BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama

Standard Companion Guide Related to Batch Processing

(Claims, Acknowledgments, Remittances)

Trading Partner and Transaction Information

Instructions related to Transactions based on the Accredited Standards Committee (ASC) X12 Implementation Guides, version 005010

Companion Guide Version Number: 4.0
May 2022

Disclaimer

Express permission to use ASC X12 copyrighted materials within this document has been granted. The instructions in this document are based on ASC X12 Implementation Guides (TR3). The full versions of the Implementation Guides required for successful implementation are available at http://store.x12.org.

This document may be freely redistributed in its entirety or in parts. The content of this document may not be altered by external entities. This document may not be sold for profit or used in commercial documents without the written permission of Blue Cross and Blue Shield of Alabama.

The information in this document is subject to change. The most recent version will be posted on the Blue Cross and Blue Shield of Alabama website at: **AlabamaBlue.com/providers/vendors/companion.cfm.** If you are referencing a downloaded copy, it is the responsibility of the reader to verify the correct version. Blue Cross and Blue Shield of Alabama will track revision changes using a Change Control Summary Table.

This document contains references to websites that may be useful or of interest to Practice Management software vendors, Clearinghouses, and providers. However, Blue Cross and Blue Shield of Alabama is not responsible for the content or privacy practices used by other site owners, nor does it endorse the information contained at these external sites.

The information in the **Transaction Instruction (TI) Section 3 – Instruction Tables** is intended to serve only as a companion document for the ASC X12 Type 3 Technical Reports (TR3) adopted under the Health Insurance Portability and Accountability Act (HIPAA). The tables contain requirements to be used for processing data in the Blue Cross and Blue Shield of Alabama claims processing system, specifically: ASC X12N/005010X221 Health Care Claim Payment/Advice (835), ASC X12N/005010X222 Health Care Claim: Professional (837), ASC X12N/005010X223 Health Care Claim: Institutional (837), ASC X12N/005010X224 Health Care Claim: Dental (837), and any Type 1 Errata published by ASC X12 and adopted under HIPAA. Also included is guidance for acknowledgment TR3s, specifically: ASC X12N/005010X214 Health Care Claim Acknowledgment (277), and ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (999), and any Type 1 Errata published by ASC X12.

The use of this document is solely for the purpose of clarification. This document supplements, but does not contradict any requirements in the ASC X12N implementation guides.

Please reference **AlabamaBlue.com/Providers** for additional information and questions.

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Trading Partner Information) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Trading Partner Information (TPI) component or the Transaction Instruction (TI) component must be included in every CG. The components may be published as separate documents or as a single document.

The TPI component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The TI component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The TI component content is limited by ASC X12's copyrights and Fair Use statement.

This Companion Guide (CG) contains both types of data:

1. TPI - Instructions for electronic communications/connectivity information (CCI) with Blue Cross and Blue Shield of Alabama for batch processing, and;
2. TI - Supplemental information related to batch transactions while ensuring compliance with the associated ASC X12 Technical Type Report 3 (TR3), also referred to as implementation guidance.

Batch transactions supported by Blue Cross and Blue Shield of Alabama are:

1. 837D: Health Care Claim: Dental (837) – 005010X224A2
2. 837I: Health Care Claim: Institutional (837) – 005010X223A2
3. 837P: Health Care Claim: Professional (837) – 005010X222A1
4. 999: Implementation Acknowledgment for Health Care Claim – 005010X231A1[†]
5. 277 HCCA: Health Care Claim Acknowledgment (277) – 005010X214[‡]
6. 835: Health Care Claim Payment/Advice (835) – 005010X221A1

[†] *The 999 is of the same standard format as current Health Insurance Portability and Accountability Act (HIPAA) transactions. Although it is not an official HIPAA covered transaction, it is required to be used as an acknowledgment for the 5010 version of the 837D, 837I and 837P transactions.*

