH position must be numeric, A, B, N, or X.
5. If 10TH positions is A, B, N, or X, the 11TH position must be numeric and remaining positions blank.

Examples: XUA123456X1      XUK123456B1

If 1ST -3RD positions are not alpha
1. 1ST - 6TH positions must be numeric
2. 7TH position must be numeric or A, B, N, or X.
3. If 7TH position is A, B, N, or X, the 8TH position must be numeric and remaining positions blank.
4. If 7TH positions is numeric, then 8TH position must be numeric.
5. If 8TH position is numeric and 9TH position is present, then 9TH position must be numeric.
6. If 9TH position is present, then the 10TH position must be present and numeric (1-9) or C

If contract is OUT OF STATE (out of area) a valid alpha prefix must be present.

Example: YAA123456789

If contract is FEDERAL, the 1ST position must be ‘R’ and the 2ND thru 9TH positions must be numeric.

Example: R034567810

COVERED FROM DATE INVALID

1. Must be six numeric positions. Ex: 010196
2. Must be on or prior to the current date.

COVERED FROM IS A FUTURE DATE

1. Must be a valid date on or prior to the current date.
2. Must be six numeric positions. Ex: 010196
COVERED THRU DATE INVALID
1. Must be a valid date on or after covered from date (first date of service.)
2. Must be six numeric positions. Ex: 122096
3. Must be present if ‘Covered From’ is present
4. Must be on or prior to the current date

DATE OF BIRTH INVALID
Must be a valid date on or before covered date or first date of service.

DIAG AND PATIENT SEX CONFLICT
1. 1ST Two positions must not be 62 or 63 if sex is M
2. 1ST Two positions must not be 60 if sex is F

DIAG CODE IS INVALID
Principal diagnosis code:
1. Principal diag cannot be blank
2. Principal diagnosis cannot begin with ‘E’
3. Must be a valid code for the thru date of service.

DIAG CODE IS MISSING
Diagnosis codes principal or other:
1. Must be present
2. Must be a valid code for the thru date of service.
3. Principal diagnosis cannot be an ‘E’ diagnosis code
4. Other diagnosis must be numeric or begin with E or V

DIAG DIGITS 4 OR 5 REQUIRED
Diagnosis code identified requires 4TH or 5TH position to further describe.

DIAGNOSIS CODE INVALID
Diagnosis codes principal or other:
1. Must be present
2. Must be a valid code for the thru date of service.
3. Principal diagnosis cannot be an ‘E’ diagnosis code.
4. Other diagnosis code must be numeric or begin with E or V.

DISCHARGE STATUS INVALID
Status
1ST and 2ND positions must be numeric and a code of 01-07, 20, 31, or 32.

DUPLICATE CLAIM- PREV RECEIVED
This claim was previously received by BCBSLA. Please do not resubmit.
DUPLICATE DIAGNOSIS CODE
ICD-9 diagnosis code cannot be duplicated.

DUP OCCURRENCE CODE FOUND
Occurrence codes cannot be duplicated.

DXCD IS BLANK WITHIN DXCDS
Can not skip fields in between diagnosis codes

DXL HCPCS CD REQ'S DXL REV CD
DXL HCPCS code '70000' - '76139', '76141'-'77260', '77264'-'77418',
'77421'-'77424'77426'-'77429',77431'-'78989', '78991'-'89999', 'G0030'-
'G0047', 'G0056' - 'G0060', 'G0001'& '36415' is present without a DXL
revenue code of 300-307,309-312, 314,319 -324,329,333,340-342,349-
352,359,390,400-404,409,610-612,619

DXOCDT
If diagnosis code is 905.X, (late effect of fracture), the accident occurrence
date must be prior to the covered date.

FAX NEW ROOMRATE 225-297-2750
The rate entered on room and board exceeds the rate on file at BCBSLA. A
copy of the new rates should be signed by either the business office
manager, CFO, CEO or administrator and faxed to the Provider
Reimbursement Department at 225.295.2750. Three days after you send
the fax, the claim may be resubmitted electronically.

