



An Independent Licensee of the Blue Cross Blue Shield Association

Blue Cross Blue Shield of Arizona Companion Guide

June 2010

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Table of Contents

Overview 1

Transactions Sets Business Use and Description 2

Getting Started 9

Implementation Checklist 11

Control Segments/Envelope Specifications..... 11

 Control Segments – Inbound 13

 Control Segments – Outbound 15

General Transaction Information 17

270/271 Transaction Sets 19

 Guidelines 20

 271 AAA Segments..... 20

 Data Elements 21

 Information Sheet..... 24

 Service Type Guidelines 25

276/277 Transaction Sets 30

 Guidelines 30

 Data Elements 31

278 Transaction Sets 32

 Guidelines 33

 278 AAA Segments..... 34

 Data Elements 35

820 Transaction Sets 40

 Guidelines 40

 Data Elements 41

834 Transaction Sets 45

 Guidelines 45

 Data Elements 46

 Health Coverage Codes and Descriptions 47

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Table of Contents

835 Transaction Sets	48
AMT Segment	48
CAS Segment	48
PLB Segment	48
Data Elements	49
837 Transaction Sets	51
Guidelines	51
BCBSAZ Claims Errors	52
Data Elements - Health Care Claim - Professional	53
Data Elements – Health Care Claim – Professional COB	54
Data Elements – Health Care Claim – Professional Adjustments	55
Data Elements – Health Care Claim – Institutional	56
Data Elements – Health Care Claim – Institutional COB	57
Data Elements – Health Care Claim – Institutional Adjustments	59
Data Elements – Health Care Claim - Dental	60
Data Elements – Health Care Claim – Dental Adjustments	61
Frequently Asked Transaction Questions	62
270/271	64
276/277	65
278	67
820	67
834	68
835	68
837	69
837I POA (Present on Admission)	69
837I Never Event	71
837 Adjustments	72
BCBSAZ HIPAA Glossary	75
Index	79

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Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires Blue Cross Blue Shield of Arizona (BCBSAZ) and all health insurance payers to comply with the Electronic Data Interchange (EDI) standards for health care as established by the Department of Health and Human Services.

The ASC X12N 4010 & 4010-A-1 addenda versions of the National Electronic Data Interchange Transactions Set Implementation Guide (IGs) have been established as the standards for compliance of health care transactions. BCBSAZ utilized the Washington Publishing Company's (WPC) Combined version: March 2003 Implementation Guides (IGs). The IGs for each transaction are available electronically from the WPC website at <http://www.wpc-edi.com/>.

This Companion Guide is to be used with, not as a replacement for, the ASC X12N 4010 and 4010-A-1 addenda version of the HIPAA Transaction Implementation Guides.

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COMPANION GUIDE**

270/271 Transaction Set Business Use and Description

Health Care Eligibility Benefit Inquiry and Response	Transaction Set	Business Use
	ASC X12N 270 Transaction	To inquire about the eligibility, coverage, or benefits associated with <ul style="list-style-type: none"> • a benefit plan • employer • plan sponsor • subscriber or a dependent under the subscriber's policy
	ASC X12N 271 Transaction	To communicate information about or changes to <ul style="list-style-type: none"> • eligibility • coverage • benefits from information sources , insurers, sponsors, and health plans to information receivers, i.e., the following: <ul style="list-style-type: none"> • physicians • hospitals • third-party administrators • government agencies

Description

- Provides a method for the following sources to inquire about eligibility, coverage, and benefits associated with a subscriber's policy:
 - physicians
 - hospitals
 - third-party administrators
 - government agencies
 - Does not provide a history of benefit use
-

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COMPANION GUIDE**

276/277 Transaction Set Business Use and Description

Health Care
Claim Status
Request and
Response

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 276 Transaction	Used by health care providers, recipients of health care products or services, or their authorized agents to request the status of a health care claim or encounter from a health care payer.
ASC X12N 277 Transaction	Used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent the status of a health care claim or encounter.

Description

- Provides a method for providers and recipients of health care products or services to request the status of a health care claim or encounter from a health plan or payer
 - The 276 request may occur at the summary or service level
 - The 277 response may be at a summary or service line detail level
 - The 276 transaction set is not intended to replace the Health Care Claim transaction set (837), but rather to occur after the receipt of a claim or encounter information
 - The 277 transaction set is not intended to replace the Health Care Claim Payment / Advice Transaction set (835), and therefore, should not be used for account payment posting
-

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COMPANION GUIDE**

278 Transaction Set Business Use and Description

Health Care
Services
Request for
Review and
Response

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 278 Transaction	Used to transmit health care service information, i.e., subscriber, patient, demographic and diagnosis, or treatment data between the following referring sources <ul style="list-style-type: none">• health care providers• health care providers furnishing services• utilization management organizations• payers• plan sponsors and• health plans for the purpose of request for review, certification, notification, or reporting the outcome of a health care services review.

Description

- Provides a method for health care providers to obtain certification for certain health care services based on the subscriber's contract
 - Used by both the provider (request) and the health plan (response)
 - Can be used for certification appeal review requests and associated responses
 - Can be used for extended certification review requests and associated responses
-

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COMPANION GUIDE**

820 Transaction Set Business Use and Description

Payroll
Deducted
and Other Group
Premium
Payment for
Insurance
Products

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 820 Transaction	Used to initiate: <ul style="list-style-type: none">• an electronic premium payment that includes the remittance detail needed by the premium receiver to properly apply the payment, or• a payment without the remittance detail. The remittance detail is sent separately to the premium receiver.

Description

- Provides a method for employers, employees, unions, and associations to make and keep track of payments of health plan premiums to their health insurers.
 - Can be used to make a payment, send a remittance advice, or make a payment and send a remittance advice.
 - Contains payment data related to a group employer's billing for health care premiums.
 - Can be an order to a financial institution to make payment to a payee.
 - Can also be a remittance advice identifying the detail needed to post payment to the payee's accounts receivable system.
 - The remittance advice can go directly from payer to payee, through a financial institution, or through a third-party agent.
-

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COMPANION GUIDE**

834 Transaction Set Business Use and Description

Benefit
Enrollment
and
Maintenance

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 834 Transaction	Used to establish communication between the sponsor of a health benefit and the health plan or payer for the purpose of providing the following enrollment data: <ul style="list-style-type: none">• subscriber and dependents information• employer information, and• health care provider information.

Description

- Provides a method for the exchange of enrollment data between health benefit sponsors and health plans or payers.
 - The sponsor is the backer of the coverage, benefit or product. A sponsor can be an employer, union, government agency, association or insurance company.
 - The health plan or payer refers to an entity that pays claims, administers the insurance product or benefit, or both.
-

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COMPANION GUIDE**

835 Transaction Set Business Use and Description

Health Care
Claim
Payment
Advice

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 835 Transaction	Used by a health plan to: <ul style="list-style-type: none">• make a payment to a financial institution for a health care provider (sending payment only)• send an Explanation of Benefits (EOB) remittance advice directly to a health care provider (sending data only).

Transaction Description

- Contains an explanation of payment and/or adjustment detail from the health plan.
 - One 835 transaction set reflects a single payment device – one 835 corresponds to one check or one Electronic Funds Transfer (EFT) payment. Multiple claims can be referenced within one 835.
 - Permits auto-posting of payments to the health care provider's practice management software or patient financial services accounts receivable system.
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COMPANION GUIDE**

837 Transaction Set Business Use and Description

Health Care
Claim
Professional,
Institutional,
and Dental

<i>Transaction Set</i>	<i>Business Use</i>
ASC X12N 837 Transaction	<p>Used to submit health care claim billing information and/or encounter information from health care providers to health plans or payers, either directly or via intermediary billing services or claims clearinghouses.</p> <p>The 837 transaction can also be used to transmit health care claims and billing payment information between the following:</p> <ul style="list-style-type: none">• health plans or payers with different payment responsibilities where coordination of benefits is required, or• health plans and regulatory agencies to monitor the rendering, billing and/or payment of health care services within a specific health care/insurance industry segment.

Transaction Description

Separate 837 transaction sets support the submission of institutional, professional, and dental claim and/or encounter data.

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COMPANION GUIDE**

Getting Started

**Becoming
a Trading
Partner**

The first step in becoming an electronic submitter is to contact eSolutions at the phone number listed below. You may also contact eSolutions for additional information on enrollment procedures or electronic transaction questions. For HIPAA content information, visit BCBSAZ's public website at www.azblue.com.

**Electronic
Submission
Options**

Important! Providers have the option to connect to BCBSAZ either through 1) a direct connection to BCBSAZ or 2) connecting through a third party clearinghouse. Call eSolutions with questions concerning any method of connectivity at the phone numbers listed below.

**eSolutions
Contact
Information**

Address

Blue Cross Blue Shield of Arizona
eSolutions
2444 W Las Palmaritas Drive
Phoenix, AZ 85021-4883

Contact Numbers

<i>If the Information You Need Is...</i>	<i>The Phone Number Is...</i>
To become a trading partner, help with a connectivity questions, to set up electronic transactions or for customer support of existing connections	(602) 864-4844 or (Out-of-state) (800) 232-2345 ext. 4844 (In-state) (800) 650-5656
FAX	(602) 864-3117

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Getting Started, Continued

BCBSAZ Direct Connect Requirements

If your software vendor offers the ASC X12N, 4010-A-1 transactions and can connect directly to BCBSAZ, please call eSolutions at (602) 864-4844 or (800) 650-5656 to initiate the set up process to submit electronic transactions directly to BCBSAZ.

- In some cases, BCBSAZ requires a signed and executed Trading Partner Agreement prior to testing any ASC X12N HIPAA Transaction.

If your software vendor cannot connect directly, please see the section titled Connecting Through a Third – Party Clearinghouse below.

Connecting Through a Third-Party Clearinghouse

The following information will assist you with connecting through a third-party clearinghouse.

- Contact your software vendor to see if they are affiliated with a clearinghouse. Some software vendors will require that the provider/submitter connect through a designated clearinghouse.
 - The third-party clearinghouse is responsible for assisting the provider/submitter with the communication connection between the provider/submitter and clearinghouse.
-

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COMPANION GUIDE**

Implementation Checklist

HIPAA ASC X12N Transactions Implementation Check List

- Trading Partner Agreement**
Direct connect providers may need to complete a Trading Partner Agreement and Customer Profile sheet. Check with your eSolutions Account Rep to confirm.

- BCBSAZ Companion Guide**
The guide details situational data elements unique to BCBSAZ for processing each transaction. It should be used in conjunction with the Washington Publishing Company (WPC) *Combined March 2003 Electronic Data Interchange Transaction Set Implementation Guide 4010-A-1 version (Implementation Guide)*. A link is available on BCBSAZ's website at www.azblue.com.

- Complete the required HIPAA testing with BCBSAZ**
 - BCBSAZ will have submitters test all transactions:
 - 1) For HIPAA compliance via BCBSAZ's HIPAA testing website.
 - 2) With BCBSAZ translators, clearinghouse* payer specific edits.

- Once testing is successfully completed, BCBSAZ will implement the HIPAA Transaction ASC X12N 4010-A-1.

Control Segments/Envelope Specifications

Acknowledgment Transactions	BCBSAZ will acknowledge all inbound HIPAA batch transactions with either a TA-1 Interchange Acknowledgment or a 997 Functional Acknowledgment transaction.
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TA-1 Interchange Acknowledgment	For either batch or real-time transactions, a TA-1 will be sent for compliance failures at the X12 Interchange Envelope level [within the Interchange Control Header (ISA) and Trailer (IEA) segments], resulting in rejection of the entire Interchange.
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* *The clearinghouse operated by BCBSAZ is not a clearinghouse as defined by HIPAA. The BCBSAZ clearinghouse will not translate electronic transactions sent from a non-standard format into a HIPAA standard format or from a HIPAA format into a non-standard format.*

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COMPANION GUIDE**

Control Segments/Envelope Specifications, Continued

**997 Functional
Acknowledgment**

If a valid interchange is received, a 997 acknowledgement transaction will be sent which provides the results of the compliancy status of the electronic file. The acknowledgement results are one of the following:

- A transaction set Acknowledgment Code (AK501) of 'A' indicates that the batch transaction passed compliance and was accepted.
- A non-compliant batch or real-time transaction will have a transaction set Acknowledgment Code of 'R' (rejected). The entire transaction set, Header (ST) to transaction set Trailer (SE) is rejected if any part of the transaction fails compliance.

