CareFirst, Inc.

HIPAA Transactions & Code Sets

Companion Guide

Refers to the Implementation Guides Based on X12 version 004010A1

Companion Guide Version: 8.0

November 12, 2004

This Companion Guide is issued in an effort to provide the trading partners of CareFirst, Inc. with the most up-to-date information related to standard transactions. Any and all information in this guide is subject to change at any time without notice. Each time you test or submit a standard transaction, we recommend that you refer to the most recently posted Companion Guide to ensure you are using the most current information available.

This Companion Guide is applicable to all lines of business within CareFirst, Inc.

Disclosure Statement

This document has been designed to assist both technical and business areas of our trading partners who wish to submit HIPAA standard transactions. It contains specifications of the transaction, contact information, and other information we believe may be helpful to our trading partners in working with us toward compliance with HIPAA transaction and code set requirements.

All instructions in this document were written using information known at the time of publication and may change. The most up-to-date version of the Companion Guide is available on the CareFirst, Inc. (CareFirst) Web site (http://www.carefirst.com).

Please be sure that any printed version you use is the same as the latest version available at the CareFirst Web site. Most users will choose to test their systems and transmissions; the X12 file responses you receive during testing are not a guarantee of payment. CareFirst is not responsible for the performance of software you may use to complete these transactions.

Change Summary - Document History

Version	Date	Description
1.0	May 14, 2003	Original Issue
2.0	July 7, 2003	Updated 834 table; revised format of Appendices; added more detailed zip file instructions
3.0	August 4, 2003	Added content for 270/271, 276/277, 835. Updates to 837.
4.0	August 24, 2003	Updated tables for 834, 835 and 837. Added FAQs.
5.0	December 8, 2003	Additional content and revised tables for 278 and 835. Added additional FAQs. Added Appendix J – Reading a 997.
6.0	December 15, 2003	Updates to 835 table. Remove references to “direct submission.”
7.0	February 26, 2004	Added content for 820. Entire section Added content for 834. Entire section
8.0	November 12, 2004	Revisions to 834, 835, 837I and 837 P

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1. Introduction

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Administrative Simplification provisions, the Secretary of the Department of Health and Human Services (HHS) was directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Audience

This document is intended to provide information to our trading partners about the submission of standard transactions to CareFirst. It contains specifications of the transactions, helpful guidance for getting started and testing your files as well as contact information. This document includes substantial technical information and should be shared with both technical and business staff.

Purpose of the Companion Guide

This Companion Guide to the ASC X12N Implementation Guides, inclusive of addenda, adopted under HIPAA clarifies and specifies the data content required when data is transmitted electronically to CareFirst. File transmissions should be based on this document, together with the X12N Implementation Guides.

This guide is intended to be used **in conjunction with** X12N Implementation Guides, not to replace them. Additionally, this Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

This HIPAA Transactions and Code Sets Companion Guide explains the procedures necessary for trading partners of CareFirst to conduct Electronic Data Interchange (EDI) transactions. These transactions include:

- Health Care Eligibility Benefit Inquiry and Response ASC X12N 270/271
- Health Care Claim Status Request and Response ASC X12N 276/277
- Health Care Services Review-Request for Review and Response ASC X12N 278
- Payroll Deducted and Other Group Premium Payment ASC X12N 820
- Benefit Enrollment and Maintenance ASC X12N 834
- Health Care Claim Payment/Remittance Advice ASC X12N 835
- Health Care Claim: Institutional ASC X12N 837I
- Health Care Claim: Professional ASC X12N 837P
- Health Care Claim: Dental ASC X12N 837D
- Health Care Claim: Pharmacy NCPDP5.1

All instructions in this document were written using information known at the time of publication and are subject to change. Future changes to the document will be available on the CareFirst Web site (http://www.carefirst.com).

Please be sure that any printed version is the same as the latest version available at the CareFirst

website. CareFirst is not responsible for the performance of software you may use to complete these transactions.

1.1 Scope

This guide is intended to serve as the CareFirst Companion Guide to the HIPAA standard transaction sets for our Maryland, District of Columbia and Delaware operations. This document supplements, but does not replace, any requirements in the Implementation Guides and addenda. It assumes that the trading partner is familiar with the HIPAA requirements in general, and the HIPAA X12 requirements in particular.

This guide will be expanded and updated as additional standard transactions are ready for testing. Consult Section 7 – Transaction Details Update History – to determine if you have the most current version for the standard transaction of interest to you.

This guide will be useful primarily when first setting up the structure of data files and the process for transmitting those files to CareFirst.

1.2 Implementation Guides

Implementation Guides are available from the Washington Publishing Company's Web site at http://hipaa.wpc-edi.com/HIPAA_40.asp.

1.3 Glossary

A glossary of terms related to HIPAA and the Implementation Guides is available from the Washington Publishing Company's Web site:
http://www.wedi.org/snip/public/articles/HIPAA_GLOSSARY.PDF

1.4 Additional Information

The CareFirst entities acting as health plans are covered entities under the HIPAA regulations. CareFirst is also a business associate of group health plans, providing administrative services (including enrollment and claims processing) to those group health plans. Submitters are generally either covered entities themselves, or are business associates of covered entities, and must comply with HIPAA privacy standards. As required by law, CareFirst has implemented and operationalized the HIPAA privacy regulations. Therefore, it can be expected that protected health information (PHI) included in your test or live data provided in ACS X12N transactions will be handled in accordance with the privacy requirements, and we expect that submitters as covered entities or business associates of covered entities will also abide by the HIPAA privacy requirements.

1.5 CareFirst Contacts

All inquiries regarding set-up, testing, and file submission should be directed to hipaa.partner@carefirst.com.

2. Getting Started

CareFirst will accept X12 standard transactions from all covered entities and business associates. If you are not currently doing business with CareFirst under a provider, business associate, broker, or other agreement, please contact hipaa.partner@carefirst.com for instructions on how to submit files to us.

Blue Cross and Blue Shield of Delaware can accept direct submission of 837 Claim transactions and return 835 Remittance Advice transactions from registered trading partners. The Maryland region and National Capital area have contracted with preferred vendor clearinghouses to submit 837 Claims and receive 835 Remittance Advice transactions from CareFirst

CareFirst does not currently accept 270/271 and 276/277 transactions in a batch mode.
This information is available through CareFirst Direct which is a free web-based capability. For more information on CareFirst Direct refer to our website at www.CareFirst.com, in the Electronic Service

This chapter describes how a submitter interacts with CareFirst for processing HIPAA-compliant transactions.

2.1 Submitters

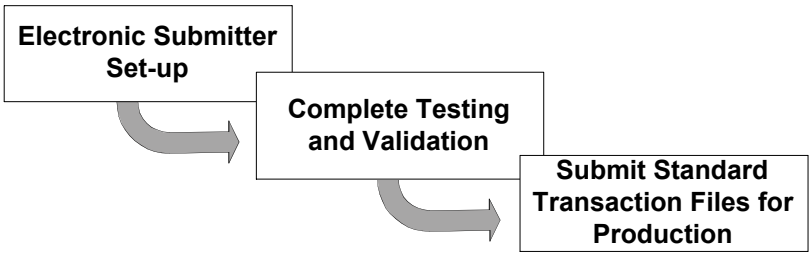
A submitter is generally a covered entity or business associate who submits standard transactions to CareFirst. A submitter may be acting on behalf of a group of covered entities (e.g., a service bureau or clearinghouse) or may be submitting inquiries or data for a provider or group health plan. When you register, you are acting as a "submitter." Some X12 transactions are "response" transactions (e.g. 835, 271). In those transactions the "submitter" will receive CareFirst's response. In these cases, the user may be referred to as the "receiver" of the transaction. This Companion Guide will use the terms "you" and "submitter" interchangeably.

2.2 Support

Questions related to HIPAA compliance requirements or to the file submission and response process should be sent to hipaa.partner@carefirst.com.

2.3 Working with CareFirst

In general, there are three steps to submitting standard transactions to the CareFirst production environment.



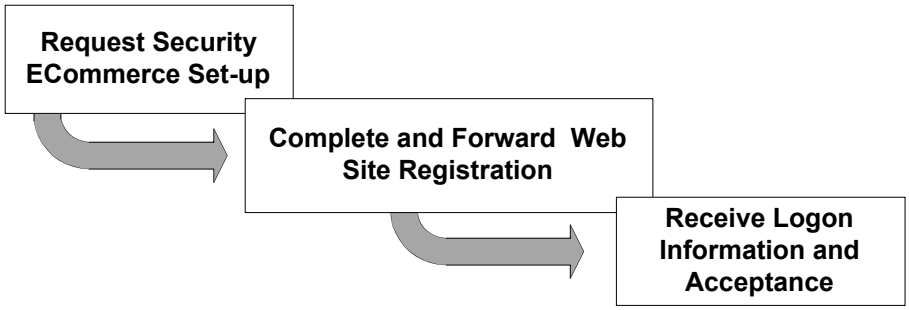
Step	Description
1	You will be asked to register with CareFirst for both electronic commerce and EDI transmissions. Section 2.4 provides details on the registration process.
2	Once you are registered, you will be able to log in to the E-Submitter Secure File Transfer (SFT) Web site that allows you to submit files for validation testing. Validation testing ensures that our systems can exchange standard transactions without creating a disruption to either system.
3	After demonstrating that your files are HIPAA-compliant in our test system, you may then submit files to the production environment, which is also accomplished through the SFT Web site.

2.4 E-Submitter Set-up

All CareFirst submitters will be asked to complete the appropriate set-up and authorization process in order to transmit electronic files to CareFirst. The process is as follows:

Blue Cross and Blue Shield of Delaware can accept direct submission of 837 Claim transactions and return 835 Remittance Advice transactions from registered trading partners. At this time, CareFirst has contracted with preferred vendor clearinghouses to submit 837 Claims and receive 835 Remittance Advice transactions from CareFirst for the Maryland region and National Capital area.

CareFirst does not currently accept 270/271 and 276/277 transactions in a batch mode. This information is available through CareFirst Direct which is a free web-based capability. For more information on CareFirst Direct refer to our website at www.CareFirst.com, in the Electronic Service section.



Stage	Description
1	To obtain forms send a request to hipaa.partner@carefirst.com.
2	Complete and return the forms to CareFirst. Be sure to indicate which standard transactions you will submit.
3	Within 7 – 10 business days, your electronic registration will be complete. CareFirst will contact you with information about how to access the Web site for transmitting HIPAA-related transactions.

3. Testing with CareFirst

CareFirst encourages all submitters to participate in testing to ensure that your systems accurately transmit and receive standard transactions through Secure File Transfer (SFT).

3.1 Phases of CareFirst's testing

Phase 1 – Checks compliance for WEDI/SNIP testing types 1 and 2 PLUS CareFirst specific requirements and verifies your receipt of the appropriate 997 acknowledgement.

Phase 2 – Checks compliance for all applicable WEDI/SNIP testing types, and validates your ability to receive the associated 997 or appropriate response transaction (e.g. 835 or 277).

Completion of these phases indicates that your systems can properly submit and receive standard transactions.

3.2 ANSI File Requirements

For testing purposes, create a zipped ANSI X12 test file that includes at least 25 live transactions. Be sure that your zipped file only includes **one** test file. If you wish to submit multiple files, please zip them separately and send one at a time.

Do not include dummy data. This file should contain transaction samples of all types you will be submitting electronically.

Please name your files in the following format: [TP Name - Transaction - date_timestamp].zip
An example of a valid filename would be: TradingPartner-834-042803_110300.zip

For assistance analyzing your test results, contact hipaa.partner@carefirst.com.

3.3 Third-Party Certification

Certification is a service that allows you to send a test transaction file to a third party. If the test file passes the edits of that third party, you will receive a certification verifying that you have successfully generated HIPAA-compliant transactions at that time. The certificate implies that other transactions you may send to other parties will also pass applicable edits.

CareFirst does not require anyone sending HIPAA transactions to be certified by a third party. However, we encourage third-party certification. The process of becoming certified will assist you in determining whether your system is producing compliant transactions.

3.4 Third-Party Testing

As an alternative to certification, you can contract with a third party to test your transactions. Third-party testing allows you to assess how well your transactions meet the X12 and HIPAA Implementation Guide standards prior to conducting testing with each of your trading partners.