FEP 490 REQUIRES SAME FRM THRU
If outpatient and surgical revenue code is present, statement from and
through dates must be the same.

FEP DATE OF SERVICE INVALID
If outpatient and surgical revenue code is present, statement from and
through dates must be the same.

FEP REMARKS INVALID
If outpatient, when billing for revenue codes 42X, 43X, or 44X on a federal
contract, the actual dates of service must be entered in the remarks field.
Ex. 421 on 8/1 8/3 8/4 8/15, 431 on 8/1 8/3 8/15
HCPCS

1. The CPT/HCPCS procedure code range is:

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021-10022</td>
<td>91100-91299</td>
<td>C1088</td>
</tr>
<tr>
<td>10040-31574</td>
<td>92511</td>
<td>C1300</td>
</tr>
<tr>
<td>31576-36399</td>
<td>92950-92973</td>
<td>C9700-</td>
</tr>
<tr>
<td>36416-36599</td>
<td>92975-92998</td>
<td>C9702</td>
</tr>
<tr>
<td>36601-69990</td>
<td>93501-93572</td>
<td>C9708</td>
</tr>
<tr>
<td>91000-91055</td>
<td>99183</td>
<td>G0167</td>
</tr>
</tbody>
</table>

2. A valid CPT/HCPCS code within the code range listed in #1 above is required when revenue codes 36X, 481, 49X, 790, and 799 are billed unless ICD-9-CM diagnosis codes V64.1, V64.2, or V64.3 are present. If multiple 481 revenue codes are billed, only one of the lines has to contain a valid CPT/HCPCS code.

3. Since revenue code 071 (Louisiana Mandated Service Charge) indicates an outpatient procedure was performed, a claim without a valid CPT/HCPCS code listed in #1 will be returned.

4. A valid CPT/HCPCS code is required for the following revenue codes: 420, 430, 440, 45X, 471, 480, 634-636, 750, 759, 761, 940, and 949. The CPT/HCPCS code does not have to but can be a procedure or diagnostic or therapeutic code listed in #1 or #5. When procedures or diagnostic and therapeutic services are performed, the appropriate CPT/HCPCS code must be given.

5. The Diagnostic and Therapeutic CPT/HCPCS code range is:

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>36400-36415</td>
<td>G0050</td>
<td>J2430</td>
</tr>
<tr>
<td>36600</td>
<td>G0102-G0107</td>
<td>J2993-J2997</td>
</tr>
<tr>
<td>70010-89399</td>
<td>G0120-G0122</td>
<td>J9000</td>
</tr>
<tr>
<td>90939</td>
<td>G0125</td>
<td>J9045</td>
</tr>
<tr>
<td>92974</td>
<td>G0130-G0132</td>
<td>J9190</td>
</tr>
<tr>
<td>91060-91065</td>
<td>G0210-G0234</td>
<td>J9201</td>
</tr>
<tr>
<td>93000-93350</td>
<td>G0236-G0239</td>
<td>J9206</td>
</tr>
<tr>
<td>93600-96999</td>
<td>G0242-G0243</td>
<td>J9265</td>
</tr>
<tr>
<td>97010-97546</td>
<td>J0640</td>
<td>J9310</td>
</tr>
<tr>
<td>A4641-A4647</td>
<td>J1245</td>
<td>J9355</td>
</tr>
<tr>
<td>A9500-A9510</td>
<td>J1440-J1441</td>
<td>Q0136</td>
</tr>
<tr>
<td>C8900-C8914</td>
<td>J1561-J1565</td>
<td>Q0166</td>
</tr>
<tr>
<td>G0001</td>
<td>J1745</td>
<td>Q0179</td>
</tr>
<tr>
<td>G0030-G0047</td>
<td>J2405</td>
<td>Q0180</td>
</tr>
</tbody>
</table>

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Professional-only CPT/HCPCS codes are NOT valid for billing radiological facility services. A few examples of these codes follow: 76140, 77427 and 77261-77263.