[‡] *The 277 HCCA is of the same standard format as current HIPAA transactions. Although it is not yet covered under HIPAA, it is compatible with all HIPAA requirements and is created in response to a health care claim (837) transaction.*

Table of Contents

Document Change Summary Log 7

Trading Partner Information (TPI) 9

1. Introduction 9
   - 1.1 Purpose 9
   - 1.2 Scope 9
     - 1.2.1 Batch vs. Real-time 9
   - 1.3 Overview 9
   - 1.4 References 9
   - 1.5 Additional Information 10
     - 1.5.1 EDI Acronyms specific to batch transactions 10

2. Getting Started 12
   - 2.1 Working Together 12
   - 2.2 Trading Partner Registration 12
     - 2.2.1 Client (Provider) Paperwork 12
   - 2.3 Trading Partner Testing and Certification Process 13
   - 2.4 Process for New Vendors 13
   - 2.5 Process for Testing with Existing Vendors 13
   - 2.6 Setup Notification/Approval 13

3. Testing and Certification Requirements 14
   - 3.1 Testing Requirements 14
     - 3.1.1 File Naming Convention 15
   - 3.2 Certification Requirements 17
   - 3.3 Going “Live” 17

4. Connectivity/Communications 18
   - 4.1 Process Flows 18
   - 4.2 Transmission Administrative Procedures 18
     - 4.2.1 Re-transmission Procedures 19
     - 4.2.2 Claim Collection and Acknowledgment Schedule 19
     - 4.2.3 Inbound File Drop-off and Outbound File Pickup Location 19
   - 4.3 Communication/Network Protocols 19
     - 4.3.1 Internet 19
     - 4.3.2 VPN over the Internet 20
     - 4.3.3 File Compression 20
     - 4.3.4 Password Resets 21
     - 4.3.5 Instructions for using *myFileGateway* Portal via HTTPS 21

5. Contact Information 27
5.1 EDI Customer Service 27
5.2 EDI Technical Assistance 27
5.3 Provider Services 27
5.4 Applicable EDI Websites/Email 27

6. Control Segments/Envelopes 29
6.1 ISA-IEA 29
6.1.1 Claims 29
6.1.2 Remittances 29
6.1.3 Delimiters 29
6.1.3.1 Text Fields 30
6.1.4 Character Sets 30
6.2 GS-GE 30
6.2.1 *Claims* 30
6.2.2 *Remittances* 31
6.3 ST-SE 31

7. Acknowledgements and Reports 32
7.1 ASC X12 Acknowledgments 32
7.2 Report Inventory 33

8. Additional Trading Partner Information 35
8.1 Implementation Checklist 35
8.2 Transmission Examples 35
8.3 Trading Partner Agreement 36
8.4 Frequently Asked Questions 36
8.5 Other Resources 36

9. Trading Partner Information Change Control Summary 37

Transaction Instruction (TI) 38

10. TI Introduction 38
10.1 Background 38
10.1.1 Overview of HIPAA Legislation 38
10.1.2 Compliance According to HIPAA 38
10.1.3 Compliance According to ASC X12 38
10.2 Intended Use 38

11. Included ASC X12N Implementation Guides 39

12. Instruction Tables 40
12.1 Health Care Claim: Professional - 005010X222A1 40
12.2 Health Care Claim: Institutional - 005010X223A2 41
12.3 Health Care Claim: Dental - 005010X224A2 41
12.4 Implementation Acknowledgment for Health Care Insurance (999)-005010X231A1 .. 41
12.5 Health Care Claim Acknowledgment (277) - 005010X214 42
12.6 Health Care Claim Payment/Advice (835) - 005010X221A1 43

13. TI Additional Information 44
13.1 Business Scenarios 44
13.2 Payer Specific Business Rules and Limitations 44
13.2.1 .....
Scheduled Maintenance 44
13.3 Frequently Asked Questions 44
13.4 Other Resources 47
13.4.1 .....
External Code Sources. 47

14. Transaction Instruction (TI) Change Summary 48

Appendix A: Checklist Forms. 49
Communications/Connectivity Test Checklist 50
Enrollment and Test Results Checklist 51

Document Change Summary Log

Information regarding version and change control pertinent to any section of this document has been consolidated. The Change Control Summary sections in the Table of Contents: 1) Trading Partner Information (TPI) Section 9, and; 2) Transaction Instruction (TI) Section 5, will be contained in this single Document Change Summary Log for ease of reference.

