# Quick Points

January 3, 2012

## Important notice on 5010 claim submission to Blue Cross and BlueLink TPA

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) and BlueLink TPA are now accepting HIPAA version 5010 claims. If you are currently submitting 5010 claims, Availity will no longer be down-converting these claims to the 4010 formats for processing by Blue Cross.

With the implementation of HIPAA 5010, Blue Cross is required under Minnesota Statute § 62J.536 to acknowledge the claims received using a standard acknowledgment (TA1, 999 or 277CA). Blue Cross has chosen to acknowledge claims with the 277CA, Health Care Claim Acknowledgement. Blue Cross will no longer be sending our proprietary Payer Edit Report (PA02) to communicate acceptance or denial of individual claim records. The detailed information regarding acceptance or rejection will be contained in the 277CA, Health Care Claim Acknowledgement.

We provide the most logical and clear response to each HIPAA 5010 claim using the Health Care Claim Status Category Code (code source 507) and the Health Care Claim Status Code (code source 508). However, in some situations the Health Care Claim Status Codes do not provide a clear description of the status of the claim.

Providers utilizing Availity as their clearinghouse, have a choice as to how they receive this acknowledgment information from Blue Cross. The provider may receive the acknowledgment information in one of two ways:

- The provider may receive the 277CA created by Availity based on Blue Cross' 277CA, **or**
- The provider may receive a report created by Availity from the Blue Cross information

Providers not utilizing Availity as their clearinghouse, should check with their clearinghouse on how acknowledgment information is processed and the options which may be available.

### Temporary help guide

Blue Cross created a temporary help guide to assist with your interpretation if you have chosen to receive the 277CA. This guide does not include all the Health Care Claim Status Category Code (code source 507) and the Health Care Claim Status Code (code source 508) combinations, but instead lists those we identified as requiring additional descriptions. In this guide, we provide extended descriptions for the use of the Health Care Claim Status Category Code (code source 507) and the Health Care Claim Status Code (code source 508) combinations. This guide is temporary and will not be maintained through the quarterly updates to these code sets. This guide is a tool to help understand how we have used the codes to best describe the action taken on a claim.

### Additional information

If you would like more information on the HIPAA 5010 277CA, Health Care Claim Acknowledgement, visit the Minnesota Administrative Uniformity Committee (AUC) website at **health.state.mn.us/auc** or the Washington Publishing website at **wpc-edi.com**. The Washington Publishing Company also provides online viewable lists of the Health Care Claim Status Category Code (code source 507) and the Health Care Claim Status Code (code source 508).

*Enclosure: 277CA Health Care Claim Acknowledgement Temporary Health Guide*



Distribution: Available on providers.bluecrossmn.com
QP1-12

# 277CA Health Care Claim Acknowledgement Temporary Help Guide

| 507 Code | 508 Status Cd-1 / Entity Code | 508 Status Cd-2 / Entity Code | 508 Status Cd-3 / Entity Code | New Message Text | Extended Description |
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| A2 | 20 | | | Multiple legacy provider IDs found for contracting provider # in 2010AA loop (inst & prov/billing prov/non xover/npi1) | Claim is accepted but pended for match to contracting entity. No action required by provider. |
| A2 | 20 | | | Multiple legacy provider IDs found for contracting provider # in 2010AA loop (inst & prov/billing prov/xover/npi3) | Claim is accepted but pended for match to contracting entity. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for contracting prov # in 2010AA loop (inst & prof/billing prov/non xover/NPI5) | Claim is accepted but pended for match to contracting entity. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for contracting prov # in 2010AA loop (inst & prof/billing prov/xover/NPI6) | Claim is accepted but pended for match to contracting entity. No action required by provider. |
| A2 | 20 | | | PA received claim from PTV, billing legacy number selected is not valid, return to PTV | Claim is accepted but pended for match to contracting entity. No action required by provider. |
| A2 | 20 | | | Claim type mismatch - billing provider 2010AA loop | Claim is pended in preadjudication as the provider appears to be of one type (professional or facility) but the claim format is of the other type. |
| A2 | 20 | | | Multiple legacy provider IDs found for rendering provider # in 2310B loop (prof/clm lvl/non xover/npi1) | Claim is accepted but pended for match to rendering entity. No action required by provider. |
| A2 | 20 | | | Multiple legacy provider IDs found for supervising provider # in 2310E loop (prof/clm lvl/non xover/npi1) | Claim is accepted but pended for match to supervising entity. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for rendering prov # in 2310B loop (prof/clm lvl/non xover/NPI5) | Claim is accepted but pended for match to rendering entity. No action required by provider. |
| A2 | 20 | | | Multiple legacy provider IDs found for rendering provider # in 2420A loop (prof/ln lvl/non xover/npi1) | Claim is accepted but pended for match to rendering entity. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for rendering prov # in 2420A loop (prof/ln lvl/non xover/NPI5) | Claim is accepted but pended for match to rendering entity. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for supervising prov # in 2420D loop (prof/ln lvl/non xover/NPI5) | Claim is accepted but pended for match to supervising entity. No action required by provider. |
| A2 | 20 | | | Multiple legacy provider IDs found for supervising provider # in 2420D loop (prof/ln lvl/non xover/npi1) | Claim is accepted but pended for match to supervising entity. No action required by provider. |