HCPCSI
CPT4 code entered is invalid
1. The CPT4 code entered in the HCPCS field is invalid. Must be a valid CPT4 code.
2. Valid CPT4/HCPCS codes for radiology and laboratory are 70010-89399, G0001, G0030-G0047, G0058-G0060, 36415.
3. Valid HCPCS codes for ambulance are A0390, A0427, A0428, A0429.

HCPCSR
CPT4 code required for this revenue code:
1. Revenue codes 360-369, 481, 490 or 499 require a surgical CPT4 code entered in the HCPCS/Rate field. Must be a CPT4 code from the following ranges: 10040-69979, 92975, 92982, 92986, 92990, 93501-93545, or 93561.
2. Revenue codes 480, 750, 759 require CPT4 codes.
4. Revenue codes 540, 541, 542, 543, 544, 545 or 549 require at least one of the following HCPCS code: A0390, A0427, A0428, A0429.

HCPCSS
1. CPT4 code entered must be surgical
2. The CPT4 code entered is not a valid surgical code. Must enter a surgical CPT4 from the following ranges: 10040 thru 69979, 92975, 92982, 92984, 92986, 92987, 92990, 92992, 93501 thru 93536, 93538 thru 93553, 93561, and 93562, or 93561.
**EXCEPTION: CPT4 codes 36415 and 36430 are not valid.

ICD9 PROC CD REQ"S 490 REV CD
Surgery revenue code not present on surgery. A surgery CPT4 is present with a non-surgery revenue code. Revenue code must be 360-369, 480, 481, 490, 499, 750, or 759.

INSUREDS NAME INVALID
Insured’s name cannot be blank. Cannot contain punctuation.
INVALID MODIFIER
The modifier submitted is invalid. When present, modifier must be one of the following codes: 22, 26, 32, 47, 50, 51, 52, 54, 55, 56, 62, 66, 76, 77, 78, 79, 80, 81, 82 or 99.

MAIL DIRECT TO PLAN ON CARD
You have entered an out of area or national account contract that must be filed directly to the address on the subscriber ID card.

MEDICAL RECORD NUMBER MISSING
Medical Record Number is required if entering an out-of-area claim.

MODINV
The modifier indicated is invalid. When present, modifier must be one of the following codes: 20, 22, 26, 32, 47, 50, 51, 52, 54, 55, 56, 62, 66, 76, 77, 78, 79, 80, 81, 82, OR 89.

NC CHGS > THAN COV CHGS
1. Charges must be present if revenue codes are given.
2. If a surgery revenue code is duplicated to show multiple procedures, both codes must have a surgical CPT code. If not, a charge must be entered.
3. If a surgery revenue code is duplicated, a charge must be present by at least one of the surgery revenue codes.

NCOV
Non-covered
1. Must be completed if status is ‘31’ or ‘32’
2. Must be completed if revenue codes 180-189 are present and must be equal to the number shown in the units field corresponding to revenue codes 180-189.

NON COVERED DAYS INVALID
1. Must be completed if status is 31 or 32
2. Must be completed if revenue codes 180-189 are present and must be equal to the number shown in the units field corresponding to revenue codes 180-189.
OCC ACCIDENT DIAG NOT FOUND
For inpatient and outpatient claims: If an occurrence code of 15 is present then a diagnosis code within the accident range (525.11, 692.71, 692.76, 692.77, 692.82, 733.93 to 733.95 and 733.10 to 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6, V15.85, V71.3-V71.6) must be present in the principal diagnosis field.
NOTE: A diagnosis code beginning with an ‘E’ other than E903-E9049, E9300-E9499 or E9500-E959 is considered an accident.