More information on the TA-1 Interchange Acknowledgment and the 997 Functional Acknowledgment transactions can be found in *HIPAA Transaction Implementation Guides 4010-A1-Appendix B, EDI Control Directory*.

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COMPANION GUIDE**

Control Segments/Envelope Specifications - Inbound

**ISA
Interchange
Control
Header
Segment**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003				
<i>Data Element</i>	<i>Data Element ID</i>	<i>Size</i>	<i>Value</i>	<i>Notes/Comments</i>
Authorization Information Qualifier	ISA01	2/2	00	
Authorization Information	ISA02	10/10		Space filled.
Security Information Qualifier	ISA03	2/2	00	
Security Information/Password	ISA04	10/10		Space filled.
Interchange ID Qualifier/ Qualifier for Trading Partner ID	ISA05	2/2	ZZ	
Interchange Sender ID/Trading Partner ID	ISA06	15/15		BCBSAZ assigns 8-digit Sender ID code; left-justified, space filled.
Interchange ID Qualifier/Qualifier for BCBSAZ	ISA07	2/2	33	
Interchange Receiver ID/BCBSAZ	ISA08	15/15	53589	Left-justified, space filled
Interchange Date	ISA09	6/6		YYMMDD
Interchange Time	ISA10	4/4		HHMM
Interchange Control Standards ID	ISA11	1/1	U	
Interchange Control Version Number	ISA12	5/5	00401	
Interchange Control Number/Last Control Number	ISA13	9/9		Sender determines the control number; must match IEA02.
Acknowledgment Request	ISA14	1/1	01	
Usage Indicator	ISA15	1/1	P T	P=Production T=Test
Component Element Separator	ISA16	1/1		Sender determines the component element separator.

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COMPANION GUIDE**

Control Segments/Envelope Specifications – Inbound, Continued

**GS Functional
Group
Header
Segment**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003				
<i>Data Element</i>	<i>Data Element ID</i>	<i>Size</i>	<i>Value</i>	<i>Notes/Comments</i>
Functional Identifier Code	GS01	2/2		Code is defined in the Implementation Guide of the specific transaction in question.
Application Sender's Code	GS02	2/15		BCBSAZ assigns the Sender ID Code that must be submitted within the transaction.
Application Receiver's Code	GS03	2/15	53589	
Date	GS04	8/8		CCYYMMDD
Time	GS05	4/8		HHMM
Group Control Number	GS06	1/9		Sender determines the control number; must match GE02.
Responsible Agency Code	GS07	1/2	X	
Version/Release/Industry Identifier Code	GS08	1/12	00401 0X???A1	The question marks are defined in the Implementation Guide of the specific transaction in question.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Control Segments/Envelope Specifications – Outbound

**ISA
Interchange
Control
Header
Segment**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003				
<i>Data Element</i>	<i>Data Element ID</i>	<i>Size</i>	<i>Value</i>	<i>Notes/Comments</i>
Authorization Information Qualifier	ISA01	2/2	00	
Authorization Information	ISA02	10/10		Space filled.
Security Information Qualifier	ISA03	2/2	00	
Security Information/Password	ISA04	10/10		Space filled.
Interchange ID Qualifier/Qualifier for BCBSAZ ID	ISA05	2/2	33	
Interchange Sender ID/ BCBSAZ ID	ISA06	15/15	53589	Left-justified, space filled.
Interchange ID Qualifier/ Qualifier for Trading Partner ID	ISA07	2/2	ZZ	
Interchange Receiver/ Trading Partner ID	ISA08	15/15		BCBSAZ-assigned Sender ID is used as Receiver ID on outbound transactions. Left justified, space filled.
Interchange Date	ISA09	6/6		YYMMDD
Interchange Time	ISA10	4/4		HHMM
Interchange Control Standards ID	ISA11	1/1	U	
Interchange Control Version Number	ISA12	5/5	00401	
Interchange Control/ Last Control Number	ISA13	9/9		Sender (BCBSAZ) determines the control number; must match IEA02.
Acknowledgment Request	ISA14	1/1	0	BCBSAZ will always use '0' (No Acknowledgment Requested).
Usage Indicator	ISA15	1/1	P T	P=Production T=Test
Component Element Separator	ISA16	1/1		Sender determines the component element separator.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Control Segments/Envelope Specifications – Outbound, Continued

**GS Functional
Group Header
Segment**

GS Functional Group Header Segment				
<i>Data Element</i>	<i>Data Element ID</i>	<i>Size</i>	<i>Value</i>	<i>Notes/Comments</i>
Functional Identifier Code	GS01	2/2		Code is defined in the Implementation Guide of the specific transaction in question.
Application Sender's Code	GS02	2/15	53589	
Application Receiver's Code	GS03	2/15		BCBSAZ-assigned Sender ID Code is used as Receiver's Code on outbound transactions.
Date	GS04	8/8		CCYYMMDD
Time	GS05	4/8		HHMM
Group Control Number	GS06	1/9		Sender (BCBSAZ) determines the control number; must match GE02.
Responsible Agency Code	GS07	1/2	X	
Version/Release/ Industry Identifier Code	GS08	1/12	004010 X???A1	The question marks are defined in the Implementation Guide of the specific transaction in question.

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COMPANION GUIDE**

General Transaction Information

Introduction

eSolutions will issue an eight-digit sender ID to be used within the HIPAA transactions that the trading partner has elected to send/receive.

Transmission Guidelines

- Do not concatenate multiple ISA/IEA interchanges within a file.
- Submit one GS/GE functional group within one ISA/IEA interchange envelope structure.
- Transaction responses for batch transactions will be placed in an electronic mailbox for pickup by the provider.
- Submit data in uppercase.
- For batch transactions, the file naming convention is, "0000SSSS.###"

Note: "0000SSSS" indicates the 8 digit sender ID number assigned by BCBSAZ. "###" defines the transaction number, i.e 837,

Outbound Delimiters

BCBSAZ will use the following delimiter character set for all outbound transactions to our trading partners:

<i>Delimiters Character</i>	<i>Purpose</i>
Asterisk (*)	Used to separate elements within a segment
Colon (:)	Used for composite elements
Tilde (~)	Represents the end of a segment

Inbound Delimiters

Important! The use of (*), (:) and (~) other than as a delimiter is expressly prohibited. Do not use these delimiters in any data elements of the file. Using these delimiters in any data elements will create syntax error that will cause your file to fail compliance.

BCBSAZ will accept any standard delimiter for inbound transactions as defined in Section A of the Implementation Guides.

(continued on next page)

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

General Transaction Information, Continued

Decimals

The decimal element, represented as 'R' in the Implementation Guides may contain explicit decimal points and is used for numeric values that have a varying number of decimal positions. The decimal point always appears in the character stream if it is at any place other than the right-end.

Examples

- If the monetary amount submitted is \$30.00, the data will look like '30' with no decimal present in the character stream.
 - If the monetary amount submitted is \$30.25, the data will look like '30.25' with the decimal present in the character stream.
-

**HIPAA
Guidelines
on Monetary
Decimals**

For implementation under HIPAA Guidelines, decimal data elements containing monetary amounts will be limited to a maximum length of 10 characters, including reported or implied places for cents (implied value of '00' after the decimal point).

**Triad
Separators**

Important! The use of triad separators, i.e., the commas in 1,000,000, is expressly prohibited and will result in compliance failure at the point of entry.

**Leading
Zeros**

Leading zeros should be suppressed unless needed to satisfy a minimum length requirement.

**Trailing
Zeros**

Trailing zeros following the decimal point should be suppressed unless needed to indicate precision.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

Introduction

The 270/271 ASC X12N – Health Care Eligibility Benefit Inquiry and Response transactions defines a format to electronically transfer health care eligibility and benefit information.

These transactions are used by inquiry submitters to determine if an information source organization (i.e., payer, employer, HMO) has a particular subscriber's and/or dependents health care eligibility and benefit information on file. The data is used to verify an individual's eligibility and benefit information, but does not provide a benefit history.

<i>Transaction Type</i>	<i>Description</i>
ASC X12N 270 Transaction	Health Care Eligibility Benefit inquiry from a submitter (information receiver) to an information source organization. This transaction is used for requesting eligibility and benefit information.
ASC X12N 271 Transaction	Health Care Eligibility Benefit response from an information source organization to a submitter (information receiver). This transaction is used to respond to eligibility and benefit coverage inquiries.

The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 270/271- Health Care Eligibility Benefit Inquiry and Response transaction.

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

270/271 Guidelines

- The 270/271 eligibility inquiry and response transaction can be conducted for local BCBSAZ, FEP (Federal Employee Program) and BlueCard (Out-of-Area) members.
- Subscriber ID requirements to submit BCBS claims are as follows:
 - Local members - Three-digit alpha prefix.
 - FEP members - Alpha prefix begins with 'R'.
 - Out-of-Area members - A minimum of three-digit alpha prefix.
- The 271 response transaction will also return an INS segment that identifies a "change" for any of the following data fields: provider ID, subscriber ID, first, last name and date of birth.
- The NPI is required on all electronic transactions.
- Batch inquiries will be broken down and processed as individual transactions by BCBSAZ. You will receive individual responses for each transaction
- The 270/271 transaction is capable of responding to past, present and future inquiries. Future inquiries must be less than or equal to 14 days in the future.
- For Corporate Health Service (CHS) plans eligibility and benefit inquiries, contact the CHS plan or applicable third-party administrator (TPA) located on the back of the member's card

AAA Segments

Potential scenarios which result in failure of the request transaction and creation of the 271 AAA segment response are:

- system time-out
- future date of service greater than 14 days
- membership validation
- provider ID validation

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response

**270/271
Data Elements**

Implementation Guide Version: 4010 A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
44	2100A	<u>NM101</u> Information Source Name	Entity Identifier Code	PR	2/3	Insert 'PR' (Payer)
45		<u>NM102</u> Information Source Name	Entity Type Qualifier	2	1/1	Insert '2' (Non-Person Entity)
46		<u>NM108</u> Information Source Name	Identification Code Qualifier	NI	1/2	Insert 'NI' (NAIC)
		<u>NM109</u> Identification Code	Information Source Identifier	53589	2/80	Insert '53589'
52	2100B	<u>NM108</u> Identification Code Qualifier	Identification Code Qualifier	24, 34, FI, SV or XX	1/2	Effective 5/23/08, only 'XX' should be submitted
53		<u>NM109</u> Identification Code	Information Source Identifier		1/2	Effective 5/23/08, only the NPI should be submitted
72	2100C	<u>NM103</u> Subscriber Name	Subscriber Last Name		1/35	Must be present, if the patient is the subscriber
		<u>NM104</u> Subscriber Name	Subscriber First Name		1/25	
73	<u>NM108</u> Subscriber Name	Identification Code Qualifier	MI	1/2		
	<u>NM109</u> Subscriber Name	Subscriber Primary Identifier		2/80		

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**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response, Continued

**270/271
Data Elements,
Continued**

Implementation Guide Version: 4010 A-1		WPC Combined Version: March 2003				
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
84	2100C	<u>DMG01</u> Subscriber Demographic Information	Date Time Period Format Qualifier	D8	2/3	The DMG segment is situational but must be present if the patient is the subscriber; if it is used, this element is required.
		<u>DMG02</u> Subscriber Demographic Information	Subscriber Date of Birth		1/35	Must be present if the patient is the subscriber, i.e., 2100C, DMG segment is created.
		<u>DMG03</u> Subscriber Demographic Information	Gender Code	F, M	1/1	
D8		<u>DTP01</u> Subscriber Date	Date Time Qualifier	307	3/3	The DTP segment is situational. If it is used to specify a date of service, other than "today", this element is required. It is used only if the patient is the subscriber.
		<u>DTP02</u> Subscriber Date	Date Time Period Format Qualifier		2/3	
		<u>DTP03</u> Subscriber Date	Date Time Period		1/35	
	2100D	<u>NM103</u> Dependent Name	Dependent Last Name		1/35	Must be present if the patient is a dependent
		<u>NM104</u> Dependent Name	Dependent First Name		1/25	

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**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response, Continued

**270/271
Data
Elements,
Continued**

Implementation Guide Version: 4010 A-1				WPC Combined Version: March 2003		
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
125	2100D	<u>DMG01</u> Dependent Demographic Information	Date Time Period Format Qualifier	D8	2/3	The DMG segment is situational but must be present if the patient is a dependent; if used, this element is required.
		<u>DMG02</u> Dependent Demographic Information	Dependent Date of Birth		1/35	Must be present if the patient is a dependent, i.e., 2100D, DMG01 is used.
		<u>DMG03</u> Dependent Demographic Information	Gender Code	F, M	1/1	Must be present if the patient is a dependent, i.e., 2100D, DMG segment is created.
130		<u>DTP01</u> Dependent Date	Date Time Qualifier	307	3/3	The DTP segment is situational. If it is used to specify a date of service other than "today", this element is required. It is used only if the patient is a dependent.
		<u>DTP02</u> Dependent Date	Date Time Period Format Qualifier	D8	2/3	
		<u>DTP03</u> Dependent Date	Date Time Period		1/35	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

270/271-ASC X12N-Health Care Eligibility Benefit Inquiry and Response, Continued

270 Information Sheet Vendors and Clearinghouses must not truncate the 271 Response when returning the response data back to the provider.