Version	Date	Section	Comment
DRAFT	09/01/2010	All	Initial draft version of document
DRAFT2	01/11/2011	TPI: 6.1.2, 6.1.3, 6.1.4,6.2, 6.3, 7.1 TI: 3.0, 4.2	Updated with required revisions per Data Interchange Standards Association (DISA) review
1.0	02/24/2011	Final version 1.0 for publication	Version approved by DISA
1.1	4/30/2012	3.1.1 12.1, 12.2, 12.3	Corrected 999 file naming convention: [submitter].[filename].[ccyymmdd].[hhmmss].9995010 to [submitter].[filename].[ccyymmdd].[hhmmss].999 Added list of Claim Frequency Type codes supported in 2300 loop, CLM05-3.
	2/15/2013	2.1.1	Removed P.O. Box 12566, no longer used.
1.2	11/11/2014	2.2.1 3.1 4 6.1.1 13.2.1 13.3	Changed paperwork submission instructions from fax to email Removed 4010 to 5010 transition reference Updated all of Section 4 to reflect modified communication and network protocols for use with new FTP server Removed Reference to National Health Plan ID Updated scheduled routine maintenance window Updated FAQ #8
2.0	07/21/2015	6.3	Added Encounter claims information
3.0	01/01/ 2022	CLM03 PWK	Added Voided Claims Information Added Attachments and Surprise Billing

Trading Partner Information (TPI)

1. Introduction

1.1 Purpose

The purpose of the **Trading Partner Information (TPI)** section is to explain the steps necessary for proper electronic data interchange (EDI) between healthcare providers and Blue Cross and Blue Shield of Alabama (hereinafter referred to as 'Blue Cross'). The majority of our providers use a business associate for their data exchange needs, such as a Practice Management software vendor or a clearinghouse (both hereinafter referred to as "Vendor"). This document may be used by those entities to ensure their clients are set up correctly for EDI with Blue Cross.

1.2 Scope

The TPI Section of this guide is intended to be used by vendors and/or providers in understanding the appropriate process for initializing and maintaining a data exchange relationship with Blue Cross. Information about the steps necessary to connect to the Blue Cross batch server for claims delivery and the retrieval of acknowledgments and remittances are located within the TPI section. The EDI enrollment process is addressed in this section as well.

1.2.1 Batch vs. Real-time

Batch transactions are typically delivered to a location (server) where they are "picked-up" on a fixed schedule and run through specific processes. Complete responses or acknowledgments to a batch submission (such as a claim file) are usually available for retrieval within 24 business hours. This Batch CG addresses those types of transactions.

Real-time transactions/messages refer to requests that should receive a response within a short period of time (usually a few seconds to under a minute). The companion guide for Blue Cross real-time transactions titled, **Standard Companion Guide Related to Real-time Processing** is located at: **AlabamaBlue.com/providers/vendors/companion.cfm.**

1.3 Overview

The data within the TPI Section is intended to assist trading partners in successfully achieving communications and connectivity requirements. Data in TPI Sections 1 through 3 mainly focus on communicating with Blue Cross EDI staff and testing at various levels. TPI Sections 4 through 8 are geared toward connectivity, processes, file generation and time frames.

1.4 References

This trading partner Companion Guide is not intended to be used as a primary or stand-alone reference for ASC X12 TR3s. To program correctly for the electronic transactions addressed in the **Transaction Instruction (TI)** Section of this document, you must refer to 005010X214, 005010X221, 005010X222, 005010X223, 005010X224, and 005010X231.