OCC-CI
Occurrence codes 1-4:
1. Must be numeric
2. An occurrence code 01 - 05 must be present if diagnosis code found in the principal or diagnosis1 field is within the range of: 525.11, 692.71, 692.76, 692.77, 692.82, 733.93 to 733.95 and 733.10 to 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6, V15.85, V71.3-V71.6. Note: Diagnosis codes beginning with an ‘E’ other than E903-E9049, E9300-E9499 or E9500-E959 are considered accident.
3. Occurrence code 01-05 must be present if accident hour is present.
4. Must be one of the following:
   01 – Auto accident
   02 – Auto accident/nofault
   03 – Accident/tort liability
   04 – Accident/employment
   05 – Accident/other than above
   11 – Onset of symptoms
   25 – Date benefits terminated by primary payer
   41 – Date of first test for pre-admit test

OCC CD 1, 2, 3, 4. 5 OR 11 REQ’
If revenue code 450 is present, occurrence code 01-05 or 11 must be present.

OCC CD 40 & 41 INVALID ON SURG
Occurrence code 40 and 41 cannot be present on a surgery claim.

OCC CD 40 REQD W/ 41 ON OUTPAT
If occurrence code 41 is present, occurrence code 40 must be present.

OCC CD 41 REQD W/ 40 ON OUTPAT
If occurrence code 40 is present, occurrence code 41 must be present.
OCCURRENCE CODE INVALID
1. Occurrence code must be numeric
2. If revenue code 450 is present, occurrence code 01-05 or 11 must be present.
3. An occurrence code 01-05 must be present if diagnosis code found in the principal or diagnosis 1 field is within the range of (525.11, 692.71, 692.76, 692.77, 692.82, 733.93 - 733.95, 733.10 - 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6, V15.85, V71.3-V71.6)
   NOTE: Diagnosis codes beginning with an ‘E’ other than E903-E9049, E9300-E9499 OR E9500-E959 are considered accident.
4. Occurrence code 01-05 must be present if accident hour is present.
5. Must be one of the following:
   01 – Auto accident
   02 – Auto accident/no fault
   03 – Accident/tort liability
   04 – Accident/employment
   05 – Accident/other than above
   11 – Onset of symptoms
   25 – Date benefits terminated by primary payer
   41 – Date of first test for pre-admit test

OCCURRENCE DATE IS INVALID
Occurrence Date
1. If occurrence code 01-05, 11 or 41 is used, the occurrence date must be equal or prior to the covered from date.
2. If occurrence code 40 is present, the date cannot be prior to or equal the covered from or thru date.
3. If revenue code 450 is present, you must indicate occurrence code 01-05 or 11 with accident date or onset of symptoms.

PAT STATUS PROV PPS STATUS
Discharge status vs provider number:
1. Discharge status cannot be 30 if filing claims for a FMP (Fair Market Pricing) Provider.
2. Claims for FMP providers cannot be split billed.

PATIENT ADDRESS NOT PRESENT
1. Must be present if not BCBSLA contract.
2. Must be present if benefits are not assigned to your facility.(assignment field contains ‘N’).
3. Must be alpha numeric.
PATIENT CITY INVALID
Address city:
1. Must be present if contract is not a BCBSLA contract.
2. Must be present if benefits are not assigned to your facility (assignment field contains 'N').
3. First two positions must be alpha.
4. Remaining positions must be alpha or blank.

PATIENT FIRST NAME INVALID
First name:
1. 1ˢᵗ and 2ⁿᵈ positions must be alpha
2. Remaining positions must be alpha or blank

PATIENT LAST NAME INVALID
Last name:
1. 1ˢᵗ and 2ⁿᵈ positions must be alpha
2. Remaining positions must be alpha or blank

PATIENT NAME INVALID
The first name field cannot contain any of the following: baby, babygirl, babyg, babyboy, babyb, girl, girl, bab, boy, infant, twin, or newbor etc.
The child’s given name must be submitted.