For information on third-party certification and testing, please see the WEDI/SNIP white paper at http://www.wedi.org/snip/public/articles/testing_whitepaper082602.pdf.

For a list of vendors offering HIPAA testing solutions, please see the WEDI/SNIP vendor lists at http://www.wedi.org/snip/public/articles/index%7E4.htm.

3.5 Browser Settings

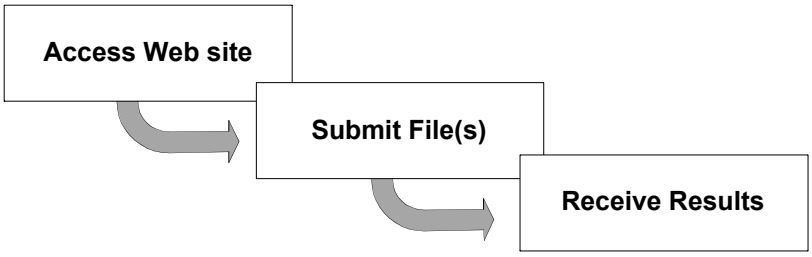
The HIPAA-compliant applications developed by CareFirst use cookies to manage your session. If you have set your browser so that it does not allow cookies to be created on your PC, the applications will not function properly. For additional information on cookies and instructions on how to reset these settings, please review the Help section in your browser.

4. Submitting Files

4.1 Submission Process

The Secure File Transfer (SFT) Web site will allow users to transmit many file types to CareFirst using a standard internet browser. Please refer to the appendix for each standard transaction you are interested in sending.

Each file submission consists of the following stages:



Stage	Description
1	Go to the Secure File Transfer (SFT) Web site. Log in using your submitter ID and password provided by CareFirst.
2	Submit a file for testing or production.
3	Review acknowledgements and results in your SFT mailbox. **Note**: In the testing phase, Stages 1 and 2 will need to be repeated until the file is validated according to the CareFirst testing standards.

5. Contact information

All inquiries regarding set-up, testing, and file submission should be directed to hipaa.partner@carefirst.com.

6. Transaction Details Update History

CareFirst will update this Companion Guide when additional information about the covered transactions is available. The following list will indicate the date of the last update, and a general revision history for each transaction.

Appendix A: 270/271 – Last Updated July 11, 2003

First release 7/11/03

Appendix B: 276/277 – Last Updated July 11, 2003

First release 7/11/03

Appendix C: 278 – Last Updated November 17, 2003

Table updates 11/17/03
First release 10/6/03

Appendix D: 820 – Last Updated April 15, 2004

First release 4/15/04

Appendix E: 834 – Last Updated November 12, 2004

Table updates 11/12/04
Table updates 4/15/04
Table updates 8/29/2003
Table updates 6/10/2003
First release 5/14/03

Appendix F: 835 – Last Updated November 12, 2004

Table updates 11/12/04
Table updates 12/8/03
Added File Receipt Schedule and Table updates 10/6/03
Table updates 8/11/03
First release 7/21/03

Appendix G: 837 I – Last Updated November 12, 2004

Table updates 11/12/04
Table updates 4/15/04
Table updates 8/11/03
Table updates 7/21/2003
Table updates 6/6/2003
First release 5/14/03

Appendix H: 837 D – Not Yet Released

Appendix I: 837 P – Last Updated November 12, 2004

Table updates 11/12/04
Table updates 4/15/04
Table updates 8/11/03
Table updates 7/21/2003
Table updates 6/6/2003
First release 5/14/03

7. Appendices and Support Documents

The Appendices include detailed file specifications and other information intended for technical staff.

This section describes situational requirements for standard transactions as described in the X12N Implementation Guides (IGs) adopted under HIPAA. The tables contain a row for each segment of a transaction that CareFirst has something additional, over and above, the information contained in the IGs. That information can:

- Specify a sub-set of the IGs internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to electronic transactions with CareFirst.

In addition to the row for each segment, one or more additional rows may be used to describe CareFirst's usage for composite and simple data elements and for any other information.

Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

7.1 Frequently Asked Questions

The following questions apply to several standard transactions. Please review the appendices for questions that apply to specific standard transactions.

Question: I have received two different Companion Guides that I've been told to use in submitting transactions to CareFirst. One was identified for CareFirst; the other identified for CareFirst Medicare. Which one do I use?

Answer: The CareFirst Medicare A Intermediary Unit is a separate division of CareFirst, which handles Medicare claims. Those claims should be submitted using the Medicare standards. All CareFirst subsidiaries (including CareFirst BlueCross BlueShield, CareFirst BlueChoice, BlueCross BlueShield of Delaware) will process claims submitted using the CareFirst standards, as published in our Companion Guide.

Question: I submitted a file to CareFirst and didn't receive a 997 response. What should I do?

Answer: The most common reason for not receiving a 997 response to a file submission is a problem with your ISA or GS segment information. Check those segments closely:

- The ISA is a fixed length and must precisely match the Implementation Guide.
- In addition, the sender information must match how your user ID was set up for you.

If you are unable to find an error, or if changing the segment does not solve the problem, copy the data in the ISA and GS segment and include them in an e-mail to hipaa.partner@carefirst.com.

Question: Does CareFirst require the use of the National Provider ID (NPI) in the Referring Physician field?

Answer: The NPI has not yet been developed; therefore CareFirst does not require the NPI nor any other identifier (e.g., SSN, EIN) in the Referring Physician field. On a situational basis, for BlueChoice claims, a specialist may enter the eight-character participating provider number of the referring physician.

Question: Does CareFirst accept and use Taxonomy codes?

Answer: CareFirst accepts Taxonomy codes, but does not use them in our adjudication system at this time.

7.2 Contact information

For all inquiries related to HIPAA compliance requirements or to the file submission and response process contact hipaa.partner@carefirst.com.

8. Appendix A: 270/271 Transaction Detail

8.1 CONTROL SEGMENTS/ENVELOPES

8.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

8.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

8.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

8.2 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N Implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N Implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

270						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
B.5		**ISA 08**	Interchange Receiver ID	15		CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
B.5		**ISA13**	Interchange Control Number	9		CareFirst recommends every file must have a unique identifier.
B.6		**ISA16**	Component Element Separator	1		CareFirst recommends to always use ':' (colon).
B.8		**GS03**	Application Receiver's Code	15		CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE

270						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
TRANSACTION SET HEADER						
39		**BHT02**	Transaction Set Purpose Code	2	**13**	CareFirst recommends always setting to '13' for Request
DETAIL - INFORMATION SOURCE LEVEL						
44	**2100A**	**NM101**	Entity Identifier Code	2	**PR**	CareFirst recommends always setting to 'PR' for Payer
45	**2100A**	**NM102**	Entity Type Qualifier	1	**2**	CareFirst recommends always setting to '2' for Non-Person Entity
46	**2100A**	**NM108**	Identification Code Qualifier	2	**PI**	CareFirst recommends always setting to PI for Payer ID Number.
46	**2100A**	**NM109**	Information Source Primary Identifier	5	**See Note**	CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
DETAIL - INFORMATION RECEIVER LEVEL						
52	**2100B**	**NM108**	Identification Code Qualifier	2	**24**	CareFirst recommends always setting to '24' for Employer's Identification Number.
DETAIL - SUBSCRIBER LEVEL						
68	**2000C**	**HL04**	Hierarchical Child Code	1	**0 – Patient is Subscriber** **1 – Patient is Dependent**	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
72	**2100C**	**NM104**	Name First	25		CareFirst recommends this field be used (only if subscriber is patient)
73	**2100C**	**NM108**	Identification Code Qualifier	2	**MI**	CareFirst requires this field always and recommends setting to MI for Member Identification Number
73	**2100C**	**NM109**	Subscriber Primary Identifier	3/17		CareFirst requires this field always. CareFirst recommends you must include 1-3 Character Alpha Prefix as shown on Customer ID Card for ALL PLAN Codes.
84	**2100C**	**DMG01**	Date Time Period Format Qualifier	2	**D8**	CareFirst requires this field always if subscriber is patient
84	**2100C**	**DMG02**	Subscriber Birth Date	8		CareFirst requires this field always if subscriber is patient
84	**2100C**	**DMG03**	Subscriber Gender Code	1	**M – Male** **F – Female**	CareFirst recommends this field be used (only if subscriber is patient)
86	**2100C**	**INS02**	Individual Relationship Code	2	**18 – Self**	CareFirst recommends this field be used (only if subscriber is patient)
88	**2100C**	**DTP01**	Date/Time Qualifier	3	**307**	CareFirst recommends always setting to 307 for Eligibility
88	**2100C**	**DTP02**	Date Time Period Format Qualifier	2	**D8**	CareFirst will only accept one Eligibility Date, not a date range, so recommends always setting to D8 for CCYYMMDD
88	**2100C**	**DTP03**	Date Time Period	8		CareFirst recommends limiting the occurrence of the DTP segment to 1. CF is expecting only 1 occurrence of the SUBSCRIBER-DATE. Future dates will not be accepted and the date must also be within the last calendar year.

270						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
90	**2110C**	**EQ01**	Service Type Code	2	**30**	CareFirst will respond with a general medical response: 30 – Health Benefit Plan Coverage
DETAIL - DEPENDENT LEVEL						
115	2100D	**NM104**	Name First	25		CareFirst recommends this field be used (only if dependent is the patient).
125	2100D	**DMG01**	Date Time Period Format Qualifier	2	**D8**	CareFirst requires this field always if dependent is patient
125	2100D	**DMG02**	Dependent Birth Date	8		CareFirst requires this field always if dependent is patient
125	2100D	**DMG03**	Dependent Gender Code	1	**M – Male** **F – Female**	CareFirst recommends this field be used (only if dependent is patient)
127	2100D	**INS02**	Individual Relationship Code	2	**01 – Spouse** **19 – Child** **34 – Other Adult**	CareFirst recommends this field be used (only if dependent is patient)
130	2100D	**DTP01**	Date/Time Qualifier	3	**307**	CareFirst recommends always setting to 307 for Eligibility
130	2100D	**DTP02**	Date Time Period Format Qualifier	2	**D8**	CareFirst will only accept one Eligibility Date, not a date range, so recommends always setting to D8 for CCYYMMDD
130	2100D	**DTP03**	Date Time Period	35		CareFirst recommends limiting the occurrence of the DTP segment to 1. CF is expecting only 1 occurrence of the DEPENDENT-DATE. Future dates will not be accepted and the date must also be within the last calendar year.
132	2110D	**EQ01**	Service Type Code	2	**30**	CareFirst will respond with a general medical response: 30 – Health Benefit Plan Coverage

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- Response will include Subscriber ID, Patient Demographic Information, Primary Care Physician Information(when applicable), Coordination of Benefits Information (when applicable), and Detailed Benefit Information for each covered Network under the Medical Policy

- The EB Loop will occur multiple times providing information on EB01 Codes (1 – 8, A, B, C, & L), Policy Coverage Level, Co-Pay/Co-Insurance amounts and relevant frequencies, and Individual & Family Deductibles, all encompassed within a General Medical Response (Service Type = 30).

- When Medical Policy Information is provided, basic eligibility information will be returned for dental and vision policies

- The following AAA segments will be potentially returned as errors within a 271 response:

#	Exception Description	HIPAA Error Response Code		
		AAA01	**AAA03**	**AAA04**
1	Patient Date of Birth is greater than the current System Date	N – No	58 – Invalid/ Missing Date of Birth	C – Please correct and resubmit
2	Date of Service does not fall within the last calendar year	N – No	62 – Date of Service Not Within Allowable Inquiry Period	C – Please correct and resubmit

#	Exception Description	HIPAA Error Response Code		
		AAA01	AAA03	AAA04
3	Date of Service is greater than the current System Date	N – No	63 – Date of Service in Future	C – Please correct and resubmit
4	Patient Date of Birth is greater than Date of Service	N – No	60 – Date of Birth Follows Date(s) of Service	C – Please correct and resubmit
5	Cannot identify patient	Y – Yes	67 – Patient Not Found	C – Please correct and resubmit
6	Membership number is not on file	Y – Yes	75 – Subscriber/ Insured not found	C – Please correct and resubmit
7	There is no response from the legacy system.	Y – Yes	42 – Unable to respond at current time.	R – Resubmission allowed

8.3 FREQUENTLY ASKED QUESTIONS

Question: We currently submit claims and eligibility inquiries through RealMed. Will that ability continue? Will it apply to all CareFirst plans?