A TR3 is a set of standards developed by the ASC X12N subcommittee that specify format and data requirements to be used for the electronic transactions for that specific TR3. These TR3 documents are available for purchase in PDF and/or hard copy formats at the ASC X12 website: **http://store.x12.org/.**

1.5 Additional Information

1.5.1 EDI Acronyms specific to batch transactions

ANSI	American National Standards Institute
ASC X12	The Accredited Standards Committee (ASC) X12 was tasked to develop uniform standards for inter-industry electronic interchange of business transactions by the American National Standards Institute. "ASC X12 develops, maintains, interprets, publishes and promotes the proper use of American National and UN/EDIFACT International Electronic Data Interchange Standards."†
CCI	Communications/Connectivity Information
CG	Companion Guide
DISA	The Data Interchange Standards Association is chartered by ASC X12 to serve as their Secretariat for the X12 standards development process.
EDI	Electronic Data Interchange
FTP	File Transfer Protocol – This is a method available to deliver and retrieve batch files to and from Blue Cross.
IT	Information Technology
HCCA	Health Care Claim Acknowledgment – The HCCA is created using the 277 Transaction with 005010X214 in the ST03 and TH in the BHT06 to indicate its intent.
HIPAA	Health Insurance Portability and Accountability Act – Federal law that addresses various aspects of healthcare that include pre-existing conditions, privacy, security, and transactions and codes sets.
LAN	Local Area Network - A system that links together electronic office equipment and forms a network within an office or building.
NPI	National Provider Identifier
PHI	Protected Health Information - The HIPAA Privacy Rule defines PHI as individually identifiable health information about the past, present, or future physical or mental health or condition (including the provision of his/her healthcare, insurance, payment status, etc.) of an individual.
TAR	Text Audit Report – This is a plain text file that contains interpreted data from the 277 HCCA for entities that do not have software to translate the 277 HCCA into a human readable file. This file cannot be used for posting into a practice management system since it is not in a static format. Vendors should program for retrieving and translating the 277 HCCA if their system will be pulling data into their software for posting or tracking purposes.
TI	Transaction Instruction
TR3	Technical Type Report 3 – The report type used to contain implementation guidance for a specific ASC X12 transaction. *Prior to 5010 this type of instruction was contained in documents referred to as Implementation Guides (IG).*

TRANFILE	Transmission File – This file contains high-level status of an 837 transmission prior to running through standard and implementation edits such as whether a file was unzipped successfully or if the file was rejected due to invalid format (this is not an ASC X12 transaction).
X12N	See ASC: Within X12 there are committees designated with a letter. N represents Insurance
UN/EDIFACT	United Nations/Electronic Data Interchange for Administration, Commerce and Transport
WEDI	Workgroup for Electronic Data Interchange "MISSION**:** To provide multi-stakeholder leadership and guidance to the healthcare industry on how to use and leverage the industry's collective technology, knowledge, expertise and information resources to improve the administrative efficiency, quality and cost effectiveness of healthcare information." ‡

† Excerpt from the ASC X12 website: www.x12.org
‡ Excerpt from the WEDI website: www.wedi.org

2. Getting Started

2.1 Working Together

Within the EDI Department at Blue Cross, there are EDI Vendor Consultants assigned to specific vendors to establish partner relationships. This process allows Blue Cross to support our provider community in an efficient manner by communicating directly with the vendors that support provider systems.

If vendors do not yet have a relationship with Blue Cross and would like to begin testing to establish themselves as a trading partner, they should contact the EDI Department at **EDIVendortesting@bcbsal.org** or call 205-220-6899.

Established vendors should notify their EDI Vendor Consultant of their intention to begin testing a new transaction or to upgrade to a new version. Vendors who have an established relationship with Blue Cross may contact their assigned EDI Vendor Consultant, email **Ask-EDI@bcbsal.org,** or call 205-220-6899.