PATIENT STATUS INVALID
1. Patient Status is required for all inpatient claims.
2. 1ˢᵗ and 2ⁿᵈ positions must be numeric and a code of 01-07, 20, 31, or 32.

PAYER 2
If secondary insurance information is present, then a secondary payer name must be entered.

PAYER ID/SUB ID INVALID
1. If the contract alpha prefix is not XU?, then this field must be completed.
2. If outpatient, must be completed if indicating secondary insurance information (COB)

PAYNM1
Must be present and the name of the primary payor.

PRECERT DAYS APPROVED. SPLIT BILL –
If the from and thru dates entered on an inpatient stay does not match the Pre-certification on file. The claim should be split to reflect the approved
PROC
Procedure codes: If present, must be a valid ICD9-CM3 code. If procedure date is present, a procedure code is required.

PROC CD & PATIENT SEX CONFLICT
Procedure code indicated conflicts with sex relationship code entered.

PROC DIGITS 3 OR 4 REQUIRED
Procedure Code:
3rd or 4th position is required to describe the procedure performed.

PROF?
Professional claim:
1. Must be ‘Y’ OR ‘N’
2. Must by ‘Y’ if BCBSLA handles the professional coverage.

PROVIDER NUMBER NOT IN TABLE
The provider number submitted on this claim is not set up to submit electronic claims to BCBSLA. Please contact BCBSLA EDI department at 225. 291.4334 Option 2.

PROVIDER NUMBER NOT ON FILE
The Provider Number must be the 5-digit provider number assigned by BCBSLA to the provider, facility or the designated provider sub unit providing the billed services.

PROVIDER TERMINATED
The BCBSLA provider number must be effective for the date of service filed on claim.

PTCT# 1
1st Position of the patient control number must be completed.

R&B DAYS EXCEED COVFM&THRU DTE
Units of the accommodation revenue codes are greater than the number of covered days.

RATE
1. Rate must be at least 3 numeric positions
2. Must be present if one of the following revenue codes are used: 071, 100-101, 110-117, 119,120-127, 129, 130-137, 139, 140-147, 149, 150-157, 159, 170-174, 179, 200-204, 206-209, 210-214, 219, 381, 382, 389
REL

Patient’s relationship to insured must be valid and present.

RELATION TO INSURED INVALID

1. If patient is not the insured, you must complete this field.
2. If entered, must be 01-05, 10, 13, OR 16.

RELEASE OF INFORMATION INVALID

The release of information must be “Y” if you are filing electronically. This means you have signed written authority to release medical or billing information for purposes of claiming insurance benefits.

RELEASE OF INFORMATION NOT CONFIRMED

The release of information must be “Y” if you are filing electronically. This means you have signed written authority to release medical or billing information for purposes of claiming insurance benefits.

REMARKS MISSING

1. If a revenue code ends in ‘9’, enter description and charge in remarks.
2. If 3rd position of type bill is ‘5’ or ‘6’, enter required information for adjustments/late charges.
3. If occurrence code 01 - 03 or 04 is present, but no accident diagnosis (525.11, 692.71,692.76, 692.77, 692.82 733.93 to 733.95 and 733.10 to 733.19, 800-994, 995.2, 995.4, 995.9, V15.5, V15.6,V15.85, V71.3-V71.6) or a diagnosis code beginning with an ‘E’ other than E903-E9049, E9300-E9499 or E9500-E959 is present in Prin Diag or Diag 1, enter type of accident, date and time of accident in remarks field.
4. If outpatient, when billing for revenue codes 42X, 43X, or 44X on a Federal contract, the actual dates of service must be entered in the remarks field. EX: 421 ON 8/1 8/3 8/4 8/15, 431 ON 8/1 8/3 8/15

REMARKS NOT REQUIRED

The remarks field cannot contain information unless required. If you feel the information entered should be accepted, please call 225.291.4334 for determination on edit change.