BCBSAZ only supports one service type (EQ Segment) per transaction.

Service Type EQ Segment	Description	Comments
98	Office Visit	Do not use 03
42	Home Health	Do not use 14
80	Immunization	Do not use 19
12	Prosthetic Device	Do not use 75
34	Chiropractic Office Visits	Use 33
59	Licensed Ambulance	Do not use 56, 57 or 58
5	Diagnostic Lab	Do not use 66
AI	Substance Abuse	Do not use AJ or AK
AL	Vision	Do not use BR (for medical)
12	Durable Medical	Do not use 11
62	MRA and PET	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**270 Service
Type
Guidelines**

Service Type	HIPAA Description	Included Service Types on Response	Comments
1	Medical Care	1*, 48, 50, 52, 98, A7, A8	
2	Surgical	2, 7, 8, 20	
3	Consultation	48, 50, 52, 98, A7, A8	
4	Diagnostic X-Ray	4	
5	Diagnostic Lab	5	
6	Radiation Therapy	6	
7	Anesthesia	7	
8	Surgical Assistance	8	
9	Other Medical		
10	Blood Charges		
11	Used Durable Medical Equipment		Please use Service Type 12
12	DME Purchase	12	
13	Ambulatory Service Center Facility	13	
14	Renal Supplies in the Home		
15	Alternate Method Dialysis		
16	Chronic Renal Disease (CRD) Equipment		
17	Pre - Admission Testing		
18	DME Rental	18	
19	Pneumonia Vaccine		Please use Service Type 80
20	Second Surgical Opinion	20	
21	Third Surgical Opinion		
22	Social Work		
23	Diagnostic Dental	24, 25, 26, 35, 38, 39, 41	
24	Periodontics	24, 25, 26, 35, 38, 39, 41	
25	Restorative	24, 25, 26, 35, 38, 39, 41	
26	Endodontics	24, 25, 26, 35, 38, 39, 41	
27	Maxillofacial Prosthetics		
28	Adjunctive Dental Services	24, 25, 26, 38, 39, 41	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**270 Service
Type
Guidelines,
Continued**

Service Type	HIPAA Description	Included Service Types on Response	Comments
30	Health Benefit Plan Coverage	48, 50, 52, 98, A7, A8	
32	Plan Waiting Period		
33	Chiropractic	4, 33	
34	Chiropractic Office Visits		Please use Service Type 33
35	Dental Care	35	Service Type 35 is the Dental Baseline
36	Dental Crowns	24, 25, 26, 35, 38, 39, 41	
37	Dental Accident		Please use Service Type 30
38	Orthodontics	24, 25, 26, 35, 38, 39, 41	
39	Prosthodontics	24, 25, 26, 35, 38, 39, 41	
40	Oral Surgery	40	
41	Routine (Preventive) Dental	24, 25, 26, 35, 38, 39, 41	
42	Home Health Care	42, 43, A3	
43	Home Health Prescriptions		
44	Home Health Visits		
45	Hospice	45	
46	Respite Care		
47	Hospital	47*, 48, 99, 50, 51, 52, A0	
48	Hospital - Inpatient	48, 99	
49	Hospital - Room and Board		
50	Hospital - Outpatient	50, 51, 52, A0	
51	Hospital - Emergency Accident	51	
52	Hospital - Emergency Medical	52	
53	Hospital - Ambulatory Surgical	53	
54	Long Term Care		
55	Major Medical		
56	Medically Related Transportation		Please use Service Type 59
57	Air Transportation		Please use Service Type 59

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**270 Service
Type
Guidelines,
Continued**

Service Type	HIPAA Description	Included Service Types on Response	Comments
58	Cabulance		Please use Service Type 59
59	Licensed Ambulance		
60	General Benefits	60*	
61	In-vitro Fertilization	61	
62	MRI/CAT Scan	62	
63	Donor Procedures		
64	Acupuncture		
65	Newborn Care	65	
66	Pathology		Please use Service Type 5
67	Smoking Cessation		
68	Well Baby	68, 80, BH	
69	Maternity	69	
70	Transplants		
71	Audiology Exam		
72	Inhalation Therapy		
73	Diagnostic Medical	4, 5, 62, 73	
74	Private Duty Nursing		
75	Prosthetic Device		Please use Service Type 12
76	Dialysis	76	
77	Otological Exam		
78	Chemotherapy	78	
79	Allergy Testing		
80	Immunizations	80	
81	Routine Physical	81	
82	Family Planning	82	
83	Infertility	83, 61	
84	Abortion	84	
85	AIDS		
86	Emergency Services	51, 52, 86, 98	
87	Cancer		
88	Pharmacy	88	Service Type 88 is the Pharmacy Baseline
89	Free Standing Prescription Drug	88	
90	Mail Order Prescription Drug	88	
91	Brand Name Prescription Drug	88	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**270 Service
Type
Guidelines,
Continued**

Service Type	HIPAA Description	Included Service Types on Response	Comments
92	Generic Prescription Drug	88	
93	Podiatry	93	
94	Podiatry-Office Visits		
95	Podiatry - Nursing Home Visits		
96	Professional(Physician)		
97	Anesthesiologist		
98	Professional (Physician) Visit - Office	98	
98	Professional (Physician) Visit - Office	98	
99	Professional (Physician) Visit - Inpatient	99	
A0	Professional (Physician) Visit - Outpatient	A0	
A1	Professional (Physician) Visit - Nursing Home		
A2	Professional (Physician) Visit - Skilled Nursing Facility		
A3	Professional (Physician) Visit - Home	A3	
A4	Psychiatric		
A5	Psychiatric - Room and Board		
A6	Psychotherapy	A6	
A7	Psychiatric - Inpatient	A6, A7	
A8	Psychiatric - Outpatient	A6, A8	
A9	Rehabilitation		
AA	Rehabilitation - Room and Board		
AB	Rehabilitation - Inpatient		
AC	Rehabilitation - Outpatient		
AD	Occupational Therapy		
AE	Physical Medicine		
AF	Speech Therapy	AF	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**270 Service
Type
Guidelines,
Continued**

Service Type	HIPAA Description	Included Service Types on Response	Comments
AG	Skilled Nursing Care - Room and Board	AG	
AH	Skilled Nursing Care - Room and Board		
AI	Substance Abuse	AI	
AJ	Alcoholism		Please use Service Type AI
AK	Drug Addiction		Please use Service Type AI
AL	Vision (Optometry)	AL	Service Type AL is the Vision Baseline
AM	Frames	AL, AN	
AN	Routine Exam	AL, AN	
AO	Lenses	AL, AN	
AQ	Nonmedically Necessary Physical		
AR	Experimental Drug Therapy		
BA	Independent Medical Evaluation		
BB	Partial Hospitalization (psychiatric)		
BC	Day Care (Psychiatric)		
BD	Cognitive Therapy		
BE	Massage Therapy		
BF	Pulmonary Rehabilitation		
BG	Cardiac Rehabilitation	BG	
BH	Pediatric	BH	
BI	Nursery		
BJ	Skin		
BK	Orthopedic		
BL	Cardiac		
BM	Lymphatic		
BN	Gastrointestinal		
BP	Endocrine		
BQ	Neurology		
BR	Eye		Please inquire using Service Type AL
BS	Invasive Procedures		

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

276/277-ASC X12N- Health Care Claim Status Request and Response

Introduction

The 276/277 ASC X12N - Health Care Claim Status Request and Response transactions defines a format to electronically transfer the subscriber's and/or dependent's health care claim status information. These transactions and their descriptions consist of the following :

<i>Transaction Type</i>	<i>Description</i>
ASC X12N 276 Transaction	This transaction is used for requesting information. The Claim Status inquiry is from a submitter (information receiver) to an information source organization.
ASC X12N 277 Transaction	This transaction is used to respond with claim status information. The Claim Status response is from an information source organization to a submitter (information receiver).

The information below and on the following pages define situational data elements unique to BCBSAZ for processing the ASC X12N 276 - Health Care Claim Status Request and Response transaction.

**276/277
Guidelines**

- Subscriber ID requirements to submit BCBS claims are as follows:
 - Local members - Three-digit alpha prefix.
 - FEP members - Alpha prefix begins with 'R'.
 - Out-of-Area members - A minimum of three-digit alpha prefix.
 - If an incorrect subscriber alpha prefix is submitted on a local BCBSAZ request, the 277 response will contain the corrected alpha prefix.
 - The NPI is required on all electronic transactions.
 - Batch inquiries will be broken down and processed as individual transactions by BCBSAZ. Therefore, you will receive individual responses.
 - If the claim was paid by Electronic Funds Transfer (EFT), the EFT trace number in the 277 response will be a BCBSAZ tracking number, not the EFT number used by the bank.
 - Provider claim status inquiries for all services provided in Arizona on behalf of any BCBS Plan must be submitted to BCBSAZ.
 - For Corporate Health Service (CHS) Plans claim status inquiries, contact the CHS Plan or applicable third-party administrator (TPA) located on the back of the member's card
-

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

276/277-ASC X12N- Health Care Claim Status Request and Response, Continued

**276/277 Data
Elements**

Implementation Guide Version 4010A-1			WPC Combined Version: March 2003			
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
55-56	2100A	<u>NM108</u> Payer Name	Identification Code Qualifier	NI	1/2	Insert 'NI' (NAIC Code).
		<u>NM109</u> Payer Name	Payer Identifier		2/0	Insert '53589'.
76	2100D	<u>NM109</u> Subscriber Name	Subscriber Identifier		2/80	Must be complete ID number, including the alpha prefix.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N- Health Care Services Review–Request for Review and Response

Introduction

The ASC X12N 278 Health Care Services Review-Request for Review and Response transaction defines a format to electronically transfer a subscriber's and/or dependent's health care referral, pre-certification and pre-authorization review, request, and response between providers and review entities.

It processes information from primary participants such as, providers and Utilization Management Organizations (UMOs), where the entity inquiring is the primary provider and the service provider.

<i>Transaction Type</i>	<i>Description</i>
ASC X12N 278-13 Transaction	This transaction is used to request information related to pre-certification and pre-authorization. This is a Health Care Services Review-Request from a submitter (information receiver) to an information source organization.
ASC X12N 278-11 Transaction	This transaction is used to respond to referral, pre-certification and pre-authorization inquiries. This is a Health Care Services response from an information source organization to a submitter (information receiver).

The information on the following pages details situational data elements unique to BCBSAZ for processing the HIPAA 278 Health Care Services Review–Request for Review and Response transaction.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N- Health Care Services Review–Request for Review and Response, Continued

**278
Guidelines**

Important! When the 278-11 response is sent, the HCR02 Certification Number may or may not be present. This number only confirms the return response and does not confirm approval of the 278-13 request. Therefore, it is imperative to check each Service Line for the appropriate HCR01 Action Code (A1, A3, A4, A6, CT or NA). The following guidelines will assist you in processing the 278 transaction.

General Guidelines

- BCBSAZ will only accept batch 278 HIPAA transactions.
- Batch inquiries will be broken down and processed as individual transactions by BCBSAZ. You will receive individual responses.