**277CA Health Care Claim Acknowledgement Temporary Help Guide**

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| A2 | 20 | | | NPI not on xwalk and provider is not Blue Cross and Blue Shield of Minnesota (NPI8) | Claim accepted but pended for set up of provider not contracted with Blue Cross. No action required by provider. |
| A2 | 20 | | | NPI on Portico but no legacy prov ID found for supervising prov # in 2310D loop (prof/clm lvl/non xover/NPI5) | Claim is accepted but pended for match to supervising entity. No action required by provider. |
| A3 | 491 | 538 | | Encounter ID must be 'CH' or '31' (4010) | Claim is rejected for correction of encounter ID. Provider must correct and resubmit. |
| A3 | 491 | 538 | | Encounter ID must be 'CH' or '31' (5010) | Claim is rejected for correction of encounter ID. Provider must correct and resubmit. |
| A3 | 562 | 135 | 21 | Billing Prov/Svc Facility Prov ID is not an atypical provider | Claim is rejected as the Billing provider or Service Facility Provider should be an NPI. Provider must correct and resubmit. |
| A3 | 562 | 135 | 21 | Multiple provider ID types are not allowed on same claim | Claim is rejected for provider to correct provider ID(s). A single claim must contain only NPI identifiers or only atypical identifiers. Provider must correct and resubmit. |
| A3 | 135 | 562 | 21 | Billing Provider ID or Service Facility Provider ID must be present | Claim is rejected as both the billing provider and service facility provider are not present. At least one of these must be present for adjudication. Provider must correct and resubmit. |
| A3 | 562 | 26 | | Unable to locate NPI on Portico for contracting provider in 2010AA loop (inst & prof/billing prov/non xover) | Claim is rejected as the provider has not reported their NPI to the payer. NPI must be reported prior to submitting claims. |
| A3 | 277 | 481 | 732 | Provider with electronic claim submission capability must submit electronically | Claim is rejected because it was submitted on paper but must be submitted to the payer electronically. |
| A3 | 562 | 26 | | Unable to find Billing Provider NPI on crosswalk | Claim is rejected as the provider has not reported their NPI to the payer. NPI must be reported prior to submitting claims. |
| A3 | 116 | 677 | | The claim must be submitted through your local Blue Plan | Claim is rejected as provider must submit this claim to the local Blue Plan. |
| A3 | 132 | 21 | | UMPI provider IDs are not allowed at Billing/Service Facility loops | Claim is rejected. Provider must resubmit with either the NPI or, if atypical, the Blue Cross contracting ID as the Billing/Service Facility provider. |
| A3 | 400 | | | Claim level COB amounts do not balance | Claim is rejected. Provider must resubmit with correct amounts in the previous payer fields. These amounts must balance per HIPAA rules. |
| A3 | 400 | | | Line level COB amounts do not balance | Claim is rejected. Provider must resubmit with correct amounts in the previous payer fields. These amounts must balance per HIPAA rules. |

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| A3 | 400 | | | Claim level combined with line level COB amounts do not balance | Claim is rejected. Provider must resubmit with correct amounts in the previous payer fields. These amounts must balance per HIPAA rules. |
| A6 | 530 | 162 | | When Clm Freq Type Cd (CLM05-3) indicates clm is an adj then this REF segment must contain the original claim number | Claim is rejected. Claim is a replacement or void claim so the original claim number is required. Provider must correct and resubmit. |
| A6 | 570 | 454 | 21 | Description is required when service is a non-specific procedure code | Claim is rejected as the required description was not submitted with the non-specific procedure code. Provider must add the description and resubmit. |
| A6 | 286 | - | | If Report Type Cd (PWK01) = EB (EOB) then PWK02 (Transmission Cd) must not = AA (available at provider site) | Claim is rejected as the EOB necessary to adjudicate the claim was not submitted. Provider must resubmit the claim with the accompanying attachment. |
| A6 | 286 | - | | If Report Type Cd (PWK01) = EB (EOB) then PWK02 (Transmission Cd) must not = AA (available at provider site) | Claim is rejected as the EOB necessary to adjudicate the claim was not submitted. Provider must resubmit the claim with the accompanying attachment. |
| A7 | 751 | | | Ambulance P/U location state code invalid | Claim is rejected as the ambulance pick up location contains an invalid state code. Provider must correct and resubmit. |
| A7 | 500 | 266 | 21 | Ambulance P/U location ZIP code invalid | Claim is rejected as the ambulance pick up location contains an invalid ZIP code. Provider must correct and resubmit. |
| A7 | 535 | | | Original Claim found in an Adjustment COBA ID file | Replacement or void claim is rejected as the original claim was received as a Medicare Crossover claim. This replacement or void must be sent to CMS for processing and crossover. |
| A7 | 535 | | | Adjustment Claim found in an Original COBA ID file | Replacement or void claim is rejected as the original claim was received as a Medicare Crossover claim. This replacement or void must be sent to CMS for processing and crossover. |
| A7 | 535 | 530 | | When Clm Feq Cd (CLM05-3) indicates this clm is an original clm then 2330B/REF01 cannot eq T4 (indicating clm is an adj) | Claim is rejected as the claim frequency code indicates this is an original claim but a payer original claim number is included on the claim record. Provider must correct and resubmit. |
| A7 | 704 | 732 | | If Delay Reason Cd = 11 (other) then add'l documentation is required in either the NTE or PWK segments.add SV202-7 and SV101-7 | Claim is rejected as it was submitted without additional documentation to describe the reason for the delay in submission. Provider must correct and resubmit with documentation. |