Answer: RealMed has informed us that they are HIPAA-compliant. We expect that we will continue our relationship with RealMed for real-time claims and inquiry submission.

8.4 ADDITIONAL INFORMATION

For more information on these transactions, or access to our Web site, please contact hipaa.partner@carefirst.com.

9. Appendix B: 276/277 – Transaction Detail

9.1 CONTROL SEGMENTS/ENVELOPES

9.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

9.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

9.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

9.2 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

276						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
B.5		**ISA08**	Interchange Receiver ID	15		**CareFirst recommends to:** **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
B.6		**ISA16**	Component Element Separator	1		CareFirst recommends to always use ':' (colon)
B.8		**GS03**	Application Receiver's Code	15		**CareFirst recommends to:** **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
DETAIL - INFORMATION SOURCE LEVEL						

276						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
55	2100A	**NM108**	Identification Code Qualifier	2	**PI**	CareFirst recommends always setting to 'PI' for Payer ID Number
56	2100A	**NM109**	Payer Identifier	5	**See Note**	CareFirst recommends to: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
DETAIL – SERVICE PROVIDER LEVEL						
68	2100C	**NM108**	Identification Code Qualifier	2	**FI – Fed. Tax ID** **SV – Service Provider ID**	CareFirst recommends that Loop 2100C be repeated twice, with the following data: 1. 'FI' 2. 'SV'
69	2100C	**NM109**	Provider Identifier	2/80		CareFirst recommends that Loop 2100C be repeated twice, with the following data: 1. Federal Tax ID 2. Service Provider ID Set to PV40 # for CareFirst MD Set to PA&R # for CareFirst DC Set to Provider ID submitted with claim for CareFirst DE
DETAIL – SUBSCRIBER LEVEL						
70	2000D	**HL04**	Hierarchical Child Code	1	**0 – Patient is Subscriber** **1 – Patient is Dependent**	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
75	2100D	**NM104**	Subscriber First Name	1/25		CareFirst recommends this field be used (only if subscriber is patient)
75	2100D	**NM108**	Identification Code Qualifier	2	**MI**	CareFirst recommends always setting to MI for Member Identification Number and requires this field
86	2200D	**DTP03**	Date Time Period	17		CareFirst requires this field always. The following situations must be met for dates to be considered valid: - The 'From Date of Service' must be within the last 3 years - The 'From Date of Service' and 'To Date of Service' must not span more than one calendar year - The 'To Date of Service' must not be greater than the current System Date
DETAIL – DEPENDENT LEVEL						
99	2100E	**NM104**	Patient First Name	1/25		CareFirst recommends this field be used (only if subscriber is patient)
112	2200E	**DTP03**	Date Time Period	17		CareFirst requires this field always. The following situations must be met for dates to

276						
Page #	**Loop ID**	**Reference**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
						be considered valid: - The 'From Date of Service' must be within the last 3 years - The 'From Date of Service' and 'To Date of Service' must not span more than one calendar year - The 'To Date of Service' must not be greater than the current System Date

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- CareFirst will respond with all claims that match the input criteria, returning claim level information and all service lines.
- Up to 99 claims will be returned on the 277 response. If more than 99 claims exist that meet the designated search criteria, an error message will be returned requesting that the Service Date Range be narrowed.
- 277 responses will include full Claim Detail.
- Header Level Detail will be returned for all claims that are found.
- Line Level Detail will be returned for all claims found with Finalized Status. In some cases, claims found with Pended Status will be returned with no Line Level Details.
- The following status codes will potentially be returned as error responses within a 277:

#	Exception Description	HIPAA Error Response Code	
		STC01-1	STC01-2
1	Claim Service Period From Date is greater than three years ago	E0: Response not possible – Error on submitted request data	187: Dates of Service
2	Claim Service Period To Date is greater than the current System Date	E0: Response not possible – Error on submitted request data	187: Dates of Service
3	Patient Date of Birth is greater than the current date	E0: Response not possible – Error on submitted request data	158: Entity's Date of Birth
4	Claim Service Period To Date is less than Claim Service Period From Date	E0: Response not possible – Error on submitted request data	187: Dates of Service
5	Claim Service Period Date Range (To – From) is greater than one calendar year	E0: Response not possible – Error on submitted request data	187: Dates of Service
6	Patient Date of Birth is greater than Claim Service Period From Date	E0: Response not possible – Error on submitted request data	158: Entity's Date of Birth
7	The legacy data-store is unable to be reached or no response received from query	E1: Response not possible – System Status	484: Business application currently not available
8	There are more than 99 claims that match the designated search criteria.	R5: Request for more specific detail – Additional information, as a follow up to a previous request, is needed. More specific information is requested	187: Dates of Service
9	No matching claim records found on legacy.	A4: The claim/ encounter cannot be found in the adjudication system	35: Claim/ encounter not found

9.3 FREQUENTLY ASKED QUESTIONS

Question: My office currently uses IASH to respond to claim denials and adjustments. Is this still available?

Answer: Yes. Current users of IASH (and other DCACCESS) functions have been migrated to our new web-based application called CareFirst Direct which includes IASH features. To sign-up for CareFirst Direct go to our website, www.CareFirst.com, in the Electronic Service section. Any questions concerning CareFirst Direct can be directed to hipaa.partner@CareFirst.com

9.4 ADDITIONAL INFORMATION

For more information on these transactions, or access to our Web site, contact hipaa.partner@carefirst.com.

10. Appendix C: 278 – Transaction Detail

10.1 CONTROL SEGMENTS/ENVELOPES

10.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

10.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

10.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

10.2 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

278 Inbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.5		**ISA08**	**8**	Interchange Receiver ID	15		**CareFirst recommends to:** **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
B.5		**ISA13**	13	Interchange Control Number	9		CareFirst recommends every file must have a unique identifier
B.6		**ISA16**	16	Component Element Separator	1		CareFirst recommends to always use ':' (colon).

278 Inbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.8		**GS03**	3	Application Receiver's Code	15		CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
Transaction Set Header							
51		**BHT02**	2	Transaction Set Purpose Code	2		CareFirst recommends always setting to '13' for Request
Detail – Utilization							
57	**2010A**	**NM109**	9	Information Source Primary Identifier	5		CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
Detail - Requester							
62	**2010B**	**NM109**	9	Information Source Primary Identifier	5		CareFirst recommends: **For Professional Providers:** Set to 00580 for CareFirst DC Set to 00690 for CareFirst MD Set to 00570 for CareFirst DE **For Institutional Providers:** Set to 00080 for CareFirst DC Set to 00190 for CareFirst MD Set to 00070 for CareFirst DE
Detail – Subscriber Level							
74	**2000C**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
90	**2010C**	**NM108**	8	Identification Code Qualifier	8		CareFirst recommends set 'MI' for Plan Code 00070 and 00570 (DE), 00080 and 00580 (DC), 00190 and 00690 (MD).
91	**2010C**	**NM109**	9	Identification Code	80		CareFirst recommends that the Identification Code include the 1-3 Character Alpha Prefix as shown on Customer ID Card for Plan Codes 00080 and 00580 (DC) , 00190 and 00690 (MD). CareFirst requires that the Identification Code include the 1-3 Character Alpha Prefix for Plan Codes 00070 and 00570 - (DE).
Detail – Dependent Level							

278 Inbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
97	**2000D**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
119	**2010D**	**INS02**	2	Individual Relationship Code	2	01 – Spouse 19 – Child 34 – Other Adult	CareFirst recommends this field be used (only if dependent is patient)
Detail – Service Provider Level							
122	**2000E**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
123	**2000E**	**MSG01**	1	Free-Form Message Text	264		CareFirst recommends using this for information about the provider that would assist the CareFirst associate in making a decision about the authorization request that could not be placed in a 278 x12 field
138	**2000F**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
142	**2000F**	**UM02**	2	Certification Type Code	1	I –Initial Request	For 10/16/2003, CareFirst is only accepting code "I" for initial requests. At a future date to be determined, CareFirst will accept other codes.
Detail – Service Level							
142	**2000F**	**UM02**	2	Certification Type Code	1	I –Initial Request	For 10/16/2003, CareFirst is only accepting code "I" for initial requests. At a future date to be determined, CareFirst will accept other codes.
150	**2000F**	**REF01**	1	Reference Identification Qualifier	3		Since CareFirst is only accepting initial requests on 10/16/2003, this field will only be used for informational purposes
150	**2000F**	**REF02**	2	Reference Identification	30		Since CareFirst is only accepting initial requests on 10/16/2003, this field will only be used for informational purposes
207	**2000F**	**CR608**	8	Certification Type Code	1	I –Initial Request	For 10/16/2003, CareFirst is only accepting code "I" for initial requests. At a future date to be determined, CareFirst will accept other codes.
211	**2000F**	**MSG01**	1	Free-Form Message Text	264		CareFirst recommends using this for information about the service that would assist the CareFirst associate in making a decision about the authorization request that could not be placed in a 278 x12 field

278 Outbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
Transaction Set Header							
219		**BHT02**	2	Transaction Set Purpose Code	2		CareFirst recommends always setting to '11' for Response
UMO Level							

278 Outbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
222	**2000A**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
Requester Level							
235	**2000B**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
Detail – Subscriber Level							
246	**2000C**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
263	**2010C**	**NM108**	8	Identification Code Qualifier	8		CareFirst recommends set 'MI' for Plan Code 00070 and 00570 (DE), 00080 and 00580 (DC), 00190 and 00690 (MD).
263	**2010C**	**NM109**	9	Identification Code	80		CareFirst recommends that the Identification Code include the 1-3 Character Alpha Prefix as shown on Customer ID Card for Plan Codes 00080 and 00580 (DC), 00190 and 00690 (MD). CareFirst requires that the Identification Code include the 1-3 Character Alpha Prefix for Plan Codes 00070 and 00570 - (DE).
Detail – Dependent Level							
272	**2000D**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
289	**2010D**	**NM108**	8	Identification Code Qualifier	8		CareFirst recommends set 'MI' for Plan Code 00070 and 00570 (DE), 00080 and 00580 (DC), 00190 and 00690 (MD).
289	**2010D**	**NM109**	9	Identification Code	80		CareFirst recommends that the Identification Code include the 1-3 Character Alpha Prefix as shown on Customer ID Card for Plan Codes 00080 and 00580 (DC), 00190 and 00690 (MD). CareFirst requires that the Identification Code include the 1-3 Character Alpha Prefix for Plan Codes 00070 and 00570 - (DE).
298	**2010D**	**INS02**	2	Individual Relationship Code	2	**01 – Spouse 19 – Child 34 – Other Adult**	CareFirst recommends this field be used (only if dependent is patient)
Detail – Service Provider Level							
301	**2000E**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
302	**2000E**	**MSG01**	1	Free-Form Message Text	264		CareFirst recommends using this for information about the provider that would assist the CareFirst associate in making a decision about the authorization or referral request that could not be placed in a 278 x12 field

278 Outbound							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
Service Level							
319	**2000F**	**HL04**	4	Hierarchical Child Code	1	0 – Patient is Subscriber 1 – Patient is Dependent	CareFirst recommends always setting to '0' for Patient = Subscriber and '1' for Patient = Dependent
326	**2000F**	**UM02**	2	Certification Type Code	1	I –Initial Request	For 10/16/2003, CareFirst is only accepting code "I" for initial requests. At a future date to be determined, CareFirst will accept other codes.
334	**2000F**	**REF01**	1	Reference Identification Qualifier	3		Since CareFirst is only accepting initial requests on 10/16/2003, this field will only be used for informational purposes
334	**2000F**	**REF02**	2	Reference Identification	30		Since CareFirst is only accepting initial requests on 10/16/2003, this field will only be used for informational purposes
382	**2000F**	**CR608**	8	Certification Type Code	1	I –Initial Request	For 10/16/2003, CareFirst is only accepting code "I" for initial requests. At a future date to be determined, CareFirst will accept other codes.
383	**2000F**	**MSG01**	1	Free-Form Message Text	264		CareFirst recommends using this for information about the service that would assist the CareFirst associate in making a decision about the authorization or referral request that could not be placed in a 278 x12 field