278-13 Request

- The NPI is required on all electronic transactions. Urgent and Non-Urgent 278-13 requests should be submitted with separate Level of Service Codes, per patient event.
- Subscriber ID requirements to submit BCBS claims are as follows:
 - Local members - Three-digit alpha prefix.
 - FEP members - Alpha prefix begins with 'R'.
 - Out-of-Area members - A minimum of three-digit alpha prefix.
- BCBSAZ will accept default values of all 9's on TRN02 and TRN03.

278-11 Response

- 278 responses sent from other Plans may not be considered final and can be followed-up with a letter, phone call, etc. Please contact the appropriate BCBS Plan for status.
- If the TRN is submitted at the subscriber level and BCBSAZ determines the patient is the dependent the response will be returned at the dependent level.
- If the TRN is submitted at the dependent level and BCBSAZ determines the patient is the subscriber the response will be returned at the subscriber level.
- If an incorrect subscriber alpha prefix is submitted on a local BCBSAZ request, the 278 response will contain the corrected alpha prefix.

(continued on next page)

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N- Health Care Services Review–Request for Review and Response, Continued

AAA Segments

Potential scenarios which result in failure of the request transaction and creation of the 278 AAA segment response are:

- system time-out
- membership validation
- provider ID validation (NPI algorithm)

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

**278 Data
Elements**

Implementation Guide Version: 4010A-1			WPC Combined Version: March 2003			
IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71	2010A	<u>NM108</u> Utilization Management Organization Name (UMO)	UMO ID Code	PI	1/2	Insert 'PI' (Payer Identification).
		<u>NM109</u> Utilization Management Organization Name (UMO)			2/80	Insert '860004538' for UMO (BCBSAZ) ID Code.
83	2010B	<u>PER02</u> Requester Contact Information	Requester Contact Name		1/60	This information must be submitted to identify the Contact Name.
		<u>PER03</u> Requester Contact Information	Requester Communica- tion Number Qualifier	EM FX TE	2/2	At least one Qualifier and up to three associated communication numbers must be submitted.

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278 Data
Elements,
Continued

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
83	2010B	<u>PER04</u> Requester Contact Information	Requester Communication Number		1/80	This information must be submitted as the contact communication number. Note: If additional Contact Communication Numbers are available, please use elements PER05 through PER08.
60	2010CA	<u>NM103</u> Subscriber Name	Subscriber Last Name		1/35	This information is required if the subscriber is the patient.
60		<u>NM104</u> Subscriber Name	Subscriber First Name		1/35	
141	2010DA	<u>NM103</u> Dependent Name	Dependent Last Name		1/35	This information is required when the dependent loop is used.
141		<u>NM104</u> Dependent Name	Dependent First Name		1/35	
145		<u>DMG02</u> Dependent Demograp hic Information	Dependent Date of Birth		1/35	
145		<u>DMG03</u> Dependent Demo- graphic Information	Gender Code	F, M	1/1	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

278 Data
Elements,
Continued

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
83	2010B	<u>PER04</u> Requester Contact Information	Requester Communication Number		1/80	This information must be submitted as the contact communication number. Note: If additional Contact Communication Numbers are available, please use elements PER05 through PER08.
60	2010CA	<u>NM103</u> Subscriber Name	Subscriber Last Name		1/35	This information is required if the subscriber is the patient.
60		<u>NM104</u> Subscriber Name	Subscriber First Name		1/35	
141	2010DA	<u>NM103</u> Dependent Name	Dependent Last Name		1/35	This information is required when the dependent loop is used.
141		<u>NM104</u> Dependent Name	Dependent First Name		1/35	
145		<u>DMG02</u> Dependent Demograp hic Information	Dependent Date of Birth		1/35	
145		<u>DMG03</u> Dependent Demo- graphic Information	Gender Code	F, M	1/1	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

**278 Data
Elements,
Continued**

Implementation Guide Version: 4010A-1		WPC Combined Version: March 2003				
IG Page #	Loop ID	Reference	Name	Codes	Length	Comments
153	2010E	<u>NM103</u> Service Provider Name	Service Provider Last or Organization Name		1/35	Required for processing by BCBSAZ.
161		<u>PER02</u> Service Provider Contact	Service Provider Contact Name	Free form	1/60	This information is required to identify the Contact Name.
		<u>PER03</u> Service Provider Contact	Service Provider Communication Number Qualifier	EM FX TE	2/2	
		<u>PER04</u> Service Provider Contact	Service Provider Contact Communication Number		1/80	Note: If additional Contact Communication Numbers are available, please use elements PER05 through PER08.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

278-ASC X12N: Health Care Services Review–Request for Review and Response, Continued

**278 Data
Elements,
Continued**

Implementation Guide Version: 4010A-1				WPC Combined Version: March 2003		
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
170		<u>UM02</u> Health Care Services Review Information	Certification Type Code		1/1	Insert the selected certification type code to indicate type of certification. Note: If '1' is selected, then UM06 must be submitted with value of '03' or 'U' to indicate the level of service as Urgent. Otherwise, the request will be treated as non-urgent.
170- 173		<u>UM03</u> Health Care Services Review Information	Service Type Code		1/2	Required by BCBSAZ to indicate classification of service.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products

Introduction

The 820 ASC X12N Payroll Deducted and Other Group Premium Payment for Insurance Products is used to initiate group premium payment transactions with or without remittance detail.

The information on the following pages details situational data elements unique to BCBSAZ for processing this type of transaction.

**820
Guidelines**

The following are guidelines for processing the 820 transaction:

- Receiving Depository Financial Institution ID Number and Receiver Bank Account Number will be provided after execution of the Trading Partner Agreement.
 - ACH payment dollars must include remittance detail with group section number and will be processed through the ACH Network and financial institutions.
 - BCBSAZ expects premium payments to be made in the same currency as billed (United States Dollars); therefore, the Non-US Dollars Currency segment should not be used.
-

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products,
Continued**

**820 Data
Elements**

		Implementation Guide Version: 4010A-1		WPC Combined Version: March 2003				
IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments		
36		<u>BPR01</u> Financial Information	Transaction Handling Code	C	1/ 2	Insert 'C' (Payment Accompanies Remittance Advice) when format is X12N including ACH payment.		
				I		Insert 'I' (Remittance Information Only), when submitting a check and separate remittance detail.		
37		<u>BPR03</u> Financial Information	Credit/ Debit Flag Code	C	1/1	Insert 'C' (Credit).		
37/38		<u>BPR04</u> Financial Information	Payment Method Code	ACH	3/3	Insert 'ACH' (Automated Clearing House) when format is X12N including ACH payment.		
				CHK		Insert 'CHK' (Check) when submitting a check and separate remittance detail.		
38		<u>BPR05</u> Financial Information	Payment Format Code	CTX	1/10	Insert 'CTX' (Corporation Trade Exchange) when format is X12N including ACH payment.		
39-41		<u>BPR06</u> thru <u>BPR15</u>	Bank Information		2/2	Data Elements must be used when format is X12N including ACH payment (BPR04 = 'ACH').		
41		<u>BPR13</u> Financial Information	Receiving Depository Financial Institution ID Number		3/12	Number determined upon completion of Trading Partner Agreement.		
				<u>BPR14</u> Financial Information	Account Number Qualifier	DA	1/3	Insert 'DA' (Demand Deposit).
				<u>BPR15</u> Financial Information	Receiver Bank Account Number		1/35	Number determined upon completion of Trading Partner Agreement.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products,
Continued**

**820 Data
Elements,
Continued**

Implementation Guide Version: 4010A-1		WPC Combined Version: March 2003				
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
43		<u>TRN01</u> Re-association Key	Trace Type Code	1	1/2	Insert '1' (Current Transaction Trace Numbers) when format is X12N including ACH payment.
				3		Insert '3' (Financial Reassociation Trace Number) when submitting a check and separate remittance detail.
46		<u>CUR</u> Non-US Dollars Currency	Non-US Dollars Currency			Segment should not be used.
48		<u>REF01</u> Premium Receiver's Identification Key	Reference Identification Qualifier	14	2/3	Insert '14' (Master Account Number).
49		<u>REF02</u> Premium Receiver's Identification Key	Reference Identification		1/30	Insert BCBSAZ Group Section Number as the ID.
57	1000A	<u>N102</u> Premium Receiver's Name	Information Receiver Last or Organization Name		1/60	Insert 'BCBSAZ'.
		<u>N103</u> Premium Receiver's Name	Identification Code Qualifier	FI	1/2	Insert 'FI' (Federal Taxpayer's Identification Number) until National Plan ID is mandated.
		<u>N104</u> Premium Receiver's Name	Receiver Identifier		2/80	Insert BCBSAZ Tax ID '860004538'.
59		<u>N301</u> Premium Receiver's Address	Receiver Address Line		1/55	Insert BCBSAZ Address 'PO BOX 81049'.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products,
Continued**

**820 Data
Elements,
Continued**

Implementation Guide Version: 4010A-1				WPC Combined Version: March 2003		
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
60		<u>N401</u> Premium Receiver's City, State, Zip	Information Receiver City Name		2/30	Insert BCBSAZ City 'PHOENIX'.
		<u>N402</u> Premium Receiver's City, State, Zip	Information Receiver State Code		2/2	Insert BCBSAZ State 'AZ'.
61		<u>N403</u> Premium Receiver's City, State, Zip	Information Receiver Zip Code		3/15	Insert BCBSAZ Zip Code '850691049'.
63	1000B	<u>N103</u> Premium Payer's Name	Identification Code Qualifier	FI	1/2	Insert 'FI' (Federal Taxpayer's ID Number) or '24' (Employer's ID Number).
				24		
75	2300A	<u>RMR01</u> Organization Summary Remittance Detail	Reference Identification Qualifier	1L	2/3	Insert '1L' (Group or Policy Number).
		<u>RMR02</u> Organization Summary Remittance Detail	Contract/ Invoice/ Account/ Group or Policy Number		1/30	Insert use BCBSAZ Group Section Number.
88	2100B	<u>NM101</u> Individual Name	Entity Identifier Code	EY	2/3	Insert 'EY' (Employee Name).
89		<u>NM108</u> Individual Name	Identification Code Qualifier	EI	1/2	Insert 'EI' (Employee ID Number).

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

820-ASC X12N- Payroll Deducted and Other Group Premium Payment for Insurance Products,
Continued

**820 Data
Elements,**
Continued

Implementation Guide Version: 4010A-1				WPC Combined Version: March 2003		
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
92	2300B	<u>RMR01</u> Individual Premium Remittance Detail	Reference Identification Qualifier	AZ	2/3	Insert 'AZ' (Health Insurance Policy Number) when invoice has not been received.
				IK		Insert 'IK' (Invoice Number) when invoice has been received.

BLUE CROSS BLUE SHIELD OF ARIZONA COMPANION GUIDE

834-ASC X12N- Benefit Enrollment and Maintenance

Introduction

The 834 ASC X12N-Benefit Enrollment and Maintenance transaction set is used to request and receive information and to transfer subscriber and/or dependent enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer.

The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 834 – Benefit Enrollment and Maintenance transaction.