REV CODE 0071 TAX DAYS TOO BIG

1. On inpatient claims the rate per day for revenue code 071 is $2.00. The units indicated for revenue code 071 can not exceed the covered days.
2. For outpatient surgery claims the rate for 071 revenue code is $1.00 and the unit of service must equal 1.

REV CODE 0071 CHARGE INVALID
The 071 revenue code for Louisiana Mandated Service Charge can only be submitted on inpatient claims or Outpatient Surgical Claims only.

**REV CODE NOT PRESENT**
A revenue code must be present on each line before revenue code 001.

**REVENUE CODE 0001 NOT PRESENT**
Revenue code 001 must be present.
REVENUE CODE INVALID

Inpatient Revenue Codes

1. Must have valid revenue code present.
2. Revenue code must be 3 numeric positions or blank
3. Revenue code must be present preceding 001 revenue code.
4. Must be valid and **not** one of the following:

   - 000     473-475, 477, 478
   - 002-009 484-488
   - 019-069 491-498
   - 070, 072-099 501-508
   - 118 513-518
   - 128 524-528
   - 138 532-538
   - 148 546-548
   - 158 561-569
   - 160-169 590-599
   - 175 600-609
   - 190-199 620, 622-623, 625-629
   - 205 639
   - 215-218 640-649
   - 225-228 653, 654, 657, 658
   - 236-238 660-669
   - 241-248 670-679
   - 254-255 680-689
   - 262-268 690-699
   - 276 701-708
   - 281-289 711-718
   - 293-298 725-728
   - 308 732-738
   - 313, 315-318 741-748
   - 322, 323, 325-328 751-758
   - 334, 336-338, 343-348 770-779
   - 353-358 780-789
   - 363-366, 368 790-799
   - 371-373, 375-378 805-808
   - 388 815-818
   - 393-398 890-899
   - 403-408 904-908, 913
   - 411, 414-418 925-928
   - 425-428 930-939
   - 435-438 948
   - 445-448 950-959
   - 451-455, 457, 458 460, 461 960-989
Outpatient Revenue Codes

1. Must have valid revenue code present.
2. Revenue code must be 3 numeric positions or blank.
3. Must be valid and not one of the following:
   002-009                  590-599
   020-070, 072-099         605-609
   100-109                  613-618
   118, 128, 138, 148, 158  620, 622-623, 625-629
   161-163, 165-166, 168    639
   173-174, 176-178         640-649
   186-188                  658
   190-199                  660-669
   205, 215-218, 225-228
   236-238, 241-248         680-689
   254-255                  690-699
   262-268                  701-718
   276                      725-728
   281-288                  733-738
   294-298                  741-748
   308                      751-758
   313, 315-318             765-768
   322, 333,334             770-779
   335-338                  780-789
   343-348                  791-798
   353-358                  800-809
   363-366, 368             815-818
   372-373, 375-378         826-828
   388                      835-838
   393-398                  846-848
   404-408                  856-858
   411, 414-418             860-869
   425-428                  870-879
   435-438                  882-888
   445-448                  890-898
   451-455, 457, 458        904-908
   461-468                  913
   473-478                  926-928
   484-488                  930-939
   491-498                  948
   501-508                  950-959
   513-518                  960-989
   524-528                  532-538, 547-548
   553-558, 563-568         573-578, 583-588
SEND CLAIM TO HOME PLAN
This claim must be filed directly with the Home Plan indicated on the subscriber's id card.

SEX
Must be present. Valid codes are M or F.

SGYREV
Surgery revenue code not present on surgery:
A surgery CPT4 code is present with a non-surgery revenue code.
Revenue code must be 360-369, 480, 481, 490, 499, 750, or 759.

SOURCE OF ADMISSION INVALID
Admission source must be completed if contract is out of state (out-of-area).

SPAN CODE INVALID
The span code must be blank on BCBSLA inpatient claims.

SPLIT BILL BY DATE OF SERVICE-
This contact requires that the revenue codes indicated must be split by date of service or a specific date of service is required for each.