11. Appendix D: 820 – Transaction Detail

11.1 CONTROL SEGMENTS/ENVELOPES

11.1.1 6.1 ISA-IEA

11.1.2 6.2 GS-GE

11.1.3 6.3 ST-SE

11.2 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

820							
Page #	**Loop ID**	**Reference**	**Field #**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
Interchange Envelope							
B.3		**ISA01**	1	Authorization Information Qualifier	2	"00"	CareFirst recommends qualifier "00"
B.3		**ISA02**	2	Authorization Information	10		CareFirst recommends the maximum of 10 blank spaces
B.4		**ISA03**	3	Security Information Qualifier	2	"00"	CareFirst recommends qualifier "00"
B.4		**ISA04**	4	Security Information	10		CareFirst recommends the maximum of 10 blank spaces
B.4		**ISA05**	5	Interchange ID Qualifier	2	30	CareFirst recommends US Federal Tax Identification Number
B.4		**ISA06**	6	Interchange Sender ID	15	Tax ID	CareFirst recommends Federal Tax ID
B.4		**ISA07**	7	Interchange ID Qualifier	2	ZZ	CareFirst recommends Mutually Defined
B.5		**ISA08**	8	Interchange Receiver ID	15		CareFirst recommends 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE
B.5		**ISA13**	13	Interchange Control Number	9		CareFirst recommends every transmission must have a unique number.
B.6		**ISA16**	16	Component Element Separator	1		CareFirst recommends to always use ':' (colon).
Functional Group Envelope							
B.8		**GS02**	2	Application Sender's Code	15	Tax ID	CareFirst recommends Federal Tax ID
B.8		**GS03**	3	Application Receiver's Code	15		CareFirst recommends 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE

Transaction Header							
41		**BPR14**	14	Account Number Qualifier	3		See group contract or contact hipaa.partner@carefirst.com
41		**BPR15**	15	Account Number	35		See group contract or contact hipaa.partner@carefirst.com
1000A PREMIUM RECEIVER'S NAME							
57	**1000A**	**N102**	2	Premium Receiver's Name	60		CareFirst recommends set to CareFirst DC for 00080 CareFirst MD for 00190 CareFirst DE for 00070
57	**1000A**	**N103**	3	Premium Receiver's Identification Code Qualifier	2		Care First recommends "FI", Federal Tax Identification Number
1000A PREMIUM PAYER'S NAME							
63	**1000B**	**N103**	3	Premium Payer's Identification Code Qualifier	3	"65"	CareFirst recommends "65" National Employer Identifier
2000A ORGANIZATION SUMMARY REMITTANCE: This loop is expected only if there is no detail remittance information (Loop 2000B)							
75	**2300A**	**RMR01**	1	Organization Summary Remittance Detail Reference Identification Qualifier	3	"IK "	*CareFirst requires "IK" unless otherwise specified by trading partner agreement.*
75	**2300A**	**RMR02**	2	Organization Summary Remittance Detail Reference Identification	30		CareFirst recommends Invoice Number for CareFirst DC Invoice Number for CareFirst MD 6 digit group number plus 6 digit due date for CareFirst DE
85	**2320A**	**ADX02**	2	Organization Summary Remittance Level Adjustment	2		Informational only. Please contact Enrollment Specialist or Billing Representative if the invoice amount is incorrect or in dispute.
2000B INDIVIDUAL REMITTANCE: This loop is required if there is no Organization Summary Remittance (Loop 2000B)							
87	**2000B**	ENT03	3	Individual Remittance Identification Code Qualifier	3	"EI"	CareFirst recommends EI – Employee Identification Number
87	**2000B**	**ENT04**	4	Individual Remittance Identification Code	80		CareFirst requires the CareFirst Subscriber or Member ID
88	**2100B**	**NM103**	3	Individual Name Last Name	35		CareFirst requires the Subscriber Last Name
88	**2100B**	**NM104**	4	Individual Name First Name	25		CareFirst requires the Subscriber First Name
92	**2300B**	**RMR01**	1	Individual Premium Remittance Detail Reference Identification Qualifier	3	"IK"	CareFirst requires "IK" Invoice Number
92	**2300B**	**RMR02**	2	Individual Premium Remittance Detail Reference Identification Qualifier	30		CareFirst recommends Invoice Number for CareFirst DC Invoice Number for CareFirst MD 6 digit group number plus 6 digit due date for CareFirst DE
97	**2320B**	**ADX02**	2	Individual Premium Adjustment	2		Informational only. Please contact Enrollment Specialist or Billing Representative if the invoice amount is incorrect or in dispute.

11.3 BUSINESS SCENARIOS

1. It is expected that all 820 transactions will be related to CareFirst invoices.

2. CareFirst will support either business use – Organization Summary Remittance or Individual Remittance. However, Individual Remittance Advice is preferred.

3. All of the Individual Remittance advice segments in an 820 transaction are expected to relate to a single invoice.

4. For Individual Remittance advice, it is expected that premium payments are made as part of the employee payment and the dependents are not included in the detailed remittance information.

5. If payment includes multiple invoices, the Organization Summary Remittance must be used.

11.4 ADDITIONAL INFORMATION

Please contact hipaa.partner@carefirst.com for additional information.

12. Appendix E: 834 – Transaction Detail

12.1 CONTROL SEGMENTS/ENVELOPES

12.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

12.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

12.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

12.1.4 ACKNOWLEDGEMENTS AND/OR REPORTS

A 997 Acknowledgement will be created for each 834 file submitted for processing.

12.2 TRANSACTION DETAIL TABLE

834							
Page #	**Loop ID**	**Reference**	**Field #**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
B.4		**ISA01**	1	Authorization Information Qualifier	2		CareFirst recommends for all Plan Codes to always submit qualifier "00".
B.4		**ISA02**	2	Authorization Information	10		CareFirst recommends for all Plan Code to always submit the maximum of 10 blank spaces.
B.4		**ISA04**	4	Security Information	10		CareFirst recommends for all Plan Code to always submit the maximum of 10 blank spaces.
B.4		**ISA05**	5	Interchange ID Qualifier	2	ZZ	CareFirst recommends US Federal Tax Identification Number
B.4		**ISA06**	6	Interchange Sender ID	15	Tax ID	CareFirst recommends Federal Tax ID; if the Federal Tax ID is not available, CareFirst will assign the Trading Partner ID Number to be used as the Interchange Sender ID. Additionally the ISA06 must match the Tax ID submitted on the Trading Partner Registration Form.
B.4		**ISA07**	7	Interchange ID Qualifier	2	ZZ	CareFirst recommends Mutually Defined
B.5		**ISA08**	8	Interchange Receiver ID	15	00070 00080	CareFirst recommends CareFirst - Delaware Plan CareFirst - DC Plan

834							
Page #	**Loop ID**	**Reference**	**Field #**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
						00190	CareFirst - Maryland Plan
B.5		**ISA11**	11	Interchange Control Standards Identifier	1	U	CareFirst recommends US EDI Community of ASC X12
B.5		**ISA12**	12	Interchange Control Version Number	5	00401	See Implementation Guide
B.5		**ISA13**	13	Interchange Control Number	9	Unique Number	The Interchange Control Number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected.
B.6		**ISA14**	14	Acknowledgment Requested	1	1	A 997 will be created by CareFirst for the submitter.
B.6		**ISA15**	15	Usage Indicator	1	1	When submitting a test file use the value of "T"; conversely, when submitting a Production file, use the value of "P". Inputting a value of "P" while in test mode could result in the file not being processed. Trading Partners should only populate a "P" after given approval from CareFirst.
B.6		**ISA16**	16	Component Element Separator	1	:	CareFirst recommends using a ":".
B.8		**GS01**	1	Functional Identifier Code	2	BE	CareFirst recommends Benefit Enrollment and Maintenance
B.8		**GS02**	2	Application Sender's Code	15	Tax ID	CareFirst recommends Federal Tax ID, if the Federal Tax ID Number is not available, CareFirst will assign the Trading Partner ID Number to be used as the Application Sender's Code.
B.8		**GS03**	3	Application Receiver's Code	15	00070 00080 00190	CareFirst recommends CareFirst - Delaware Plan CareFirst - DC Plan CareFirst - Maryland Plan
B.9		**GS06**	6	Group Control Number	9	Tax ID	CareFirst recommends the Tax ID of the Account, if the Federal Tax ID is not available, CareFirst will assign a Group Control Number.
B.9		**GS07**	7	Responsible Agency Code	2	X	CareFirst recommends Accredited Standards Committee X12
B.9		**GS08**	8	Version / Release / Industry Identifier Code	12	004010X095A1	CareFirst uses 4010 Addendum
27		**ST01**	1	Transaction Set Identifier Code	3	834	CareFirst recommends no more than one transaction type per file.
31		**BGN08**	8	Action Code	2		
36	1000A	**N103**	3	Identification Code Qualifier	2	ZZ	CareFirst recommends Mutually Defined
36	1000B	**N103**	3	Identification Code Qualifier	2	FI	Federal Taxpayer's Identification Number
36	1000B	**N104**	4	Identification Code	80		CareFirst will provide the Tax ID number to the Trading Partner prior to

834							
Page #	**Loop ID**	**Reference**	**Field #**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
							submission of first test file.
48	2000	**INS06**	4	Medicare Plan Code	1		CareFirst recommends using the appropriate value of A,B,C or D for Medicare recipients. If member is not being enrolled as a Medicare recipient, CareFirst requests the trading partner to use the default value of "E – No Medicare". If the INS06 element is blank, CareFirst will default to "E – No Medicare".
49	2000	**INS09**	9	Student Status Code	1		CareFirst requests the appropriate DTP segment identifying full time student education begin dates.
50	2000	**INS17**	17	Birth Sequence Indicator	9		In the event of family members with the same date of birth, CareFirst requests the INS17 be populated.
55-56	2000	**REF01**	1	Reference Identification Qualifier	2		CareFirst requests an occurrence of REF01 with a value of F6 Health Insurance Claim Number when the value of INS06 is A,B,C or D.
55-56	2000	**REF02**	2	Reference Identification	30		CareFirst requests the Health Insurance Claim Number be passed in this element when the INS06 equals a value of A,B,C or D.
59-60	2000	**DTP01**	1	Date/Time Qualifier	3	See IG	Applicable dates are required for enrollment, changes and terminations. CareFirst business rules are as follows: When the INS06 contains a value of A,B,C or D, CareFirst requests the DTP segment DTP*D8*CCYYMMDD; and When the INS09 is populated with a Y, CareFirst requests the DTP segment DTP*D8*350*CCYYMMDD.
67	2100A	**N301**	1	Address Information	55		If this field(s) are not populated, membership will not update. In addition, CareFirst legacy systems accept 30 characters. CareFirst will truncate addresses over 30 characters.
69	2100A	**N403**	3	Postal Code	15		CareFirst will truncate any postal code over 9 characters.

834							
Page #	**Loop ID**	**Reference**	**Field #**	**X12 Element Name**	**Length**	**Codes**	**Notes/Comments**
128	**2300**	**HD04**	4	Plan Coverage Description	50	Product Identifier/ Format- 01-03 EAB - MD Format FAC - DC Format NAS - NASCO TBS - DE Format **File Type - 49** A = Audit/ Reconciliation F = Full File P = Positive File U = Transaction Only File R = Renewal Full File S = Renewal Transaction Only File T = Renewal Positive File **Submitter Type - 50** A = Administrator D = DBE G = Groups P = Private Label T = TPE V =Vendor	CareFirst requires 50 Positions identify the following: 01-03 = Product Identifier/Format 04-23 = Group Number 24-28 = Sub Group Number 29-37 = Class Code 38-41 = Rate Modifier 42 = Status 43-45 = Home Plan 46-48 = Control Plan 49 = Product Process Indicator (File Type) 50 = Product Process Indicator (Submitter Type)
129	**2300**	**HD03**	3	Insurance Line Code	3		CareFirst requests “HLT” for all medical products and the values DEN, VIS and PDG for ancillary products in separate loops.

12.3 FREQUENTLY ASKED QUESTIONS

Question: Do I have to switch to the X12 format for enrollment transactions?

Answer: The answer depends on whether you are a Group Health Plan or a plan sponsor. Group Health Plans are covered entities under HIPAA, and must submit their transactions in the standard format.

A plan sponsor who currently submits enrollment files to CareFirst in a proprietary format can continue to do so. At their option, a plan sponsor may switch to the X12 standard format. Contact hipaa.partner@carefirst.com if you have questions, or wish to begin the transition to X12 formatted transactions.