2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity.

Vendors must have a signed **Vendor/Clearinghouse Electronic Data Interchange (EDI) Agreement** on file with Blue Cross to exchange electronic data on behalf of their clients (Blue Cross providers). New Vendors will need to download, complete the information, sign and return this agreement along with the **New EDI Vendor Enrollment** form located at:
AlabamaBlue.com/providers/vendors/proEnrollment.cfm.

2.2.1 Client (Provider) Paperwork

Forms required to add or update submitter information for providers are typically submitted by the vendor. The forms submitted on behalf of providers are specific to the status of the provider:

- Vendors requesting electronic remittances for a client should use the form titled:
  EDI Enrollment Request for 835 Remittance File

All forms are located at: **AlabamaBlue.com/providers/vendors/proEnrollment.cfm.**

- New vendors should email completed forms to EDIVendorTesting@bcbsal.org or fax to 205-403-3693, Attention: New Vendor Contact
- Existing vendors should email completed forms to EDIEnrollment@bcbsal.org or fax to 205-733-7362, Attention: Enrollment

2.3 Trading Partner Testing and Certification Process

Vendors handle the enrollment process and any testing requirements for their clients. Close coordination between vendors and Blue Cross improves support, troubleshooting, research and resolution, as well as, the development of strong partnerships amongst trading partners.

Proof of certification by a third-party entity is not required by Blue Cross. However, if a vendor continues to receive standard and implementation rejections during testing, it is advised that the vendor seek assistance by one of those entities.

2.4 Process for New Vendors

Once you have completed the required forms discussed in **TPI Section 2.2** and have been approved for EDI, your EDI Vendor Consultant will contact you for further information including which connectivity option you have chosen for EDI exchange (refer to **TPI Section 4**).

2.5 Process for Testing with Existing Vendors

Approved vendors that plan on testing with existing client directories may submit test files without further notification. They must ensure the appropriate filename is used and the data element content to indicate a Test file versus Production is present. Refer to **TPI Section 3.1.3** for filename requirements and **TPI Section 8.2** to view a sample Interchange Control Header with a Test usage indicator.

2.6 Setup Notification/Approval

The vendor will receive notification of the completed setup, along with the directory information from Blue Cross, within five business days after receipt of your forms. Test files submitted prior to completing the test setup may not be processed. If the vendor has not received notification of acceptance for their paperwork within five business days, they should contact their EDI Vendor Consultant.

Blue Cross will assign a vendor's first test directory name and Submitter ID. Once the vendor is approved to submit production data, the vendor will assign directory names (if different directories are needed per client) and Submitter IDs for their clients. Although the vendor assigns this information, it must be setup by Blue Cross using the forms in **TPI Section 2.2.1**.

3. Testing and Certification Requirements

3.1 Testing Requirements

Once the vendor has notification that their client paperwork has been completed and the necessary User ID and password information have been setup they may begin to submit test claim files. The editing of test claim files is automated. Upon the submission of a test claim file, the process to "pick-up" the file, decompress it (UNZIP), validate the format, and run it through TR3 and business edits will occur without the need to alert Blue Cross of the submission.

It is important for test files to be named properly (refer to **TPI Section 3.1.1**) and to contain a **T** in the Interchange Usage Indicator (ISA15) to indicate it is a TEST file. If the file is submitted as a production file it may go through processing and enter the system for adjudication. For instance, if an existing vendor uses an existing directory to submit a test file but does not change the ISA15 and filename appropriately, the file will be treated as a production submission. Test and Production files will be submitted to the same directory. The filename and usage indicator is what determines its path for processing.