834 Guidelines

- No more than 10,000 INS segments can occur in a single 834 transaction. Multiple transactions within a single interchange can be used to transfer information on larger numbers of members.
 - Subscribers and dependents are sent as separate occurrences of Loop 2000 (Member Level Detail). The initial enrollment for the subscriber must be sent before sending the initial enrollment for any of the subscriber's dependents. The enrollment of a dependent may follow the subscriber's enrollment in the same transmission, or it may be sent separately in a later transmission.
 - It is required that Loop 2000 INS segment (Member Level detail) is sent with a termination Maintenance Type Code (024) when Health Coverage Maintenance Type Code 024 (2300-HD segment) is present. If the member being terminated is the subscriber, then all dependents linked to the subscriber will also be terminated.
 - Termination dates are not to be sent at both the Health Coverage (Loop 2300 HD Segment) and the Member Level Detail (Loop 2000 INS Segment) levels for a particular occurrence of Loop ID-2000. Terminating all covered insurance products for a dependent at the HD level is the equivalent of terminating that dependent at the INS level.
 - A maintenance file contains "adds", "changes" or "terms" request for members. The maintenance file is identified in BGN08 by a code value of '2', Change (Update). It is also recommended that Full File Audits (Verify) be used for regular weekly processing.
 - Submit Member Communications Numbers (2100A PER segment). PER03 and PER04 are required and should include the member's primary communication qualifier and the number where the member is likely to be reached. If additional communications numbers are available, use the remaining PER data elements to provide the next 'primary' communication numbers available.
-

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

834 ASC X12N- Benefit Enrollment and Maintenance

**834 Data
Elements**

		Implementation Guide Version: 4010A-1		WPC Combined Version: March 2003		
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
32	Trans Set Policy Number	<u>REF01</u> Trans Set Policy Number	Reference ID Qualifier	38	2/3	Must be submitted. Insert '38' (Master Policy Number).
33		<u>REF02</u> Trans Set Policy Number	Master Policy Number		1/30	Must be submitted. Insert Group Policy Number supplied by BCBSAZ.
38	1000B	<u>N102</u> Payer	Insurer Name		1/60	Insert 'BCBSAZ'.
		<u>N103</u> Payer	ID Code Qualifier	FI	1/2	Insert 'FI' (Federal Taxpayer's ID Number).
		<u>N104</u> Payer	Insurer ID Code		2/80	Insert '860004538' for BCBSAZ ID Code.
45	2000	<u>INS03</u> Member Level Detail	Maintenance Type Code	024	3/3	For Maintenance file, INS03 and HD01 should be submitted as "024" for term members. For Full Audits (Verify) file, INS03 and HD01 should be submitted as "030" for term members.
52	2000	<u>REF01</u> Subscriber Number	Reference ID Qualifier	OF	2/3	Insert 'OF' (Member/Subscriber Number)
		<u>REF02</u> Subscriber Number	Subscriber ID		1/30	Insert the Member/Subscriber Number as follows. <ul style="list-style-type: none"> ▪ For an existing subscriber, submit Subscriber Number ▪ For new members, submit the subscriber SSN or the words 'New Member' <ul style="list-style-type: none"> - Option 1 for subscriber's SSN - Option 2 to insert 'New Member' <p>Note: Using Option 1 or 2 for new Members is temporary until the new member receives their ID card with the new Member ID.</p>

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

834 ASC X12N- Benefit Enrollment and Maintenance, Continued

834 Data Elements, Continued

Implementation Guide Version: 4010A-1		WPC Combined Version: March 2003				
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Comments</i>
130-131	2300	HD03 Health Coverage	Insurance Line Code		2/3	See BCBSAZ Health Coverage Codes and Descriptions below.
		HD04 Health Coverage	Plan Coverage Description		1/50	
136-137		REF01 Health Coverage	Reference ID Qualifier	1L	2/3	Must be submitted. Insert '1L' (Health Coverage Group/ Policy Number)

BCBSAZ Health Coverage Codes and Descriptions

BCBSAZ health coverage codes and descriptions are listed below to assist in selecting the proper HD03 and HD04 values. HD03 IG codes not listed are not used by BCBSAZ but will be accepted with an HD04 value of "UNK" but may cause delays in processing.

Note: If you do not see a product type here, please contact eSolutions at (602) 864-4844 or (800) 650-5656.

BCBSAZ Health Coverage Codes and Descriptions				
<i>BCBSAZ Code</i>	<i>=</i>	<i>Description</i>	<i>HD03</i>	<i>HD04</i>
LIFE	=	Life	AG	LIFE
DP	=	Dental Plus	DCP	DP
DC	=	Dental Choice	DEN	DC
BC	=	Blue Choice	HMO	BC
BP	=	Blue Preferred	HLT PPO	BP
BCL	=	Blue Classic	HLT	BCL
BPS	=	Blue Preferred Saver	HLT PPO	BPS
BS	=	Blue Select	HMO	BS
UNK	=	Unknown	(HD03 values not used by BCBSAZ)	UNK

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

835-ASC X12N- Health Care Claim Payment/Advice

Introduction

The purpose of the 835 ASC X12N-Health Care Claim Payment/Advice Transaction is to facilitate the electronic transfer of health care claim payment information through an electronic remittance advice.. The information on the following pages details situational data elements unique to BCBSAZ for processing the ASC X12N 835 – Health Care Claim Payment/Advice transaction.

**AMT
Segment**

Loop 2100 – Claim Supplemental Information (Situational)

AMT segment is used to convey information only; it is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier is Non-zero.

**CAS
Segment**

Loop 2100 – Claim Adjustment (Situational)

Payers must use CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged.

**PLB
Segment**

Provider Level Adjustments

Offset detail is reported in the PLB segment. The following information will be reported in the PLB03-2 Provider Adjustment Identifier data element for the type of offset specified.

Note: The Patient Account Number when available will be provided in the Offset Detail when available.

<i>Offset Type</i>	<i>Data Reported in PLB03-2</i>
IRS Backup Withholding (PLB03-1 Adjustment Reason Code = 'IR')	IRS Backup Withholding
Claim Overpayment Offset (PLB03-1 Adjustment Reason Code = 'WO')	11-digit Offset A/R Number, space, first 8 letters of the Subscriber's Last Name, space, first 9 digits of the Subscriber ID.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

835-ASC X12N- Health Care Claim Payment/Advice

**835 Data
Elements**

		Implementation Guide Version: 4010A-1			WPC Combined Version: March 2003	
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
54	Header	<u>CUR</u>	Foreign Currency Information			Will not be used.
57		<u>REF</u>	Receiver Identification			
58		<u>REF02</u> Receiver Identification	Version Identification		1/30	
73	1000B	<u>N102</u> Payee Identification	Payee Name		1/60	'Pay To' Provider Name will be reported.
		<u>N104</u> Payee Identification Code	Payee Identification Code		2/80	
78		<u>REF02</u> Payee Additional Identification	Additional Payee Identifier		1/30	As of 5/23/08, 'Pay To' provider Tax ID will be reported.
80	2000	<u>TS3</u>	Provider Summary Information			Will not be used.
85		<u>TS2</u>	Provider Supplemental Summary Information			
112	2100	<u>NM103</u> Service Provider Name	Rendering Provider Last or Organization Name		1/35	Claim-level Rendering Provider Name will be reported if different from the 'Pay To' Provider
		<u>NM104</u> Service Provider Name	Rendering Provider First Name		1/25	
		<u>NM105</u> Service Provider Name	Rendering Provider Middle Name		1/25	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

835-ASC X12N- Health Care Claim Payment/Advice, Continued

**835 Data
Elements,
Continued**

Implementation Guide Version: 4010A-1			WPC Combined Version: March 2003			
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
113		<u>NM109</u> Service Provider Name	Rendering Provider Identifier		2/80	As of 5/23/08, NPI will be reported.
114		<u>NM1</u>	Crossover Carrier Name			Will not be used.
118		<u>MIA</u>	In-patient Adjudication Information			
123		<u>MOA</u>	Out-patient Adjudication Information			
157	2110	<u>REF02</u> Rendering Provider Information	Rendering Provider Identifier		1/30	As of 5/23/08, NPI will be reported.
160		<u>QTY</u>	Service Supplemental Quantity			Will not be used.
162		<u>LQ</u>	Health Care Remark Codes			

BLUE CROSS BLUE SHIELD OF ARIZONA COMPANION GUIDE

837-ASC X12N- Health Care Claim: Professional, Institutional, and Dental

Introduction

The 837 ASC X12N transactions defines the format to electronically transfer and exchange health care claim billing and encounter information for the following types of claims.

- ASC X12N 837 P — (Professional Claims)
- ASC X12N 837 I — (Institutional Claims)
- ASC X12N 837 D — (Dental Claims)

The information on the following pages details situational data elements unique to BCBSAZ for processing the HIPAA 837 Health Care Claim for Professional, Institutional, and Dental transactions.

837 Guidelines

- Files will reject if more than 5,000 claims are submitted within each ST/SE functional group.
- The NPI is required on all electronic transactions.
- For Corporate Health Services (CHS) claims, 2000B, SBR03 (group or policy number) must be submitted to ensure accurate routing. CHS group numbers are located on the patient's identification card.
- Subscriber ID requirements to submit BCBS claims are as follows:
 - Local members - Three-digit alpha prefix.
 - FEP members - Alpha prefix begins with 'R'.
 - CHS members – The ID number cannot begin with an alpha character; all other characters may be letters or numbers. The first character must be numeric.
 - Out-of-Area members - A minimum of three-digit alpha prefix.
- Stand-alone facilities, SurgiCenters, and skilled nursing facilities (SNFs) are required to submit an ASC X12N 837 Institutional format.
- The types of adjustments that are accepted electronically are those that **do NOT require medical records**. The following are examples of adjustment reasons for additions, changes or corrections. This is not an all inclusive list.
 - Patient name, Subscriber ID, Dates of service, Billed charges,
 - Adding and changing of modifiers (*with the exception of 22, 59, 62, 63, 66, as these modifiers require medical records*)
 - Dispute a duplicate denial (i.e. procedure repeated on same day)
 - Place of Service, Provider number
 - Age-related procedure code, Number of units
 - Changes to the diagnosis sequence on non-DRG claims (if all codes on original claim)
 - Late charges to inpatient or outpatient claims
 - Other billing
 - Anesthesia time
 - Other insurance carrier COB payment

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COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Professional, Institutional, and Dental, Continued

**BCBSAZ
Claims
Errors**

The following values will result in a BCBSAZ Clearinghouse* claim error:

- In 2400, SV103 (Unit or Basis for Measurement Code) the value 'F2' (International Unit) will not be accepted. This value is only used for NDC codes.
-

** The clearinghouse operated by BCBSAZ is not a clearinghouse as defined by HIPAA. The BCBSAZ clearinghouse will not translate electronic transactions sent from a non-standard format into a HIPAA standard format or from a HIPAA standard format into a non-standard format.*

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Professional, Continued

**837-
Professional
Data
Elements,
Continued**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
106	2000B	<u>SBR03</u> Subscriber Information	Subscriber Group Number		1/30	For CHS claims, the appropriate Group Number must be submitted in this element.
114	2010BA	<u>NM108</u> Subscriber Information	Subscriber Primary ID	MI	1/2	Insert 'MI' (Member ID Number).
		<u>NM109</u> Subscriber Information	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for non-CHS claims.
160	2300	<u>CLM</u>	Claim Information		1/80	No more than 5000 CLM segments should be submitted within the ST/SE Functional Group.
383	2400	<u>SV101-1</u> Professional Service	Product or Service ID Qualifier	HC	2/2	'HC' (HCPCS Codes) is the only value accepted for this element by BCBSAZ.
385		<u>SV103</u> Professional Service	Unit or Basis for Measurement Code	MJ or UN	2/2	The F2 value is <u>not</u> accepted by BCBSAZ. 'MJ' (Minutes) or 'UN' (Units) must be used.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Professional-Coordination of Benefits (COB)

**837-
Professional
COB
Data
Elements**

Note: 837 Professional COB billing is done at the line level (2430 loop)

Implementation Guide Version: 4010A-1		WPC Combined Version-March 2003				
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
164	2300	<u>CLM07</u>	Medicare Assignment Code		1/1	If primary payer is Medicare, the Medicare Assignment Code must be present.
462	2400	<u>AMT01/02</u>	Approved Amount	AAE	1/3 1/18	The amount approved by the primary payer must be entered in AMT02 with the qualifier 'AAE' in AMT01.
533-534	2430	<u>SVD02</u>	Paid Amount		1/18	The amount paid by the primary payer must be entered in SVD02.
537-540	2430	CAS01/02/03 <u>CAS05/06</u>	Line Adjustment	PR 1 2	1/2 1/5 1/18	If applicable, primary payer deductible and coinsurance amounts must be entered in CAS03 (and CAS05, if both amounts are applicable) with 'PR' in CAS01 and '1' (deductible) and/or '2' (coinsurance) in CAS03 (and CAS06).