Question: I currently submit proprietary files to CareFirst. If we move to HIPAA 834 format, can we continue to transmit the file the same way we do today? Can we continue with the file transmission we are using even if we change tape format into HIPAA layout?

Answer: If you continue to use your current proprietary submission format for your enrollment file, you can continue to submit files in the same way. If you change to the 834 X12 format, this process would change to using the web-based file transfer tool we are developing now.

12.4 ADDITIONAL INFORMATION

Plan sponsors or vendors acting on their behalf who currently submit files in proprietary formats have the option to continue to use that format. At their option, they may also convert to the X12 834. However, group health plans are covered entities and are therefore required to submit standard transactions. If you are unsure if you are acting as a plan sponsor or a group health plan, please contact your legal counsel. If you have questions, please contact hipaa.partner@carefirst.com.

13. Appendix F: 835 – Transaction Detail

13.1 CONTROL SEGMENTS/ENVELOPES

13.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

13.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

13.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

13.2 TRANSACTION CYCLE AND PROCESSING

In order to receive an electronic 835 X12 Claim Payment/Remittance from CareFirst, a receiver must be setup to do so with CareFirst. See Section 2, "Getting Started."

The 835 Claim Payment/Advice transaction from CareFirst will include paid and denied claim data on both electronic and paper claims. CareFirst will not use an Electronic Funds Transfer (EFT) process with this transaction. This transaction will be used for communication of remittance information only.

The 835 transaction will be available on a daily or weekly basis depending on the line of business. Claims will be included based on the pay date.

For new receivers: The 835 transaction will be created for the first check run following your production implementation date. We are unable to produce retrospective transactions for new receivers.

Existing receivers: Prior 835 transaction sets are expected to be available for up to 8 weeks. For additional information, contact hipaa.partner@carefirst.com.

13.3 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

835							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT /SEGMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.4		ISA	05	INTERCHANGE ID QUALIFIER	2	ZZ	Qualifier will always equal "ZZ"
B.4		ISA	06	INTERCHANGE SENDER ID	15		DE: 00070 OR 00570 MD: 00190 (Institutional Only) OR 00690 DC: 00080 (Institutional Only) OR 00580
B.5		ISA	13	INTERCHANGE CONTROL NUMBER	9		Will always be unique number
44	NA	BPR	01	TRANSACTION HANDLING CODE	1		MD, DC, DE, FEP MD will only use 1 qualifier: "I" (Remittance Information Only) NASCO will use the following 2 qualifiers: "I" (Remittance Information Only) "H" (Notification Only)
46	NA	BPR	03	CREDIT / DEBIT FLAG CODE	1		Qualifier will always equal "C"
46	NA	BPR	04	PAYMENT METHOD CODE	3		DC: Qualifier will either be "ACH" or "CHK" or "Non" MD, FEP MD: Qualifier will either be "CHK" DE, NASCO: Qualifier will either be "CHK" or "NON"
53	NA	TRN	02	CHECK OR EFT TRACE NUMBER	7		DC: A check number and voucher date will be used if one is available, otherwise, "NO CHK" and voucher date and provider tax ID will be used. MD: The internal voucher number and the paid date will be used. DE: A check number will be used if one is available, otherwise, the provider number and the system date will be used. FEP MD: A check number will be used if one is available, otherwise, an internal remittance sequence number and the date will be used. NASCO: A check number will be used if one is available, otherwise, an "F" and the financial document serial number will be used.
74	1000B	N3	01-02	PAYEE ADDRESS SEGMENT	full segment		Will always contain address on file with CareFirst
75	1000B	N4	01-03	PAYEE CITY, STATE, ZIP CODE SEGMENT	full segment		Will always contain address on file with CareFirst

835							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT /SEGMENT NAME**	**Length**	**Codes**	**Notes/Comments**
89	2100	CLP	01	PATIENT CONTROL NUMBER	14		This field will only contain a Patient Control Number if it is available on the originating 837 or submitted on the paper claim
95	2100	CAS	01-19	CLAIM ADJUSTMENT SEGMENT	full segment		MD, DC: Institutional adjustments are reported at this level. NASCO: All claims adjustments are reported at this level DE, FEP MD: This level is not used.
103	2100	NM1	05	PATIENT MIDDLE NAME	25		The patient's middle initial will be provided if it is available
104	2100	NM1	09	PATIENT IDENTIFIER	17 2		DE – Subscriber ID. DC – Subscriber ID and Member Number MD – Subscriber base ID number FEP MD – Member Number NASCO – Subscriber ID
106	2100	NM1	01-05	INSURED NAME SEGMENT	full segment		This segment will only be populated if the patient is not the subscriber.
108	2100	NM1	01-05	CORRECTED PATIENT/INSURED NAME SEGMENT	full segment		MD, DC, DE, FEP MD will not populate this segment at this time. NASCO will provide this segment if it is available.
109	2100	NM1	07	INSURED NAME SUFFIX	10		DE, NASCO – will provide suffix, if it is available.
127	2100	REF	02	REFERENCE IDENTIFICATION			MD, DC, DE, FEP MD will send a medical record number if it is available or submitted on the paper claim. (For Qualifier EA) NASCO will send a group or policy number (For Qualifier 1L)
139	2110	SVC	01-07	SERVICE PAYMENT SEGMENT	full segment		MD, DC, DE, FEP MD - Professional claim service detail data is reported at this level. MD and DC will not provide Institutional Revenue Detail at this level of detail at this time. NASCO will report all clms at a service line level except for DRG and Per Diem institutional claims.
148	2110	CAS	01-19	SERVICE ADJUSTMENT SEGMENT	full segment		MD, DC, DE, FEP MD - Professional claim service detail data is reported at this level. MD and DC will not provide Institutional Revenue Detail at this level of detail at this time.
163	2110	LQ	02	REMARK CODE			FEP MD, NASCO will provide health remark codes. MD, DC, DE - This segment will not be populated at this time.

13.4 FREQUENTLY ASKED QUESTIONS

Question: How will CareFirst send 835 transactions for claims?

Answer: CareFirst will send 835 transactions via the preferred vendor clearinghouse to providers who have requested them. Only those submitters who have requested the 835 will receive one. If you require an 835 file, please contact your clearinghouse or hipaa.partner@carefirst.com and they will assist you.

CareFirst will supply a "crosswalk" table that will provide a translation from current proprietary codes to the HIPAA standard codes.

CareFirst will continue to provide the current proprietary ERA formats for a limited time period to assist in transition efforts. CareFirst will give 60 days notice prior to discontinuing the proprietary format ERAs.

Question: Will a Claim Adjustment Reason Code always be paired with a Remittance Remark Code?

Answer: No, Remark codes are only used for some plans. For FEP-Maryland and NASCO claims, the current remark codes will be mapped to the new standard codes. Additional information about the 835 Reason Codes is available on the CareFirst Web site at http://www.carefirst.com/providers/newsflash/NewsFlashDetails_091703.html.

Question: Will we see the non-standard codes or the new code sets (Claim Adjustment and Remittance Remark Codes) on paper EOBs?

Answer: Paper remittances will continue to show the current proprietary codes.

Question: I currently receive a paper remittance advice. Will that change as a result of HIPAA?

Answer: Paper remittances will not change as a result of HIPAA. They will continue to be generated, even for providers who request the 835 ERA.

Paper remittances will show the current proprietary codes, even after 10/16/03.

Question: I want to receive the 835 (Claim Payment Status/Advice) electronically. Is it available from CareFirst?

Answer: CareFirst sends HIPAA-compliant 835s to providers through the preferred vendor clearinghouses. Be sure to notify your clearinghouse that you wish to be enrolled as an 835 recipient for CareFirst business.

Question: On some vouchers I receive, the Patient Liability amount doesn't make sense when compared to the other values on the voucher. When I call a representative, they can always explain the discrepancy. Will the new 835 transaction include additional information?

Answer: Yes. On the 835, additional adjustments will be itemized, including per-admission deductibles and carryovers from prior periods. They will show as separate dollar amounts, with separate HIPAA adjustment reason codes.

Question: What delimiters do you utilize?

Answer: The CareFirst 835 transaction contains the following delimiters:

Segment delimiter: carriage return. There is a line feed after each segment.

Element delimiter: asterisk (*)

Sub-element delimiter: carat (^)

Question: Are you able to support issuance of ERAs for more than one provider or service address location within a TIN?

Answer: Yes. We issue the checks and 835 transactions based on the pay-to provider that is associated in our system with the rendering provider. If the provider sets it up with us that way, we are able to deliver 835s to different locations for a single TIN based on our local provider number. The local provider number is in 1000B REF02 of the 835.

Question: Does CareFirst require a 997 Acknowledgement in response to an 835 transaction?

Answer: CareFirst recommends the use of 997 Acknowledgements. Trading partners that are not using 997 transactions should notify CareFirst in some other manner if there are problems with an 835 transmission.

Question: Will CareFirst 835 Remittance Advice transactions contain claims submitted in the 837 transaction only?

Answer: No. CareFirst will generate 835 Remittance advice transactions for all claims, regardless of source (paper or electronic). However, certain 835 data elements may use default values if the claim was received on paper. (See "Paper Claim & Proprietary Format Defaults" below)

13.5 PAPER CLAIM & PROPRIETARY FORMAT DEFAULTS

Claims received via paper or using proprietary formats will require the use of additional defaults to create required information that may not be otherwise available. It is expected that the need for defaults will be minimal. The defaults are detailed in the following table.

835 PAPER AND PROPRIETARY DEFAULTS							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT /SEGMENT NAME**	**Length**	**Codes**	**Notes/Comments**
90	2100	CLP	02	CLAIM STATUS CODE	2		If the claim status codes are not available, the following codes will be sent: 1) 1 (Processed) as Primary when CLP04 (Claim Payment Amount) is greater than 0 2) 4 (Denied) when CLP04 (Claim Payment Amount) equals 0 3) 22 (Reversal of Previous Payment) when CLP04 (Claim Payment Amount) is less than 0
92	2100	CLP	06	CLAIM FILING INDICATOR CODE	2		If this code is not available and CLP03 (Total Charge Amount) is greater than 0, then 15 (Indemnity Insurance) will be sent
128	2100	REF	01	REFERENCE IDENTIFICATION QUALIFIER	1		If a rendering provider ID is present, then a value of 1A will be sent if it is a Blue Cross provider, or 1B if it is a Blue Shield provider.
140	2110	SVC	01	1-PRODUCT OR SERVICE ID QUALIFIER	2		If a procedure code is sent without this qualifier, default to HC (HCPCS).

835 PAPER AND PROPRIETARY DEFAULTS							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT /SEGMENT NAME**	**Length**	**Codes**	**Notes/Comments**
140	2110	SVC	01	2-PRODUCT / SERVICE ID	8		If service amounts are available without a procedure code, a 99199 will be sent.
50		BPR	16	CHECK ISSUE OR EFT EFFECTIVE DATE - CCYYMMDD	8		If an actual check/eft date is not available, 01-01-0001 will be sent
53		TRN	02	CHECK OR EFT TRACE NUMBER	7		If no check/eft trace number is available, "9999999" will be sent.
103	2100	NM1	03	PATIENT LAST NAME OR ORGANIZATION NAME	13		If no value is available, "Unknown" will be sent.
103	2100	NM1	04	PATIENT FIRST NAME	10		If no value is available, "Unknown" will be sent.
106	2100	NM1	02	INSURED ENTITY TYPE QUALIFIER	1		If no value is available, "IL" (Insured or Subscriber) will be sent.
107	2100	NM1	08	IDENTIFICATION CODE QUALIFIER	2		If no value is available, "34" (Social Security Number) will be sent.
107	2100	NM1	09	SUBSCRIBER IDENTIFIER	12		If no value is available, "Unknown" will be sent.
131	2100	DTM	02	CLAIM DATE - CCYYMMDD	0		If claim date is available, the check issue date will be sent.
147	2100	DTM	02	DATE - CCYYMMDD	8		If no service date is available, "01-01-0001" will be sent
165		PLB	02	FISCAL PERIOD DATE - CCYYMMDD	8		If a PLB segment is created, "12-31" of the current year will be sent as the fiscal period date.