The cut-off time for test claim submissions is 3:30 p.m. Central Time. Test files received prior to this cutoff time should receive full test results the next business day. Test files submitted after the cutoff time will not be guaranteed full test results the following business day. However, 999 acknowledgment and transmission file results should be available. The 277 Health Care Claim Acknowledgment (HCCA) will not be available until the second business day. Refer to **TPI Section 7** for more information about the acknowledgments returned during this process.

It is the submitter's responsibility to retrieve test results from their directory.

Vendors must submit test files with valid participating Blue Cross providers. Providers that are unknown to Blue Cross will reject in the 277 HCCA.

MINIMUM CRITERIA REQUIRED TO PASS TESTING:

- ./ ***Zero TR3 errors***
- ./ ***85 percent pass rate on business edits***
- ./ ***Minimum of 10 claims in each 837***
  - ***At least one claim must contain secondary information if applicable to line of business***
  - ***At least one corrected claim if applicable to line of business***
- ./ ***Minimum of three successful test file submissions that do not contain duplicate claims***

Once vendors successfully achieve the criteria required to pass claim testing, they should notify their EDI Vendor Consultant regarding their final test submission. Vendors also need to show how they display acknowledgments. Whether vendors have programmed to translate the 277 HCCA or merely retrieve the text file for their clients to print/view, the EDI Vendor Consultant will need to validate this ability within the software product. Vendors may email or fax a print screen to the EDI Vendor Consultant, allow for a remote login to demonstrate the software's ability, or if practical, arrange a meeting for onsite validation. When emailing information that displays Protected Health Information (PHI), the email should be encrypted.

Blue Cross verification regarding throughput of claims and adjudication review may also be required before approval for production is granted. Upon the review and verification that all of the requirements have been met, the EDI Vendor Consultant will send notification indicating approval status.

Upon approval/pass notification, vendors may begin transitioning existing providers to the version of compliant software that has been approved.

3.1.1 File Naming Convention

Files deposited to the batch server must follow a strict naming convention. These names determine what processes occur when they are present in a directory. The filenames will also assist in vendor programming when writing software to retrieve specific files such as acknowledgments or remittances.

Claim filename legend:

Syntax: [t,p]bc[d,i,p][nnnn].8375010.[ext]
Example: pbcp0035.8375010.zip

Usage	Line of business	Transmission number	Filename extension
t = Testing p = Production	d = Dental i = Institutional p = Professional	(per day) can be 0000 through 9999	clm = claim source file zip = compressed file

Claim Type	Naming Convention
Professional Claims – TEST	tbcpnnnn.8375010.clm (and .zip)
Professional Claims – Production	pbcpnnnn.8375010.clm (and .zip)
Institutional Claims – TEST	tbcinnnn.8375010.clm (and .zip)
Institutional Claims – Production	pbcinnnn.8375010.clm (and .zip)
Dental Claims – TEST	tbcdnnnn.8375010.clm (and.zip)
Dental Claims – Production	pbcdnnnn.8375010.clm (and.zip)
Cutoff time for processing claims is 3:30 p.m. Central Time. See acknowledgments for expected time of delivery.	

Acknowledgment filename legends:

Syntax: [submitter].[filename]. X8375010 .[ccyymmdd].[hhmmss].999
***Example*:** submtr01.pbcp0035. X8375010.20100107.172342.999

Submitter	Filename	ccyymmdd	hhmmss
8-character alphanumeric identifier assigned by Vendor	The 837 file to which the 999 is responding	Date of the 999	Time of the 999

Acknowledgment Type	Naming Convention
Implementation Acknowledgment	submitter.filename.ccyymmdd.hhmmss.999
999 files are generated every two hours beginning at 4:00 a.m. every 10 minutes and then at 6pm, 8pm, and 10pm every 10 minutes.	

Syntax: [submitter].[ccyymmdd].tranfile
***Example*:** submtr01.20100107.tranfile

Submitter	ccyymmdd	Usage
8-character alphanumeric identifier assigned by Vendor	Date of the 999	t = Testing p = Production

Acknowledgment Type	Naming Convention
Transmission File (TRANFILE)	submitter.ccyymmdd.tranfile
TRANFILEs are generated every two hours beginning at 4:30 a.m. until 6:30 p.m. Central Time seven days a week and are not compressed.	