STATE
1. Must be present if billing an out of state (out of area) claim
2. Must be present if benefits are not assigned to your facility (assigned field contains N)
3. Must be alpha

STATP#
This provider number is not allowed to submit interim bills. This provider number must submit all charges on one claim using the type of bill 111 and discharge status cannot be 30.

SUPP CONT# FILE ON SUPP SCREEN
You have entered a BCBSLA supplemental contract number. Your claim should crossover from the Medicare intermediary. If your claim does not automatically crossover, submit on the iLinkBlue hospital supplemental screen. For more information on the iLinkBlue website call 225.293.5465.
TOB INV WITH PATIENT STATUS
Type bill vs status
1. If type bill is 112 or 113 then discharge status code must be 30
2. If type bill is 114 then discharge status cannot be 30.

TOT001
The total:
1. Must be numeric and greater than zero
2. Must be present
3. Must equal total charges for revenue codes entered.
4. Must use revenue code 001 for total
5. If revenue 070 is present, charge must be subtracted from total 001.

TOTAL CHARGE = ZEROES
Revenue code 001 must be greater than zero.

TOTCHG CANNOT EXCEED $999,999
Total charges cannot be greater then $999,999.99 on one claim. If you are not an FMP provider, you should split these charges and file two separate electronic claims. FMP providers must mail the complete UB92 for processing. Submit this claim hardcopy to BCBSLA.

TOTCHG ON NASCO EXCEEDS 99,999
NASCO claims with total charges greater than $99,999.99 must be mailed to BCBSLA for processing.

TYBL
Type Bill - Inpatient
Must be 3 numeric positions
1. 1ST position must be 1 or 8
2. 2ND position must be 1, 2, or 3
3. 3RD position must be 1, 2, 3, 4, 5, or 6
4. 3RD position cannot be 2, 3, or 4 if provider participates in the Fair Market Pricing Program.

Type Bill - Outpatient
Must be 3 numeric positions
1. 1ST positions must be 1 or 8 (special facility)
2. 2ND position must be 3, or if 1ST position is 8, 2ND position must be 2 or 3
3. 3RD position must be 1, 5, or 6
4. If 5 or 6 in 3RD position, must be submitting and adjustment claim.
TYPE OF ADMISSION INVALID
Admission type must be completed if contract is out of state (out-of-area).

UNITRT
Units times the rate must equal the charges.

UNITS1
Units must equal 1 for revenue code 45X.

UNITS REQUIRED FOR REVCD
Inpatient Units Required
1. Must be numeric if present
2. Must be present if any of the following revenue codes are used on an inpatient bill: 071, 100-117, 119, 130-137, 139, 140-147, 149, 150-157, 159, 170-174, 180-189, 200-204, 206-209, 210-214, 219, 380, or 382

Outpatient Units Required
1. Must be numeric if present
2. Must be present if any of the following revenue codes are used and 2ND position of type bill is ‘3’: 301-309, 310-319, 320-329, 330-339, 340-349, 350-359, 381-382, 400-409.420, 430, 440, 610-619, 820-821, 830-831, 840-841, or 850

VALAMT
Value Amount
1. If a value code is present, then a value amount is required.
2. For inpatient billing, if value code 45 is present, then value amount must equal 0100-2300, or 9900
3. For outpatient billing, if value code 45 is present, then value amount must equal 0000-2300 or 9900

VCACHR
Value code accident hour
1. If occurrence code 01-05 is present, then value code 45 (accident hour) and hour accident occurred is required.
2. To indicate the accident hour, use codes for admit hour followed by two zeros.
   Example: Accident hour 5:45 pm use 1700

VLCBLD
Value code blood furnished
If revenue code 380, 381, or 382 is present, value code 37 (pints of blood furnished) and value amount is required. Value amount must be numeric and equal to the sum of units for blood revenue codes.
ZIP

1. Must be present if contract is out of state (out of area)
2. Must be present if benefits are not assigned to your facility