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Professional-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Professional, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

**837-Professional
Adjustment
Data
Elements**

Implementation Guide Version: 4010 A1 WPC Combined Version: March 2003						
IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
164	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	Required Must be equal to 7 = Debit; or 8 = Credit
216		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	Required Insert "F8"
		REF02 Claim Information	Reference Identification	AN	1/30	Required For BlueCard Host ICN/DCN must be 15-17 numeric characters. For Local & FEP ICN/DCN must be 15 numeric characters.
232		NTE01 Claim Information	Note Reference Code	ADD	3/3	Required Insert "ADD"
		NTE02 Claim Information	Description	AN	1/80	Required Must contain the adjustment reason and narrative explaining why the claim is being adjusted.

837 ASC X12N- Health Care Claim: Institutional

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

**837-
Institutional
Data
Elements**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
108	2010 BA	<u>NM108</u> Subscriber Name	Subscriber Primary ID	MI	1/2	Insert 'MI' (Member ID Number).
		<u>NM109</u> Subscriber Name	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for Non-CHS claims.
154	2300	<u>CLM</u>	Claim Information			No more than 5000 CLM segments should be submitted within the ST/SE Functional Group.
249-250		<u>HI01-1/01-2</u> Principal Procedure Information	Principal Procedure Code List Qualifier Code	BR	1/3	Inpatient Institutional 'BR' (ICD-9-CM Procedure) is the only value accepted in this element by BCBSAZ.
				BP	1/3	Outpatient HCPCS Procedure Code
251-262	<u>HI0X-1/0X-2</u> Other Procedure Information	Other Procedure Code List Qualifier Code	BQ	1/3	Inpatient Institutional 'BQ' (ICD-9-CM Procedure) is the only value accepted in this element by BCBSAZ. Note: The 'X' represents the value 1 -12.	
			BO	1/3	Outpatient HCPCS Procedure Code	
436	2400	<u>SV202-1</u> Institutional Service Line	Product or Service ID Qualifier	HC	2/2	'HC' (HCPCS Codes) is the only value accepted in this element by BCBSAZ.
439		<u>SV204</u>	Unit or Basis for Measurement Code	F2	2/2	This value is <u>not</u> accepted by BCBSAZ; 'MJ' (Minutes) or 'UN' (Units) should be used.
103	2000B	<u>SBR03</u> Subscriber Information	Subscriber Group Number		1/30	For CHS claims, the appropriate Group Number must be submitted in this element.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Institutional-Coordination of Benefits (COB)

**837-
Institutional
COB
Data
Elements**

Note: 837 Professional COB billing is done at the line level (2430 loop)
BCBS **Secondary and Tertiary info.**

Implementation Guide Version: 4010A-1			WPC Combined Version-March 2003				
<i>IG Page #</i>	<i>Loop ID</i>	<i>Referenc e</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>	
105	2000B	<u>SBR01</u>	Subscriber Info. Payer Responsibility	"S" or "T"	1/1	If secondary or Tertiary payer is Blue Cross, the assignment code must be present.	
125	2010BB	<u>NM103</u>	Payer Name	BCBSAZ	1/3 1/18	The payer name must be entered in this field.	
164	2300	<u>CLM07</u>	Medicare Assignment Code		1/1	If Medicare is primary, the Medicare Assignment Code must be present.	
462	2400	<u>AMT01</u>	Qualifier	AAE	1/3	<table border="1" style="width: 100%;"><tr><td>Code to qualify amount</td></tr></table>	Code to qualify amount
Code to qualify amount							
462	2400	<u>AMT02</u>	Approved Amount		1/18	The amount paid/approved by the primary payer, used in a COB situation	
533 - 536	2430	<u>SVD01</u> <u>match</u> <u>NM109</u> <u>Loop</u> <u>2330B</u>	Service Line Adjustment		2/80	Identification Code	
533 - 536	2430	<u>SVD02</u>	Paid Amount	"0"	1/18	If 2400 AMT01=AAE and 2430 SVD are equal, no 2430 CAS segment is required, except if both are = 0. If they are not equal or both = 0, the 2430 CAS segment is required. If this isn't correct the claim will error for "Insufficient COB Data Submitted to Adjudicate Claim.	
537- 540	2430	CAS01/02/ 03 <u>CAS05/06</u>	Line Adjustment	PR 1 2	1/2 1/5 1/18	If applicable, primary payer deductible and coinsurance amounts must be entered in CAS03 (and CAS05, if both amounts are applicable) with 'PR' in CAS01 and '1' (deductible) and/or '2' (coinsurance) in CAS03 (and CAS06).	

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Institutional-Coordination of Benefits (COB) Continued

Note: 837 Institutional COB billing is done at the claim level (2320)

**837-
Institutional
COB
Data
Elements**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
<i>IG Page #</i>	<i>Loop ID</i>	<i>Reference</i>	<i>Name</i>	<i>Codes</i>	<i>Length</i>	<i>Notes/Comments</i>
105	2000B	<u>SBR01</u>	Subscriber Info. Payer Responsibility	"S" or "T"	1/1	If secondary or Tertiary payer is Blue Cross, the assignment code must be present.
125	2010B B	<u>NM103</u>	Payer Name	BCBSAZ	1/3 1/18	The payer name must be entered this field.
164	2300	<u>CLM07</u>	Medicare Assignment Code		1/1	If Medicare is primary, the Medicare Assignment Code must be present.
462	2400	<u>AMT01</u>	Qualifier	AAE	1/3	Code to qualify amount
462	2400	AMT02	Approved Amount		1/18	The amount paid/approved by the primary payer, used in a COB situation

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Institutional-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Institutional, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

**837-Institutional
Adjustments
Data
Elements**

Implementation Guide Version: 4010 A1 WPC Combined Version: March 2003						
IG Page #	Loop ID	Reference	Name	Codes	Length	
156	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	5 7 8	1/1	Required Insert 5 (Late Charges) 7 (Debit) or 8 (Credit)
186		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	Required Insert “F8” (Original Reference Number) Not required on CHS
187		REF02 Claim Information	Reference Identification	AN	1/30	Required Insert ICN/DCN of 15-17 numeric characters for BlueCard Host; or Insert ICN/DCN of 15 numeric characters for Local or FEP. Not required on CHS
203		NTE01 Claim Information	Billing Note	ADD	3/3	Required Insert “ADD”
204		NTE02 Claim Information	Description	AN	1/80	Required Must contain the adjustment reason and narrative explaining why the claim is being adjusted.
297		HI01 – 1 Claim Information	Condition Qualifier	BG	1/3	Required Insert “BG”
298		HI01 – 2 Claim Information	Condition Code	AN	1/30	Required Insert valid Condition Code (See page 6 for code values and descriptions).

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Dental

**837-Dental
Data
Elements,**

Implementation Guide Version: 4010A-1 WPC Combined Version: March 2003						
IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
96	2000B	SBR03 Subscriber Information	Insured Group or Policy Number		1/30	Insert the appropriate group number.
101	2010 BA	NM108 Subscriber Name	Identification Code Qualifier	MI	1/2	Insert 'MI' (Member ID Number).
102		NM109 Subscriber Name	Subscriber Primary ID		2/80	When submitting the Subscriber ID Number, a valid alpha prefix must be included for Non-CHS claims.
141	2300	CLM	Claim Information			No more than 5000 CLM segments should be submitted within the ST/SE Functional Group.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

837 ASC X12N- Health Care Claim: Dental-Adjustments

Certain conditions must be met in order for BCBSAZ to accept 837 adjustment requests. The tables provided below define, by Dental, the **required** data elements that must be submitted within each 837 adjustment request. If the information is not provided, the adjustment request will be electronically returned to the submitter/provider.

**837-Dental Data
Elements
Adjustments**

Implementation Guide Version: 4010 A1 WPC Combined Version: March 2003						
IG Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
164	2300	CLM05 – 3 Claim Information	Claim Frequency Type Code	7 8	1/1	Required Must be equal to 7 = Debit; or 8 = Credit
216		REF01 Claim Information	Reference Identifier Qualifier	F8	2/3	Required Insert "F8"
		REF02 Claim Information	Reference Identification	AN	1/30	Required For BlueCard Host ICN/DCN must be 15-17 numeric characters. For Local & FEP ICN/DCN must be 15 numeric characters.
232		NTE01 Claim Information	Note Reference Code	ADD	3/3	Required Insert "ADD"
		NTE02 Claim Information	Description	AN	1/80	Required Must contain the adjustment reason and narrative explaining why the claim is being adjusted.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Frequently Asked Transaction Questions

General

Q- “How do I begin the testing process for HIPAA transactions?”

A- Contact eSolutions at **(602) 864-4844** or **(800) 650-5656** to initiate the set up process. .

Q- “What will happen during the testing process?”

A- BCBSAZ tests HIPAA standard transactions in phases. You will be given a Sender ID number. In addition, you will receive instructions on accessing a web-based testing site contracted by BCBSAZ to ensure that transactions pass all HIPAA syntax and semantic requirements.

In the second testing phase, a test file is processed through BCBSAZ’s system to ensure the transactions meet pre-system edits. The Trading Partner will receive connectivity set up information to enable the site to send test files to BCBSAZ.

Test results will be provided to the Trading Partner in an Acknowledgment Response and/or Reports similar to what you will receive in production.

Q- “How much time will testing require?”

A- The timeline may varies depending on the support and coordination you establish with your software vendor, clearinghouse, and health plans. The accuracy of the test file, based on the Implementation Guide and the BCBSAZ Companion Guide requirements, will also help accelerate the testing process.

Q- “When can I begin to submit “live” transactions in production?”

A- After you successfully complete the second phase of HIPAA compliance testing as defined above.

Q- “Do I still have to submit a BCBSAZ specific sender ID number?”

A- Yes, the BCBSAZ specific sender ID must be sent in the Interchange Control Header ISA06 and the Functional Group Header GS02 Application Sender’s Code.

Q- “Will BCBSAZ have special requirements for HIPAA transactions?”

A- There are situational data elements BCBSAZ needs in order to conduct business and process your transactions. BCBSAZ has developed the BCBSAZ Companion Guide to supplement the HIPAA Transactions Implementation Guides, versions 4010 and 4010-A-1 addenda. The BCBSAZ Companion Guide contains specific data elements required for transactions and clarifies some of the standard uses of the transaction elements.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

**General,
Continued**

Q- “If I am only sending an 837, can I start sending other HIPAA transactions?”

A- Yes. If you want to send additional types of HIPAA transactions, contact eSolutions at **(602) 864-4844** or **(800) 650-5656**.

Q- “What is the difference between real-time and batch transactions?”

A- Batch is one or more transactions sent with the expectation that a response will not be available immediately. BCBSAZ typically responds within 24 hours or the next business day.

Real-time is a single transaction sent with the expectation that a response should be returned in the same session, typically within 60 seconds. The transactions available in real-time are the **270/271** and **276/277**.

Q- “Who is the contact for HIPAA transaction testing technical support?”

A- Contact eSolutions Customer Support at **(602) 864-4844** or **(800) 650-5656**.

**BLUE CROSS BLUE SHIELD OF ARIZONA
COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

270/271

Q- “What is the 270/271 ASC X12N transaction?”

A- This transaction provides a member’s eligibility and benefit information, but does not provide a history of benefit use.

Q- “What information will I receive from BCBSAZ in a 271 response?”

A- The 271 BCBSAZ response will provide detailed member information indicating active/inactive status on the date requested, health benefit plan coverage, and/or dental coverage.

Q- “Will I be able to send and receive 270/271 transactions in real-time?”

A- Yes, BCBSAZ accepts real-time transactions from vendors, clearinghouses, and providers. Real-time response transactions are typically sent within 60 seconds.

Q- “Can I send 270 batch inquiries?”

A- Yes, BCBSAZ accepts and processes batch 270 inquiries. Batch responses are typically provided within 24 hours or the next business day.

Q- “Can I submit BlueCard (Out-of-area) and FEP 270 requests to BCBSAZ?”

A- Yes, providers should submit BlueCard and FEP requests to BCBSAZ. BCBSAZ will forward your inquiry to the appropriate Home Plan or FEP for processing.

Q- “How long will it take to receive an answer for BlueCard (Out-of-area) and FEP requests?”

A- Providers typically receive a real-time inquiry 271 response for BlueCard and FEP requests within a maximum of 60 seconds. Batch response for BlueCard and FEP requests are typically received within a maximum of 48 hours.

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

276/277

Q- “What is the purpose of the 276/277 ASC X12N Transaction?”