While the situations are rare, in select cases an additional adjustment segment is defaulted when additional data is not available regarding an adjustment. In instances where the adjustments are at either the claim or service level, a CAS segment will be created using "OA" in CAS01 as the Claim Adjustment Group Code, and "A7" (Presumptive payment) in CAS02 as the Adjustment Reason code. In instances where the adjustment involves a provider-level adjustment, a PLB segment will be created using either a WU (“Recovery”) or CS (“Adjustment”) in PLB03.

13.6 ADDITIONAL INFORMATION

CareFirst paper vouchers have not changed, and will continue to use the CareFirst-specific message codes or local procedure codes, where applicable. The 835 electronic transaction, however, is required to comply with HIPAA-defined codes. You may obtain a conversion table that maps the new HIPAA-compliant codes to existing CareFirst codes by contacting hipaa.partner@carefirst.com. This conversion table will be available in a later release of this guide.

If the original claim was sent as an 837 electronic transaction, the 835 response will generally include all loops, segments and data elements required or conditionally required by the Implementation Guide. However, if the original claim was submitted via paper, or required special manual intervention for processing, some segments and data elements may either be unavailable or defaulted as described above.

Providers who wish to receive an 835 electronic remittance advice with the new HIPAA codes must notify their vendor or clearinghouse and send notification to CareFirst at hipaa.partner@carefirst.com.

13.7 FILE RECEIPT SCHEDULE

File Type	File Name	Frequency	Day/Time
MD Professional 835	O835.R<internal run id>CCYYMMDD.msd	Weekly	Monday 8:00 PM EST
MD Institutional 835	O835.R<internal run id>CCYYMMDD.mcd	Weekly	Monday 8:00 PM EST
FEP MD Professional 835	O835.R<internal run id>CCYYMMDD.mcd	Weekly	Friday 8:00 PM EST
FEP MD Institutional 835	O835.R<internal run id>CCYYMMDD.msd	Weekly	Friday 8:00 PM EST
DC Professional 835	O835.R<internal run id>CCYYMMDD.bsd	Daily	Mon-Fri 8:00 PM EST
DC Institutional 835	O835.R<internal run id>CCYYMMDD.bcd	Weekly	Friday 8:00 PM EST
*MD NASCO	O835.R<internal run id>CCYYMMDD.msd	Daily	Mon-Fri 8:00 PM EST
*DC NASCO	O835.R<internal run id>CCYYMMDD.bsd	Daily	Mon-Fri 8:00 PM EST

14. Appendix G: 837 I – Transaction Detail

14.1 CONTROL SEGMENTS/ENVELOPES

14.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

14.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst's use of functional group control numbers.

14.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

14.1.4 ACKNOWLEDGEMENTS AND/OR REPORTS

A 997 Acknowledgement will be created for each file submitted for processing. In addition, a CareFirst proprietary acknowledgment file will be created for each claim submitted for processing.

14.2 TRANSACTION DETAIL TABLE

Business rules for some data elements are still in development.

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

837 I							
Page #	**LOOP ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.3		ISA01	1	Authorization Information Qualifier	2		CareFirst recommends for all Plan Codes to always submit qualifier "00".
B.3		ISA02	2	Authorization Information	10		CareFirst recommends for all Plan Codes to always submit the maximum of 10 blank spaces.
B.4		ISA03	3	Security Information Qualifier	2		CareFirst recommends for all Plan Codes to always submit qualifier "00".

837 I							
Page #	**LOOP ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.4		ISA04	4	Security Information	10		CareFirst recommends for all Plan Codes to always submit the maximum of 10 blank spaces.
B.4		ISA05	5	Interchange ID Qualifier	2		CareFirst recommends for all Plan Codes to always submit "ZZ"
B.4		ISA06	6	Interchange Sender ID	15		Must match the Federal Tax ID or other identifier submitted on the Trading Partner Registration Form.
B.4		ISA07	7	Interchange ID Qualifier	2	**ZZ**	CareFirst recommends for all Plan Codes to always submit "ZZ".
B.5		**ISA08**	8	Interchange Receiver ID	15		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE
B.5		**ISA13**	13	Interchange Control Number	9		The Interchange Control Number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected.
B.6		**ISA16**	16	Component Element Separator	1		CareFirst recommends always use ' : ' [colon]
B.8		**GS02**	2	Application Sender's Code	15		Must match the Federal Tax ID or other identifier submitted on the Trading Partner Registration Form.
B.8		**GS03**	3	Application Receiver Code	15		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE
67	**1000B-HEADER - RECEIVER NAME LEVEL**						
68	1000	**NM103**	3	Name Last or Organization Name (Receiver Name)	35		CareFirst recommends set to CareFirst DC for 00080 CareFirst MD for 00190 CareFirst DE for 00070
68	1000	**NM109**	9	Identification Code (Receiver Primary Identifier)	80		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE
69	**2000A - DETAIL - BILLING/ PAY-TO PROVIDER HIERARCHICAL LEVEL**						
76	**2010AA - DETAIL - BILLING PROVIDER NAME LEVEL** **CareFirst expects the 2010AA Loop to identify the Billing Agent or Billing Service if applicable.**						
83	2010	**REF01**	1	Reference Identification Qualifier	3	1A	CareFirst requires one repeat to contain value "1A" for plan code 00070 (DE) When this loop contains the Pay-to Provider, CareFirst requires one repeat to contain value "1A" for all plan codes.

837 I							
Page #	**LOOP ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
84	2010	**REF02**	2	Reference Identification (Billing Provider Additional Identifier)	30		When this loop contains the Billing Provider, CareFirst requires for the segment with qualifier "1A": Billing Agent # for 00080 (DC) Submitter #/Billing Provider # for 00190 (MD) DE specific Blue Cross Provider # for 00070 (DE) When this loop contains the Pay-to Provider, CareFirst requires for the segment with qualifier "1A": 3 digit Provider ID # for 00080 (DC) 8 digit (6+2) Provider # for 00190 (MD) DE Secondary Provider ID for 00070 (DE)

91	**2010AB - DETAIL - PAY-TO PROVIDER NAME LEVEL**						
97	2010	**REF01**	1	Reference Identification Qualifier	3	1A	CareFirst requires one repeat to contain value "1A" for all plan codes.
98	2010	**REF02**	2	Reference Identification (Pay-to-Provider Additional Identifier)	30		CareFirst requires for the repeat with qualifier "1A": 3 digit Provider ID # for 00080 (DC) 8 digit (6+2) Provider # for 00190 (MD) DE Secondary Provider ID for 00070 (DE)
108	2010BA – DETAIL – SUBSCRIBER NAME LEVEL						
110		**NM108**	**8**	Identification Code Qualifier	**2**	MI	CareFirst recommends set to 'MI' for Plan Code 00070 (DE), 00080 (DC) and 00190 (MD).
110		**NM109**	**9**	Identification Code (Subscriber Primary Identifier)	**80**		CareFirst recommends that the Identification Code include the 1-3 Character Alpha Prefix as shown on Customer ID Card for Plan Codes 00080 (DC) and 00190 (MD). CareFirst requires that the Identification Code include the 1-3 Character Alpha Prefix for Plan Code 00070 (DE).
126	**2010BC- DETAIL - PAYER NAME LEVEL**						
127	2010	**NM103**	3	Name Last or Organization Name (Payer Name)	35		CareFirst recommends set to CareFirst for all plan codes.
128	2010	**NM109**	9	Identification Code (Payer Identifier)	80		CareFirst recommends set to 00080 for CareFirst DC 00190 for CareFirst MD 00070 for CareFirst DE
157	**2300 - DETAIL - CLAIM INFORMATION LEVEL ---- CareFirst recommends submit services related to only one Accident, LMP or Medical Emergency per claim**						
159	2300	**CLM05**	3	Claim Frequency Type Code (Claim Frequency Code)	1		CareFirst requires that the Claim Frequency Type cannot be value "0" (encounter) for Plan Codes 00080 (DC), 00190 (MD).
161	2300	**CLM09**	9	Release of Information Code	1		CareFirst requires the subscriber's signature to be on file for Plan Codes 00080 (DC), 00190 (MD) and 00070 (DE).
192	2300	**REF02**	2	Reference Identification (Claim Original Reference Number)	30		CareFirst requires the original claim number assigned by CareFirst be submitted if the claim is an adjustment
228	2300	**HI 01 - 2**	2	Industry Code (Principle Diagnosis Code)	30		CareFirst requires a specific ICD-9 Code for Plan 00080 (DC)
228	2300	**HI 01 - 2**	2	Industry Code (Admitting Diagnosis Code)	30		If present, CareFirst requires a specific ICD-9 code for Plan 00080 (DC)
228	2300	**HI 01 – 2** through HI12 - 2	2	Industry Code (Other Diagnosis Code)	30		If present, CareFirst requires a specific ICD-9 code for Plan 00080 (DC)
242	2300	**HI01 – 1**	1	Code List Qualifier Code (Principal Procedure Code)	3		If inpatient , CareFirst requires value "BR".
244 - 255	2300	**HI01 – 1** through HI12 - 1	1	Code List Qualifier Code (Other Procedure Code)	3		If inpatient, CareFirst requires value "BQ".
321	2310A - DETAIL – ATTENDING PHYSICIAN NAME LEVEL						
327	2310	**REF02**	2	Reference Identification (Attending Physician Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Attending Physician UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
328	2310B – DETAIL – OPERATING PHYSICIAN NAME LEVEL						
334	2310	**REF02**	2	Reference Identification (Operating Physician	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Operating Physician UPIN

				Secondary Identifier)			in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
335	2310C – DETAIL – OTHER PROVIDER NAME LEVEL						
341	2310	**REF02**	2	Reference Identification (Other Provider Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Other Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
342	2310D – DETAIL – REFERRING PROVIDER NAME LEVEL						
348	2310	**REF02**	2	Reference Identification (Referring Provider Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Referring Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
359	2320 – Detail – OTHER SUBSCRIBER INFORMATION LEVEL---- **CareFirst recommends Institutional COB payment data be submitted at the claim level** (Loop **2320-CAS and AMT elements)**						
367	2320	CAS02	2	Claim Adjustment Reason Code (Adjustment Reason Code)	5		For all Plan Codes CareFirst recommends an Adjustment Reason Code be submitted to indicate Primary Payer rejections on COB claims at the claim Level.
371	2320	AMT02	2	Monetary Amount (Other Payer Patient Paid Amount)	18		CareFirst recommends for all Plan Codes to submit Other Payer/Patient Paid Amounts on claims at the claim level.
444	2400 – DETAIL – SERVICE LINE NUMBER LEVEL ---- CareFirst recommends submit services related to only one Accident, LMP or Medical Emergency per claim						
448	2400	SV203	3	Monetary Amount (Line Item Charge Amount)	18		CareFirst requires for Plan Code 00190 that this amount must always be greater than "0"
New Loop	2410 – Detail – DRUG IDENTIFICATION LEVEL---- **CareFirst recommends that a NDC code be submitted for prescribed drugs and biologics when required by government regulation.**						
462	2420A – Detail – ATTENDING PHYSICIAN NAME LEVEL						
463	2420A	REF02	2	Reference Identification (Attending Physician Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Attending Physician UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
469	2420B – DETAIL – OPERATING PHYSICIAN NAME LEVEL						
475	2420B	REF02	2	Reference Identification (Operating Physician Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Operating Physician UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
476	2420C – DETAIL – OTHER PROVIDER NAME LEVEL						
482	2420C	REF02	2	Reference Identification (Other Provider Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Other Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
483	2420D – DETAIL – REFERRING PROVIDER NAME LEVEL						
489	2420D	REF02	2	Reference Identification (Referring Provider Secondary Identifier)	30		CareFirst recommends for Plan Code 00070 (DE) enter 6 byte Referring Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000

14.3 FREQUENTLY ASKED QUESTIONS

Question: Can I submit claims directly to CareFirst in the X12 format?

Answer: No. All claims must be submitted through one of the preferred clearinghouses that CareFirst has contracted with to receive and transmit claims. For additional information on the clearinghouses refer to the website, www.CareFirst.com, under Provider and Physicians in the Electronic Service section. Questions can also be directed to hipaa.partner@CareFirst.com.

Question: Will CareFirst pay the cost for claims submitted electronically ?