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| A7 | 286 | 732 | | If Delay Reason Cd = 11 (other) then PWK02 (Transmission Cd) must not = AA (available at provider site) | Claim is rejected as it was submitted without additional documentation to describe the reason for the delay in submission. Provider must correct and resubmit with documentation. |
| A7 | 509 | 255 | | First diagnosis pointer cannot point to "E" diagnosis | Claim is rejected as the primary diagnosis on one or more lines of the claim is tied to an external cause of injury code. Provider must correct either the diagnosis or the primary pointer and resubmit. |
| A7 | 745 | 454 | | Product/service qualifier must be "HC" or "HP" | Claim is rejected because the provider has used a qualifier that is not allowed by this payer. Provider must correct the qualifier and resubmit. |
| A7 | 745 | 454 | | Product/service qualifier must be "HC" | Claim is rejected because the provider has used a qualifier that is not allowed by this payer. Provider must correct the qualifier and resubmit. |
| A7 | 745 | 710 | | Product or service ID qualifier must equal "HC" or "HP" | Claim is rejected because the provider has used a qualifier that is not allowed by this payer. Provider must correct the qualifier and resubmit. |
| A7 | 745 | 710 | | Product or service ID qualifier must equal "HC" | Claim is rejected because the provider has used a qualifier that is not allowed by this payer. Provider must correct the qualifier and resubmit. |
| A7 | 751 | | | Ambulance P/O state code invalid | Claim is rejected as the ambulance drop off location contains an invalid state code. Provider must correct and resubmit. |
| A7 | 500 | 266 | | Ambulance P/O ZIP code invalid | Claim is rejected as the ambulance drop off location contains an invalid ZIP code. Provider must correct and resubmit. |
| A7 | 596 | 583 | | Non-covered charge amount cannot be greater than service line charge amount | Claim is rejected because the amount in the non-covered amount is greater than the line charge. Provide must correct the charge(s) and resubmit. |
| A7 | 454 | 710 | | Service line adjudication procedure code is invalid | Claim is rejected because the procedure code is invalid for the service date being billed. Provider must correct and resubmit. |
| A7 | 453 | 710 | | Service line adjudication procedure code modifier is invalid | Claim is rejected because the procedure code modifier is invalid for the service date being billed. Provider must correct and resubmit. |
| A7 | 258 | 454 | 732 | Unit value billed is inconsistent with procedure code. Please correct claim and resubmit | Claim is rejected because the unit value submitted with the procedure code is invalid. Provider must correct and resubmit. |

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| A8 | 693 | | | Patient paid amount must be positive value and cannot exceed total claim charge amount | Claim is rejected because either the patient paid amount is a negative value or it exceeds the total claim charge. Provider must correct this amount and resubmit. |
| A8 | 188 | | | Statement end date must be greater than or equal to statement start date | Claim is rejected because the statement end date is before the statement start date. Provider must correct and resubmit. |
| A8 | 188 | 189 | | Statement start date must be equal to or greater than admission date | Claim is rejected because the statement start date is before the admission date. Provider must correct and resubmit. |
| A8 | 158 | 188 | | Statement dates must be equal to or greater than patient's date of birth | Claim is rejected because the statement dates are before the patient's date of birth. Provider must correct and resubmit. |
| A8 | 232 | 189 | | Admit diagnosis must be a valid value for the admit date submitted | Claim is rejected because the admitting diagnosis is not valid for the admission date of the claim. Provider must correct and resubmit. |
| A8 | 158 | 187 | | Date of service must be greater than or equal to patient's date of birth | Claim is rejected because the line service date is before the patient's date of birth. Provider must correct and resubmit. |
| A8 | 187 | | | Ending date of service must be greater than or equal to beginning date of service | Claim is rejected because the ending service date is before the beginning service date. Provider must correct and resubmit. |
| A8 | 693 | | | Number of services cannot be zero or a negative value | Claim is rejected because the number of services is zero or negative. Provider must correct and resubmit. |