A- *This transaction provides a member’s claim status information.*

Q- “What information will I receive from BCBSAZ in a 277 Response?”

A- *The response typically includes the patient’s name, date of service, billed amount, processed date, paid amount, claim and line status, and procedure and revenue codes.*

Q- “Will I be able to send and receive a 276/277 in real-time?”

A- *Yes, BCBSAZ accepts real-time transactions. Real-time response transactions are typically sent within 60 seconds.*

Q- “Can I send 276 batch inquiries?”

A- *Yes, BCBSAZ accepts and processes batch 276 Inquiries. Batch responses are generally provided within 24 hours or the next business day.*

Q- “Can I submit BlueCard (Out-of-area) and FEP 276 requests to BCBSAZ?”

A- *Yes, providers should submit BlueCard and FEP requests to BCBSAZ.*

Q- “How long will it take to receive an answer for BlueCard (Out-of-area) requests?”

A- *Providers will receive a 277 response for BlueCard requests for real-time inquiries typically within a maximum of 60 seconds. Batch response will be received generally within a maximum of 48 hours.*

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

278

Q- “What is the purpose of the 278 ASC X12N Transaction?”

A- *This transaction provides the ability to electronically request pre-certifications and appeals.*

Q- “What information will I receive from BCBSAZ in a 278 response?”

A- *The 278 response provides an approval or denial of the 278 request.*

Q- “Will I be able to send and receive this information real-time or batch?”

A- *BCBSAZ accepts 278 requests in batch transactions only. Any real-time transactions will be rejected with a TA-1 Interchange Acknowledgment.*

Q- “How long will it take to receive a response for a 278 request?”

A- *BCBSAZ returns responses within Department of Labor standards.*

Q- “Can I submit 278 requests for other BCBS Plans?”

A- *Yes, providers should submit BlueCard (Out-of-area) requests to BCBSAZ.*

Q- “How long will it take to receive an answer for BlueCard (Out-of-area) requests?”

A- *BCBSAZ returns responses within Department of Labor standards.*

Q- “How will I know if my 278 request has been received for processing?”

A- *BCBSAZ acknowledges all inbound HIPAA transactions with either a TA1 Interchange Acknowledgment or a 997 Functional Acknowledgment transaction.*

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

820

Q- “What is the purpose of the 820 ASC X12N Transaction?”

A- This transaction is used to initiate premium payment with or without remittance detail from employer groups to BCBSAZ.

Q- “If I have questions or have interest in sending 820 premium payment transactions, who should I contact?”

A- For information on electronic premium payment, please contact BCBSAZ eSolutions at (602) 864-4844 or (800) 650-5656

834

Q- “What is the purpose of the 834 ASC X12N Transaction?”

A- This transaction is used to transfer benefit enrollment and maintenance information from employer groups to BCBSAZ.

Q- “If I cannot send an 834 ASC X12N, how else can I send enrollment and maintenance information to BCBSAZ?”

A- An employer group can submit an 834 Flat File. For information regarding submission of a flat file, please contact Enrollment at (602) 336-7444 or (602) 864-4337.

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

835

Q- “What is the purpose of the 835 ASC X12N Transaction?”

A- This transaction provides an electronic remittance advice in a HIPAA compliant format to health care providers.

Q- “What information will I receive from BCBSAZ on an 835?”

A- The 835 contains information about the payee, the payer, the amount and any identifying information of the payment.

Q- “What version of the 835 are we going to be receiving?”

A- You will be receiving the ASC X12N 835 4010A-1 version.

Q- “Will the 835 electronic remittance advice (ERA) work with all practice management software systems?”

A- Check with your software vendor as this feature may not be available with all practice management systems.

Q- “Must we participate in electronic funds transfer (EFT) in order to get the 835 ERA?”

A- No, EFT isn’t required to receive the ERA. Utilizing both the EFT and the ERA generally makes your accounts receivable reconciliation more efficient but EFT is not required to receive the ERA.

Q- “Will I be able to associate the EFT to the 835 ERA?”

A- There will be an EFT trace number present on the 835 ERA file for ease in reconciliation.

Q- “Will the patient account number be present in the 835 ERA?”

A- Yes. When submitted on the claim.

Q- “Will I be able to identify the accounting adjustments?”

A- Yes, there will be an Adjustment Reason Code to identify the type of offset, an eleven-digit accounts receivable number, the eight letters of the subscriber’s last name, and the first nine digits of the subscriber identification number. The patient account number will be provided when submitted on the claim.

Q- “Can we print the 835?”

A- No, it is an electronic file. Check with your software vendor for printing capability through your Practice Management System. Medicare provides software (PC-Print and Easy Print) which may enable you to print 835 transactions to a formatted paper remit.

Q- “Who do I call for 835 ERA support?”

A- Call eSolutions Customer Support at (602) 864-4844 or (800) 650-5656.

Q- “How do I get set up for ERA or EFT?”

A- Contact eSolutions at (602) 864-4844 or (800) 650-5656.

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

837

Q- “What is the purpose of the 837 ASC X12N Transaction?”

A- This transaction provides an electronic transfer and exchange of claim billing and encounter information for the following types of claims:

- Professional
- Institutional
- Dental

Q- “Do I need to send the subscriber’s group number?”

A- If the claim is for a member that belongs to a Corporate Health Services (CHS) group, the subscriber group number must be sent or the claim will reject back to the submitter.

Q- “Do I have to send the alpha prefix of the subscriber’s ID Number?”

A- Yes, the alpha prefix is part of the BCBS subscriber ID number and is used for identification and routing internally, as well as externally.

Q- “How many claims can I submit within a transaction?”

A- Please limit the volume of claims within a transaction (ST/SE Functional Group) to no more than 5000.

Q- “With the implementation of NPI how should the Tax ID be billed on a electronic claim?”

A- Claims submitted in a standard 837 format must have the Billing Tax ID in Loop 2010AA, Segment REF, data element REF02. The data element qualifier will either be EI(Tax ID) or SY(SS# 837P only). If the standard 837P(professional) format contain a “Rendering Provider or Supervising Provider” Loop(2310B or 2310E) with an REF segment for the Tax ID(Rendering/Supervising Secondary ID), **the Tax ID must be the same as the Billing Provider Tax ID.**

837 I

Q- “What is a POA?”

A- The definition of POA is -- the condition was present at the time the inpatient admission occurs. This includes conditions that develop while the patient is in the emergency room, having outpatient testing, while the patient is in observation or during an outpatient surgery.

Q- “Who is required to report POA’s?”

A- POA’s are required for all Medicare inpatient claims for acute care hospitals.

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

Q- "How do I submit POA's?"

A- 1. *In a standard 837I format, excluding the Admitting Diagnosis, a Present on Admission Indicator (POA) is required on every diagnosis code and should be populated in Loop 2300, in the K3 segment, data element K301. (Your vendor or clearinghouse should be able to assist you in creating and including this data in your file.)*

- a. *In the K3 segment the first three positions should be "POA" followed by a single POA indicator for every diagnosis, excluding the admitting diagnosis. Report on the claim the POA for the principal diagnosis listed in the first position after the letters "POA". Valid POA values for electronically submitted claims include:*

Y – the diagnosis was present on admission

N – the diagnosis was not present on admission

U – it is unknown if the diagnosis was present on admission

W – it is clinically undetermined if the diagnosis was present on admission

1 – the diagnosis is exempt from reporting for POA .

*The letter "Z" also referred to as the "POA terminator" is used to indicate the end of the data element. An example with one(1) principal and five(5) secondary diagnosis, the K3 segment should be generated as follows:
POAYNUW1YZ*

- b. *If the claim has one principal diagnosis without a secondary diagnosis on the claim, the POA should be "POA*Z". The (*)denotes any valid POA value for 837 submission. Example with a valid POA is POANZ*

2. *For claims submitted on a UB-04 claim form, the Present on Admission Indicator (POA) will be in the 8th digit of the Principal Diagnosis Code (FL 67) and the 8th digit of each of the Secondary Diagnosis Codes (FL 67 A-Q).*

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COMPANION GUIDE**

Frequently Asked Transaction Questions, Continued

Q- *“What is a Never Event?”*

A- *A Never event is identified by one of 3 hospital inpatient occurrences.*

- 1. E876.5 – Performance of wrong operation on correct patient (wrong surgery)*
- 2. E876.6 – Performance of operation (procedure) intended for another patient (wrong patient)*
- 3. E876.7 – Performance of correct operation (procedure) on wrong body part/site (wrong body part)*

Q- *“What type of facility would report a Never Event?”*

A- *Reporting a Never Event is applicable to all hospital inpatient claims that have the occurrence of at least one of the three diagnosis listed in the above question “What is a Never Event?”.*

Q- *“How do I submit a claim that includes a Never Event?”*

A- *1. For claims submitted in a standard 837I format or on a UB-04 claim form, a surgical Never Event will be submitted with the following:*

- a. Type of Bill “110”*
 - b. One of the three above diagnosis codes (E876.5, E876.6 and E876.7) present in the Principal Diagnosis code or any occurrence of Other Diagnosis Codes excluding the Admitting Diagnosis*
- 2. Claims identified as bills for a surgical Never Event using TOB 110 are bills for the non-covered services associated with the Never Event.*

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COMPANION GUIDE**

Frequently Asked Questions – 837 Adjustments

The following FAQs are to assist you with understanding the electronic 837 adjustment request process and data element requirements.

Q- “Can I submit requests for claim adjustments electronically?”

A- Yes. Effective October 1, 2008 all providers who currently send electronic 837 claims can submit 837 adjustment requests.

Q- “What kind of adjustments can I send?”

A- Providers can submit adjustments **NOT requiring Medical Records**. Lines of Business (LOBs) and Claim Types (Type of Bill) included are:

Included:

Local	Professional, Institutional & Dental
FEP	Professional, Institutional & Dental
BlueCard Host	Professional & Institutional
CHS	Institutional

Excluded:

BlueCard Host	Dental
CHS	Professional & Dental

Q- “What kinds of adjustments require Medical Records?”

A- Medical Record adjustments include but are not limited to:

- Change in Diagnosis or Procedure Codes
- Active Rehab (exhausted benefits/requiring extension)
- Services denied as not medically necessary
- Multiple surgical procedures
- Second request for deductible, coinsurance and co-payments issues. (Claims Department has previously issued uphold letter)
- Second request on Timely Filing issues (Claims Department has previously issued Timely Filing letter)
- Second request on claims that denied for “Inclusive Services” (Claims Department has previously issued uphold letter)
- Second request on DME: Exhausted Rental has met Purchase Price. (Claims Department has previously issued uphold letter)
- Claims that denied for Medical Records and provider is asking for a review but Medical Records are not attached to correspondence

Q- “How are the adjustments sent / submitted?”

A- The provider will follow the same process they currently follow to submit electronic claims. See page 51-61.

Q-. “If I have questions about the submission of electronic adjustment who should I contact?”

A. For information on electronic claim solutions, contact BCBSAZ eSolutions at (602) 864-4844 or (800) 650-5656

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COMPANION GUIDE**

Frequently Asked 837 Adjustments Questions, Continued

Q. “How do I indicate the electronic claim is an adjustment?”

A. The provider will indicate the following:

For Institutional Claims

The 3rd position of the Type of Bill (Values 5, 7 or 8) indicates the claim is an adjustment.

For Professional and Dental Claims

The Frequency Code (Values 7 or 8) associated with the Place of Service on Professional and Dental claims. This indicates the claim is an adjustment.

Q- “How do I communicate what I want to have adjusted?”

A- BCBSAZ will require the following information be submitted within the electronic 837 adjustment request.

- Frequency Code – Must be present. Indicates the claim is an adjustment.
- Claim Note – Must be present in Professional and Dental adjustment requests. Must contain the adjustment reason and narrative explaining why the claim is being adjusted (i.e. Adjustment Reason could be “Number of units”, and additional narrative could be stated as “Units billed incorrectly, changed units from 001 to 010”.)
- Billing Note – Must be present in Institutional adjustment requests. Must contain the adjustment reason and narrative explaining why the claim is being adjusted (i.e. Adjustment Reason could be “Subscriber ID corrections” and additional narrative could be stated as “Transposed Sub ID Correct ID is 850123654 for Jane Doe, DOB 10-20-1975”.)
- Original Reference Number – Must be present. Claim number of the originally adjudicated claim found on your remittance advice (the (ICN/DCN) of the claim you want adjusted.)
- Condition Codes – Must be present in Institutional adjustment requests.