Answer: CareFirst will pay the per-claim charge for claims submitted electronically, through one of the preferred clearinghouses that CareFirst has contracted with to receive and transmit claims. For more detail visit the website at www.CareFirst.com, under Provider and Physician, in the Electronic Service

Question: My office currently uses IASH to respond to claim denials and adjustments. Will this be continue to be available?
Answer: Yes. Current users of IASH (and other DCACCESS) functions have been migrated to our new web-based application called CareFirst Direct which includes IASH features. If you have not been set-up for CareFirst Direct, go to our website, www.CareFirst.com in the Electronic Service section for more information. Any questions concerning CareFirst Direct should be sent to hipaa.partner@CareFirst.com.

Question: Will CareFirst accept Medicare secondary claims electronically?
Answer: For the most up-to-date information on Medicare Secondary and COB claims, direct your inquiry to hipaa.partner@CareFirst.com. .

Question: Will Medicare and other COB claims submitted electronically adjudicate properly through the systems?
Answer: : For the most up-to-date information on Medicare Secondary and COB claims, direct your inquiry to hipaa.partner@CareFirst.com.

Question: I have heard that CMS is allowing providers to continue to submit claims in the current format. Will CareFirst be able to continue to handle crossover claims in the current format after 10/16/03?
Answer: Yes. CareFirst will be able to accept these secondary claims in the current format.

Question: What type of validator does CareFirst use? What types of validation does CareFirst enforce?
Answer: CareFirst uses Sybase for compliance checking WEDI-SNIP types 1-4.

Question: What is the most common X12 Compliance Error?
Answer: The most common compliance error is the ISA13 data element. For testing and production files, the Interchange Control Number must be unique otherwise the file will be rejected. Trading Partners are asked to ensure that each file that is submitted to CareFirst contain a unique ISA13 Control Number value. CareFirst recommends that Trading Partners use a sequentially generated number for each test and production file that is generated.

Question: What segment terminator does CareFirst prefer?
Answer: The tilde (~).

Question: Can CareFirst accept multiple Rendering Providers at the line level (2400 loop)?
Answer: No. Only one Rendering Provider can be billed per claim.

Question: Does CareFirst accept claims from non-provider billing entities?
Answer: Yes. CareFirst has assigned specific "Submitter IDs" to Billing Providers/Agents who

submit on behalf of a provider. The Billing Provider/Agent data should be submitted in Loop 2010AA REF segment when the provider utilizes a Billing Agent to create their claims. The Pay-To-Provider data should then be sent in Loop 2010AB as directed in the Implementation Guides.

Question: What if the provider does not use a Billing Agent?

Answer: CareFirst expects the Pay-To-Provider data to be submitted in Loop 2010AA when there is NO Billing Provider/Agent. As specified in the Implementation Guides, there would then be no 2010AB Loop for this scenario.

Question: Can I send required attachments in electronic format along with the claim?
Answer: No. Electronic attachments are included in a future phase of HIPAA. Providers can send an electronic claim and include in the PWK indicator that an attachment will be sent under separate cover (e.g. mail or fax). Providers can also submit claims without attachments and CareFirst will contact them when additional information is required.

Question: How should electronic signature information be completed?
Answer: Signature information should be sent in the 2300 CLM09 "Release of Information Code" segment with the appropriate values.

Question: What codes should be used for the Secondary Provider ID qualifier?
Answer: For Institutional claims, CareFirst expects a value of 1A for all lines of business and plan codes.

Question: Are Marital Status (2010AB DMG04) or Employment Status (2000B SBR08) codes required on claims?
Answer: The Implementation Guide defines these fields for "Future Use." CareFirst does not require them at this time.

14.4 MAXIMUM NUMBER OF LINES PER CLAIM

To facilitate processing, CareFirst recommends that submitters limit the number of bill lines per claim to these maximums:

TYPE OF CLAIM	RECOMMENDED MAXIMUM
Maryland	99
DC Commercial	40
DC FEP	40
BlueCard	22
Delaware	29
MD/DC NASCO	39

CareFirst will accept claims including more than the recommended number of lines if a provider is unable to roll up or limit the number of bill lines. If you have questions or need assistance, please contact hipaa.partner@carefirst.com.

14.5 ADDITIONAL INFORMATION

Submitters sending transactions to, or connected with, CareFirst's Maryland systems are referred to as "Maryland submitters." Those sending transactions to, or connected with, CareFirst's D.C. or Delaware systems are referred to as "D.C. Submitters," or "Delaware submitters," respectively.

15. Appendix H: 837 D – Transaction Detail – Not Released

15.1 CONTROL SEGMENTS/ENVELOPES

15.1.1 6.1 ISA-IEA

15.1.2 6.2 GS-GE

15.1.3 6.3 ST-SE

15.1.4 ACKNOWLEDGEMENTS AND/OR REPORTS

15.2 TRANSACTION DETAIL TABLE

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**

15.3 FREQUENTLY ASKED QUESTIONS

Question: What is CareFirst's plan for accepting electronic dental claims using the 837 format?

Answer: Electronic dental claims should be sent to our clearinghouse, WebMD, until CareFirst establishes a direct submission method. CareFirst will pay the per-transaction cost that WebMD assesses for submitting the claim.

15.4 ADDITIONAL INFORMATION

16. Appendix I: 837 P – Transaction Detail

16.1 CONTROL SEGMENTS/ENVELOPES

16.1.1 6.1 ISA-IEA

This section describes CareFirst's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

16.1.2 6.2 GS-GE

This section describes CareFirst's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description of how CareFirst expects functional groups to be sent and how CareFirst will send functional groups. These discussions will describe how similar transaction sets will be packaged and CareFirst use of functional group control numbers.

16.1.3 6.3 ST-SE

This section describes CareFirst's use of transaction set control numbers.

16.1.4 ACKNOWLEDGEMENTS AND/OR REPORTS

A 997 Acknowledgement will be created for each file submitted for processing.

16.2 TRANSACTION DETAIL TABLE

Business rules for some data elements are still in development.

LEGEND: *SHADED* rows represent "segments" in the X12N implementation guide.
***NON-SHADED* rows represent "data elements" in the X12N implementation guide.**
"Loop – specific" comments should be indicated in the first segment of the loop.

837 P							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.3		ISA01	1	Authorization Information Qualifier	2		CareFirst recommends for all Plan Codes to always submit qualifier "00".
B.3		ISA02	2	Authorization Information	10		CareFirst recommends for all Plan Codes to always submit the maximum of 10 blank spaces.
B.4		ISA03	3	Security Information Qualifier	2	"00"	CareFirst recommends for all Plan Codes to always submit qualifier "00".
B.4		ISA04	4	Security Information	10		CareFirst recommends for all Plan Codes to always submit the maximum of 10 blank spaces.
B.4		ISA06	5	Interchange Sender ID	2		Must match the Federal Tax ID or other identifier submitted on the Trading Partner Registration Form
B.4		ISA07	7	Interchange ID Qualifier	2	**"ZZ"**	CareFirst recommends for all Plan Codes to always submit "ZZ".

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Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
B.5		**ISA08**	8	Interchange Receiver ID	15		CareFirst recommends set to 00580 for CareFirst DC 00690 for CareFirst MD 00570 for CareFirst DE
B.5		**ISA13**	13	Interchange Control Number	9		The Interchange Control Number must be unique for each file; otherwise, the file is considered a duplicate file and will be rejected.
B.6		**ISA16**	16	Component Element Separator	1		CareFirst recommends always use ':' [colon]
B.6		**GS02**	2	Application Sender's Code	15		Must match the Federal Tax ID or other identifier submitted on the Trading Partner Registration Form.
B.8		**GS03**	3	Application Receiver's Code	15		CareFirst recommends set to 00580 for CareFirst DC 00690 for CareFirst MD 00570 for CareFirst DE
74	**1000B - DETAIL - RECEIVER NAME LEVEL**						
75	1000	**NM103**	3	Name Last or Organization Name (Receiver Name)	35		CareFirst recommends set to CareFirst for all plan codes
75	1000	**NM109**	9	Identification Code (Receiver Primary Identifier)	80		CareFirst recommends set to 00580 for CareFirst DC 00690 for CareFirst MD 00570 for CareFirst DE
77	**2000A - DETAIL - BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL**						
84	**2010AA - DETAIL - BILLING PROVIDER NAME LEVEL – CareFirst expects the 2010AA Loop to identify the Billing Agent or Billing Service if applicable**						
92	2010	**REF01**	1	Reference Identification Qualifier	3	1B	CareFirst requires one repeat to contain value "1B" for all plan codes.
95	2010	**REF02**	2	Reference Identification (Billing Provider Additional Identifier)	30		When this loop contains the Billing Provider, CareFirst requires for the repeat with qualifier "1B": Billing Agent Number (Z followed by 3 numerics) for 00580 (DC). 9 digit Submitter number (51NNNNNNN) for 00690 (MD) DE specific Blue Shield Provider Number for 00570 (DE) When this loop contains the Pay-to Provider CareFirst requires for the repeat with qualifier "1B": Provider ID type in position 1, ID Number in positions 2-10, and Member Number in positions 11-14. Member number cannor be "0000" for 00580 (DC). 5-6 byte provider number for 00690 (MD) DE specific Blue Shield provider number for 00570 (DE)
99	**2010AB - DETAIL - PAY-TO PROVIDER NAME LEVEL - - - -**						
106	2010	**REF01**	1	Reference Identification	3	1B	CareFirst requires one repeat to contain

837 P							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
		Repeat: 5		Qualifier			value '1B' for all Plan Codes.
107	2010	**REF02**	2	Reference Identification (Pay-to-Provider Identifier)	30		CareFirst requires for the repeat with qualifier "1B": Provider ID type in position 1, ID Number in positions 2-10, and Member Number in positions 11-14. Member number cannor be "0000" for 00580 (DC). 5-6 byte provider number for 00690 (MD) DE specific Blue Shield provider number for 00570 (DE)
108	**2000B - DETAIL - SUBSCRIBER HIERARCHICAL LEVEL**						
112	2000	**SBR09**	9	Claim Filing Indicator Code	2		CareFirst recommends for Plan Code 00570 (DE) set value to BL only
117	**2010BA - DETAIL - SUBSCRIBER NAME LEVEL**						
119	2010	**NM109**	9	Identification Code (Subscriber Primary Identifier)	80		CareFirst recommends that the Identification Code include the 1 – 3 Character Alpha Prefix as shown on Customer ID Card for Plan Codes 00580 (DC) and 00690 (MD). CareFirst requires that the Identification Code include the 1 – 3 Character Alpha Prefix for Plan Code 00570.
170	**2300 - DETAIL - CLAIM INFORMATION LEVEL - - - -** **CareFirst recommends submit services related to <u>only one</u> Accident, LMP or Medical Emergency per claim**						
173	2300	**CLM05**	1	Claim Frequency Type Code (Claim Frequency Code)	1		CareFirst requires that the Claim Frequency Type cannot be value "0" (encounter) for Plan Codes 00580 (DC), 00690 (MD).
175	2300	**CLM09**	9	Release of Information Code	1		CareFirst requires the subscriber's signature to be on file for Plan 00580 (DC), 00690 (MD) and 00570 (DE).
176	2300	**CLM11**	1	Related Causes Code (Related Causes Code)	3		CareFirst recommends for all Plan Codes to submit Related Causes Code information for accidental injuries.
188	2300	**DTP01**	1	Date/Time Qualifier (Date Time Qualifier)	3	431	If known, CareFirst recommends for all Plan Codes to submit Onset of Current Illness/Symptom date information.
194	2300	**DTP01**	1	Date/Time Qualifier (Date Time Qualifier)	3	439	If services rendered are related to an accident, CareFirst recommends for all Plan Codes to submit Accident date information.
196	2300	**DTP01**	1	Date/Time Qualifier (Date Time Qualifier)	3	484	If services rendered are related to maternity care, CareFirst recommends for all Plan Codes to submit Last Menstrual Period information.
210	2300	**DTP01**	1	Date/Time Qualifier (Date Time Qualifier)	3	096	CareFirst recommends for all Plan Codes to submit discharge date information.
228	2300	**REF01**	1	Reference Identification Qualifier	3	9F	CareFirst recommends for Plan Code 00580 (DC), if 9F is used, then enter '1B' in Loop 2310A REF01.