Q- “What are Conditions Codes?”

A- Condition Codes are Claim Change Reasons used in **Institutional claims only**. The following are the values that BCBSAZ will accept:

D0	Changes to Service Date (Statement Dates)
D1	Changes to Charges
D3	Second or Subsequent Interim PPS Bill
D7	Changes to Make Medicare the Secondary Payer
D8	Changes to Make Medicare the Primary Payer
D9	Any other Change (including changes to service level dates)
E0	Change in Patient Status

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COMPANION GUIDE**

Frequently Asked 837 Adjustments Questions, Continued

Q- “What elements will be affected in my billing system and what do I tell my vendor regarding any required changes?”

A- *The portion of the BCBSAZ Companion Guide for elements required on an 837 adjustment request (Professional, Dental and Institutional) can be found on pages 54, 58 and 60. Please use these requirements when working with your vendor to make the necessary changes to your billing systems.*

Q- “How will I know the adjustment was received by BCBSAZ?”

A- *Submitters will receive a positive 997 for complaint 837 claim files. Then they will receive the clearinghouse report also refer to as All Payer Network report (APN). This report includes the following:*

- A list of received claims including adjustment claim information.*
- Error number and descriptions of failed claims.*

Q- “Can I submit my daily electronic claims with my electronic adjustment requests in the same file?”

A- *Yes.*

Q- “Are Medicare Cross-over electronic 837 adjustments included in this process?”

A- *Yes. The Medicare contractor will send adjustment 837s to BCBSAZ for Local, FEP and Senior Product Lines of Business.*

Q- “How should I submit Medicare cross-over adjustments?”

A- *Adjustments where Medicare is primary **MUST** be sent directly to Medicare. The adjustment, once processed by Medicare, will be electronically crossed over to BCBSAZ. The provider **MUST NOT** send these adjustments directly to BCBSAZ.*

Q- “Can I continue to submit adjustment requests on paper?”

A- *Yes. Adjustment requests for corrected claims or adjustment claims that require Medical Records or other documentation **MUST** be submitted on paper. However, electronic claims are handled more quickly and it reduces paper handling.*

BCBSAZ HIPAA Glossary

- APN** *The APN stands for All Payer Network, the name of BCBSAZ's clearinghouse. The APN clearinghouse is not a clearinghouse as defined by HIPAA. The APN clearinghouse will not convert electronic transactions sent from a non-standard format into a HIPAA standard format and vice versa. BCBSAZ accepts BCBS claims for local, out-of-area and FEP, Commercial Claims for approx 700 various payers, Corporate Health Services (CHS claims) and Medicare Part B claims.*
- APN Report** *Your site connects with a dial up line or internet connection to the APN Clearinghouse and the APN puts your batch through the first set of edits to generate an APN report which you will receive within 24 hours, but you can get status as soon as 2 hours. The claims are put through a number of edits to ensure your claims have met the criteria to move forward for processing. These edits include errors such as: missing alpha prefix ID (which is necessary to route your claim properly). TOS, POS or group number, etc.*
- If the claim does not pass these edits, it is reported to you on the APN report. An erred claim can not be used for proof of timely filing until it has a successful acceptance in the APN clearinghouse. You make corrections and resubmit the claim in your next batch. If the claim passes the edits, it moves forward for processing in the APN clearinghouse. The claims are split based on BCBS, Medicare B and Commercial payers. The commercial payers are forwarded to Emdeon for processing and Medicare B claims are forwarded to ENS.*
- ASC X12N:** *The subcommittee chartered to develop electronic standards specific to the health insurance industry.*
- BlueCard: (Out-of-area)** *The BlueCard Program enables members who are traveling or living in another Plan's service area to receive all the same benefits of their contracting BCBS Plan and access to BlueCard providers and savings. It links participating healthcare providers and the independent BCBS Plans across the country through a single electronic network for claims processing and reimbursement.*
- Business Associate:** *A person who, or entity which, performs a function on behalf of a covered entity involving the use or disclosure of protected health information.*
- Code Sets:** *A set of codes used for encoding data elements, such as, tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes including the codes and descriptors of the codes.*
- Corporate Health Services (CHS):** *Provides large, self-insured groups access to the BCBSAZ provider networks. Most groups have selected a third party administrator (TPA) as their claims administrator for claims processing and verification of eligibility and benefits. BCBSAZ does not provide group health coverage for CHS accounts. Benefits for these groups may vary from BCBSAZ standard benefits.*
- Covered Entities:** *A health plan, health care clearinghouse that, or health care provider who, transmits health information electronically.*

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COMPANION GUIDE**

Data Condition:	<i>The rule that describes the circumstances a covered entity must use for a particular data element or segment.</i>
Data Content:	<i>All the data elements and code sets inherent in, but not related to the format of the transaction. Data elements related to the format are not considered data content.</i>
Data Element:	<i>The smallest named unit of information in a transaction.</i>
Data Set:	<i>A semantically meaningful unit of information exchanged between two parties, in relation to a transaction.</i>
Dependent:	<i>A person who is identifiable by an information source in association with a subscriber; not uniquely identifiable to an information source.</i>
Descriptor:	<i>The text defining a code.</i>
Format:	<i>Data elements that either provide or control the enveloping or hierarchical structure, or assist in identifying data content of a transaction.</i>
Functional Acknowledgment- 997:	<i>The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the compliancy status of the electronic file sent.</i>

BCBSAZ HIPAA Glossary, Continued

Health Care Clearinghouse:	<p><i>A public or private entity that either processes or facilitates the processing of health information in a non-standard format or containing non-standard data content into standard data elements or a standard transaction (or vice versa). Such an entity currently receives health care transactions from health care providers and other entities, translates the data from a given format into one acceptable to the intended recipient, then forwards the processed transaction to appropriate health plans and other health care clearinghouses, as necessary, for further action.</i></p> <p><i>HIPAA regulations considers the following entities to be health care clearinghouses if they conduct the foregoing activities: billing services, repricing companies, community health management information systems or community health information systems, value-added networks, and switches performing these functions.</i></p>
Health Care Provider:	<p><i>A provider of medical or other health services and other persons furnishing health care services or supplies; limited to entities who furnish or bill, and are paid for, health care services during the normal course of business.</i></p>
Health Information:	<p><i>Information, whether oral or recorded, in any form or medium, that:</i></p> <ol style="list-style-type: none"> a. <i>is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse and</i> b. <i>is related to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.</i>
Health Plan:	<p><i>An individual or group plan providing or paying medical care costs, including self-funded plans, Medicare, Medicaid, HMOs, long-term care insurers, programs for active military personnel, Indian Health Services, FEP, Medicare Choice, and Medicare supplemental policies.</i></p>
Information Receiver:	<p><i>The entity asking questions in relation to a 270 Eligibility or Benefit transaction, 276 Claim Status Inquiry transaction, and the 278 Health Care Services Review Request.</i></p>
Interchange Acknowledgment, TA-1:	<p><i>The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA-1 verifies the interchange envelope is complaint (?).</i></p>
Local Business:	<p><i>Services for Blue Cross Blue Shield of Arizona members. This excludes FEP, CHS and BlueCard programs.</i></p>
Privacy:	<p><i>Standards that define who may use and disclose "protected health information" and circumstances requiring patient authorization or consent.</i></p>

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COMPANION GUIDE**

BCBSAZ HIPAA Glossary, Continued

Protected Health Information (PHI):	<i>Individually identifiable health information including demographic information, collected from an individual, whether oral or recorded, in any form or medium.</i>
Security:	<i>Safeguards that encompass all information systems, including hardware, software, personnel policies, information practice policies, disaster preparedness, and the oversight of all these areas.</i> <i>The purpose of security is to protect the system and the information it contains from unauthorized external access and internal misuse.</i>
Segment:	<i>A group of related data elements in a transaction.</i>
Standard:	<i>A set of rules for a set of codes, data elements, transactions, or identifiers promulgated either by an organization accredited by ANSI or the HHS for the electronic transmission of health information.</i>
Standard Transaction:	<i>A transaction that complies with the applicable standard adopted under HIPAA.</i>
Subscriber:	<i>A person uniquely identifiable to information source; referred to as a member. The subscriber may or may not be the patient.</i>
Trading Partner:	<i>A sending or receiving party involved in the electronic exchange of business information.</i>
Trading Partner Agreement:	<i>An agreement between parties, whether distinct or part of a larger agreement, in relation to the electronic exchange of information transactions. For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.</i>
Transaction:	<i>A single business activity for health care EDI purposes. Transactions include claim submission, remittance advice, claim payment, claim status, eligibility and enrollment.</i>
Transaction Sets:	<i>Logical groupings of data used to convey a specific type of business information.</i>

Blue Cross Blue Shield of Arizona Companion Guide

Index

<p>Overview</p> <ul style="list-style-type: none"> <i>health insurance portability and accountability act</i> 1 <i>ansi asc x12n 4010 and 4040-a-1</i> 1 <i>washington publishing company's website</i> 1 <p>Getting Started</p> <ul style="list-style-type: none"> <i>becoming a trading partner</i>..... 9 <i>electronic submission options</i>..... 9 <i>eSolutions contact information</i>.....9 <i>bcbfaz direct connect requirements</i>..... 10 <i>connecting through a third-party clearinghouse</i> 10 <p>HIPAA Implementation Checklist..... 11</p> <ul style="list-style-type: none"> <i>clearinghouse disclaimer</i>..... 11 <p>Control Segments/Envelope Specifications 11</p> <ul style="list-style-type: none"> <i>ta-1 interchange acknowledgment</i>..... 11 <i>997 functional acknowledgment</i> 12 <i>isa interchange control header segment - inbound</i>..... 13-14 <i>isa interchange group header segment - outbound</i>..... 15-16 <p>Transaction Information, General..... 17</p> <ul style="list-style-type: none"> <i>transmission guidelines</i> 17 <i>outbound delimiters</i> 17 <i>inbound delimiters</i> 17 <i>decimals</i> 18 <i>hipaa guidelines on monetary decimals</i> 18 <i>leading zeros</i> 18 <i>trailing zeros</i>..... 18 <p>270/271 Transactions 19</p> <ul style="list-style-type: none"> <i>guidelines</i> 20 <i>corporate health services</i> 20 <i>aaa segments</i>..... 20 <i>information sheet</i>..... 24 <i>service type guidelines</i> 25-29 <p>276/277 Transactions 30</p> <ul style="list-style-type: none"> <i>guidelines</i>..... 30 	<ul style="list-style-type: none"> <i>corporate health services</i>..... 30 <p>278 Transaction..... 32</p> <ul style="list-style-type: none"> <i>guidelines</i>..... 33 <i>278-13 request</i>..... 33 <i>278-11 response</i> 33 <i>aaa segments</i>..... 34 <p>820 Transaction..... 40</p> <ul style="list-style-type: none"> <i>guidelines</i> 40 <p>834 Transaction..... 45</p> <ul style="list-style-type: none"> <i>guidelines</i> 45 <i>health coverage codes and descriptions</i>..... 47 <p>835 Transaction..... 48</p> <ul style="list-style-type: none"> <i>amt segment</i> 48 <i>cas segment</i> 48 <i>plb segment (provider level adjustments)</i>..... 48 <p>837 Transaction..... 51</p> <ul style="list-style-type: none"> <i>guidelines</i> 51 <i>bcbfaz claims errors</i> 52 <i>clearinghouse disclaimer</i>..... 52 <i>professional</i> 53 <i>institutional</i> 56 <i>dental</i> 60 <i>coordination of benefits</i> 54, 57-58 <i>adjustments</i>..... 55, 59, 61 <p>Transaction Questions 62-74</p> <ul style="list-style-type: none"> <i>270/271</i> 64 <i>276/277</i> 65 <i>278</i> 66 <i>820</i> 67 <i>834</i> 67 <i>835</i> 68 <i>837</i> 69-70 <i>present on admission (poa)</i>..... 69-70 <i>never event</i>..... 71 <i>adjustments</i> 72-74 <p>Glossary, BCBSAZ HIPAA 75-77</p>
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