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Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
228	2300	**REF02**	2	Reference Identification (Prior Authorization or Referral Number Code)	30		When segment is used for Referrals, (REF01 = "9F"), CareFirst recommends for Plan Code 00580 referral data at the claim level only in the format of two alphas (RE) followed by 7 numerics for Referral Number. When segment is used for Prior Auth, (REF01 = "1G"), CareFirst recommends For Plan Code 00570 1) One Alpha followed by 6 numerics for Authorization Number, OR 2) "AUTH N/A" , OR 3) On call providers may use AONCALL
229	2300	**REF02**	2	Reference Identification (Claim Original Reference Number)	30		(REF01 = "F8) CareFirst requires the original claim number assigned by CareFirst be submitted if claim is an adjustment.
282	**2310A - DETAIL - REFERRING PROVIDER NAME LEVEL**						
288	2310	**REF01 Repeat: 5**	1	Reference Identification Qualifier	3		CareFirst recommends use '1B' for Plan Codes 00580 (DC) and 00690 (MD). Use '1G' for Plan Code 00570 (DE).
289	2310	**REF02**	2	Reference Identification (Referring Provider Secondary Identifier)	30		CareFirst recommends for Plan Code 00580 (DC), enter Primary or Requesting Provider ID with the ID Number in positions 1 – 4, and Member Number in positions 5 – 8. CareFirst recommends for Plan Code 00570 (DE) enter 6 byte Referring Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
290	**2310B - DETAIL - RENDERING PROVIDER NAME LEVEL - - -** **Submit only one Rendering provider per claim**						
291	2310	**NM103**	3	Last Name/ Organization Name (Rendering Provider Last or Organization Name)	35		CareFirst recommends for Plan Code 00690 (MD) enter Rendering Provider Last Name
291	2310	**NM104**	4	Name First (Rendering Provider First Name)	25		CareFirst recommends for Plan Code 00690 (MD) enter Rendering Provider First Name
296	2310	**REF01 Repeat: 5**	1	Reference Identification Qualifier	3		CareFirst recommends use '1B' for Plan Codes 00580 (DC) and 00690 (MD). Use '1G' for Plan Code 00570 (DE).
297	2310	**REF02**	2	Reference Identification (Rendering Provider Secondary identifier)	30		CareFirst recommends Provider ID type in position 1, ID Number in positions 2-10, and Member Number in positions 11-14. Member number cannor be "0000" for 00580 (DC) CareFirst 6+2 Rendering Provider number For 00690(MD) 6 byte Rendering Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000 for 00570 (DE)
398	**2400 - DETAIL - SERVICE LINE LEVEL - -** **CareFirst recommends submit services related to only one Accident, LMP or Medical Emergency per claim**						

837 P							
Page #	**Loop ID**	**Reference**	**Field Num**	**X12 ELEMENT NAME**	**Length**	**Codes**	**Notes/Comments**
402	2400	**SV102**	1	Monetary Amount (Line Item Charge Amount)	18		CareFirst recommends for all Plan Codes that this amount must always be greater than "0"
403	2400	**SV103**	3	Unit or Basis for Measurement Code	2		CareFirst recommends always use 'MJ'* when related to the administration of anesthesia (Procedure Codes 00100-01995, or 01999,02100-02101).
403	2400	**SV104**	4	Quantity (Service Unit Count)	15		CareFirst recommends always use whole number(s) greater than 0.
485	2400	**AMT01**	1	Amount Qualifier Code	3		CareFirst recommends professional Commercial COB data at the detail line level only. See Implementation Guide.
485	2400	**AMT02**	2	Monetary Amount (Approved Amount)	18		CareFirst recommends professional Commercial COB data at the detail line level only. This field is designated for Commercial COB ALLOWED AMOUNT. See Implementation Guide.
488	2400	NTE01	1	Note Reference Code	3		For Plan Code 00580 (DC) and 00690 (MD), CareFirst requires value "ADD" if an NOC (not otherwise classified) procedure code was reported in Loop 2400 SV101 – 2 Procedure Code.
488	2400	NTE02	2	Description (Line Note Text)	80		For Plan Code 00580 (DC) and 00690 (MD), CareFirst requires the narrative description if an NOC (not otherwise classified) procedure code was reported in Loop 2400 SV101 – 2 Procedure Code.
New Loop	2410 – Detail – DRUG IDENTIFICATION LEVEL---- CareFirst recommends that a NDC code be submitted for prescribed drugs and biologics when required by government regulation.						
501	2420A – DETAIL RENDERING PROVIDER NAME LEVEL						
508	2420	**REF02**	2	Reference Identification (Rendering Provider Secondary Identifier)	80		CareFirst recommends for Plan Code 00570 (DE) enter 6 byte Rendering Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
541	2420F – DETAIL – REFERRING PROVIDER NAME LEVEL						
548	2420	**REF02**	2	Reference Identification (Referring Provider Secondary Identifier)	80		CareFirst recommends for Plan Code 00570 (DE) enter 9 byte Rendering Provider UPIN in format ANNNNN, AANNNN, AAANNN, OTH000 or UPN000
554	2430 – DETAIL – LINE ADJUDICATION INFORMATION LEVEL CareFirst recommends that Professional COB payment data be submitted at the detail line level. (Loop 2430-SVD and CAS elements).						
555	2430	**SVD02**	2	Monetary Amount (Service Line Paid Amount)	18		For all Plan Codes CareFirst requires the Service Line Paid Amount be submitted on COB claims at the detail line level. See Implementation Guide.
560	2430	CAS02	2	Claim Adjustment Reason Code (Adjustment Reason Code)	5		For all Plan Codes CareFirst requires an Adjustment Reason Code be submitted to indicate Primary Payer rejections on COB claims at the detail line level.
	END						

16.3 FREQUENTLY ASKED QUESTIONS

Question: We currently submit claims and eligibility inquiries through RealMed. Will that ability continue? Will it apply to all CareFirst plans?
Answer: RealMed has informed us that they are HIPAA-compliant. We expect that we will continue our relationship with RealMed for real-time claims and inquiry submission.

Question: Can I continue to submit claims in my current proprietary format, or do I have to switch to using the 837 format?
Answer: Providers can continue to submit claims in the proprietary format after 10/16/03 if the clearinghouse that you are using to transmit claims is able to convert this data to an 837format.

Question: Can I submit claims directly to CareFirst in the X12 format?
Answer: No. All claims must be submitted through one of the preferred clearinghouses that CareFirst has contracted with to receive and transmit claims. For additional information on the clearinghouses refer to the website, www.CareFirst.com, under Provider and Physicians in the Electronic Service section. Questions can also be directed to hipaa.partner@CareFirst.com.

Question: Will CareFirst pay the cost of claims submitted electronically ?
Answer: CareFirst will pay the per-claim charge for claims submitted electronically, through one of the preferred clearinghouses that CareFirst has contracted with to receive and transmit claims. For more detail visit the website at www.CareFirst.com, under Provider and Physician, in the Electronic Service section

Question: Will CareFirst accept Medicare secondary and other COB claims electronically?
Answer: For the most up-to-date information on Medicare Secondary and COB claims, direct your inquiry to hipaa.partner@CareFirst.com.

Question: Will Medicare and other COB claims submitted electronically adjudicate properly through the systems?
Answer: For the most up-to-date information on Medicare Secondary and COB claims, direct your inquiry to hipaa.partner@CareFirst.com.

Question: I have heard that CMS is allowing providers to continue to submit claims in the current format. Will CareFirst be able to continue to handle crossover claims in the current format after 10/16/03?
Answer: Yes. CareFirst will be able to accept these secondary claims in the current format.

Question: Can I send required attachments in electronic format along with the claim?
Answer: No. Electronic attachments are included in a future phase of HIPAA. Providers can send an electronic claim and include in the PWK indicator that an attachment will be sent under separate cover (e.g. mail or fax). Providers can also submit claims without attachments and CareFirst will contact them when additional information is required.

Question: How should electronic signature information be completed?
Answer: Signature information should be sent in the 2300 CLM09 “Release of Information Code” segment with the appropriate values.

Question: What codes should be used for the Secondary Provider ID qualifier?
Answer: For Professional claims, CareFirst expects a value of 1B for all lines of business and plan codes.

Question: I read that CareFirst will no longer accept Occurrence Codes 50 and 51 or Condition Codes 80 and 82. What codes should I use instead?
Answer: Use the latest version of the NUBC code set. For the most up-to-date information, direct your inquiry to hipaa.partner@CareFirst.com

Question: Are Marital Status (2010AB DMG04) or Employment Status (2000B SBR08) codes required on claims?
Answer: The Implementation Guide defines these fields for "Future Use." CareFirst does not require them at this time.

Question: What type of validator does CareFirst use? What types of validation does CareFirst enforce?
Answer: CareFirst uses Sybase for compliance checking WEDI-SNIP types 1-4.

Question: What is the most common X12 Compliance Error?
Answer: The most common compliance error is the ISA13 data element. For testing and production files, the Interchange Control Number must be unique otherwise the file will be rejected. Trading Partners are asked to ensure that each file that is submitted to CareFirst contain a unique ISA13 Control Number value. CareFirst recommends that Trading Partners use a sequentially generated number for each test and production file that is generated.

Question: What segment terminator does CareFirst prefer?
Answer: The tilde (~).

Question: Can CareFirst accept multiple Rendering Providers at the line level (2400 loop)?
Answer: No. Only one Rendering Provider can be billed per claim.

Question: Does CareFirst accept claims from non-provider billing entities?
Answer: Yes. CareFirst has assigned specific "Submitter IDs" to Billing Providers/Agents who submit on behalf of a provider. The Billing Provider/Agent data should be submitted in Loop 2010AA REF segment when the provider utilizes a Billing Agent to create their claims. The Pay-To-Provider data should then be sent in Loop 2010AB as directed in the Implementation Guides.

Question: What if the provider does not use a Billing Agent?
Answer: CareFirst expects the Pay-To-Provider data to be submitted in Loop 2010AA when there is NO Billing Provider/Agent. As specified in the Implementation Guides, there would then be no 2010AB Loop for this scenario.

16.4 MAXIMUM NUMBER OF LINES PER CLAIM

To facilitate processing, CareFirst recommends that submitters limit the number of bill lines per claim to these maximums:

TYPE OF CLAIM	RECOMMENDED MAXIMUM
Maryland	40
DC Commercial	23
DC FEP	20
BlueCard	22
Delaware	29
MD/DC NASCO	40

CareFirst will accept claims including more than the recommended number of lines if a provider is unable to roll up or limit the number of bill lines. If you have questions or need assistance, please contact hipaa.partner@carefirst.com.

16.5 ADDITIONAL INFORMATION

Submitters sending transactions to, or connected with, CareFirst's Maryland systems are referred to as “Maryland submitters.” Those sending transactions to, or connected with, CareFirst’s D.C. or Delaware systems are referred to as “D.C. Submitters,” or “Delaware submitters,” respectively.

Appendix J: Reading the 997 Acknowledgement

An abbreviated 997 acknowledgement appears below:

```
ISA*00*          *00*          *ZZ*00580          *ZZ*515108204
*031001*1734*U*00401*000000135*0*P*^
GS*FA*00580*133052274*20031001*173426*19*X*004010X098A1
ST*997*19001
AK1*HC*1
AK2*837*000000001
AK5*A
<...>
AK2*837*000000464
AK3*N4*92**8          ←AK3 Segment
AK4*3**1              ←AK4 Segment
AK5*R*5               ←AK5 Segment
<...>
AK2*837*000004189
AK5*A
AK2*837*000004190
AK5*A
AK9*P*4190*4190*4189*0          ←AK9 Segment
SE*8386*19001
GE*1*19
IEA*1*000000135
```

16.6 AK9 Segment

The summary for the submitted file is contained in the AK9 segment, which appears at the end of the 997 Acknowledgement.

- The AK9 segment is the Functional Group.
- "AK9" is the segment name.
- "P" indicates the file Passed the compliance check.
- "4190" (the first position) indicates the number of transaction sets sent for processing.
- "4190" (the second position) indicates the number of transaction sets received for processing.
- "4189" indicates the number of transaction sets accepted for processing.
- Therefore, one transaction set contained one or more errors that prevented processing. That transaction set must be re-sent after correcting the error.

16.7 AK5 Segment

The AK5 segment is the Transaction Set Response.
"R" indicates Rejection; "A" indicates Acceptance of the functional group.
Notice that most transaction sets have an "A" in the AK5 segment. However, transaction set number 464 has been rejected.

16.8 AK3 Segment

The AK3 segment reports any segment errors. Consult the IG for additional information.

16.9 AK4 Segment

The AK3 segment reports any element errors. Consult the IG for additional information.