Syntax: [submitter].[ccyymmdd].[t,p]01.277ca5010.zip
***Example*:** submtr01.20100107.p01.277ca5010.zip

Submitter	ccyymmdd	Usage
8-character alphanumeric identifier assigned by Vendor	Date of the 999	t = Testing p = Production

Acknowledgment Type	Naming Convention
277 HCCA - **TEST**	submitter.ccyymmdd.t01.277ca5010.zip
277 HCCA – Production	submitter.ccyymmdd.p01.277ca5010.zip
HCCAs will be generated nightly (Mon-Fri) and available the next business day if the claim file was submitted before the 3:30 p.m. Central cutoff time and it passed the 999 edits. This means if you submit a file after 3:30 p.m. Central Time, you may receive a TRANFILE and 999 but not receive a 277 HCCA until the second business day.	

Syntax: [submitter].[ccyymmdd].[t,p]tar.zip
***Example*:** submtr01.20100107.ptar.zip

Submitter	ccyymmdd	Usage
8-character alphanumeric identifier assigned by Vendor	Date of the 999	t = Testing p = Production

Acknowledgment Type	Naming Convention
Text Audit Report (TAR) – **TEST**	submitter.ccyymmdd.ttar.zip
Text Audit Report (TAR) – Production	submitter.ccyymmdd.ptar.zip
TARs will be generated nightly (Mon-Fri) and available the next business day if the claim file was submitted before the 3:30 p.m. Central cutoff time and it passed the 999 edits.	

Remittance filename legend:

Syntax: [submitter].[ccyymmdd].p[bc,bs][reg,fep,dom].8355010.zip
***Example*:** submtr01.20100106.pbsreg.8355010.zip

Submitter	ccyymmdd	Line of business	Remittance type
8-character alphanumeric identifier assigned by Vendor	Date of the 835 remittance	bc = Blue Cross (institutional) bs = Blue Shield (professional and dental)	reg = Regular business fep = FEP dom = Domestic

File Type	Naming Convention
Regular Cross - Production	submitter.ccyymmdd.pbcreg.8355010.zip
Regular Shield/Dental – Production	submitter.ccyymmdd.pbsreg.8355010.zip
FEP Cross - Production	submitter.ccyymmdd.pbcfep.8355010.zip
FEP Shield/Dental – Production	submitter.ccyymmdd.pbsfep.8355010.zip
Domestic Cross – Production	submitter.ccyymmdd.pbcdom.8355010.zip
Domestic Shield – Production	submitter.ccyymmdd.pbsdom.8355010.zip
Out-of-Area – Production	submitter.ccyymmdd.pbscob.8355110.zip

835 files are created on Saturdays but the filename reflects the payment date of the following Thursday (this date corresponds to the date of payment if any). Although the filename indicates the Thursday payroll date, it is available to retrieve as early as the Monday of the payroll week.

3.2 Certification Requirements

Proof of certification by a third-party entity is not required by Blue Cross. However, if a vendor continues to receive standard and implementation rejections during testing, it is advised that the vendor seek assistance by one of those entities.

3.3 Going "Live"

Once approval has been granted to submit production (live) claims, make sure to change the filenames to the appropriate syntax. Refer to **TPI Section 3.1.1** above. If you continue sending test files, they will not be picked up for live/production processing. Hence, no remittances will be generated for claims submitted and clients will not receive potential payments. In addition to the filename, you must also change the Interchange Usage Indicator (ISA15) of the Interchange Control Header from **T** (test) to **P** (production).

4. Connectivity/Communications

4.1 Process Flows

Figure 1 displays the process flow related to the submission of electronic claims and the creation and delivery of various acknowledgments and remittances.

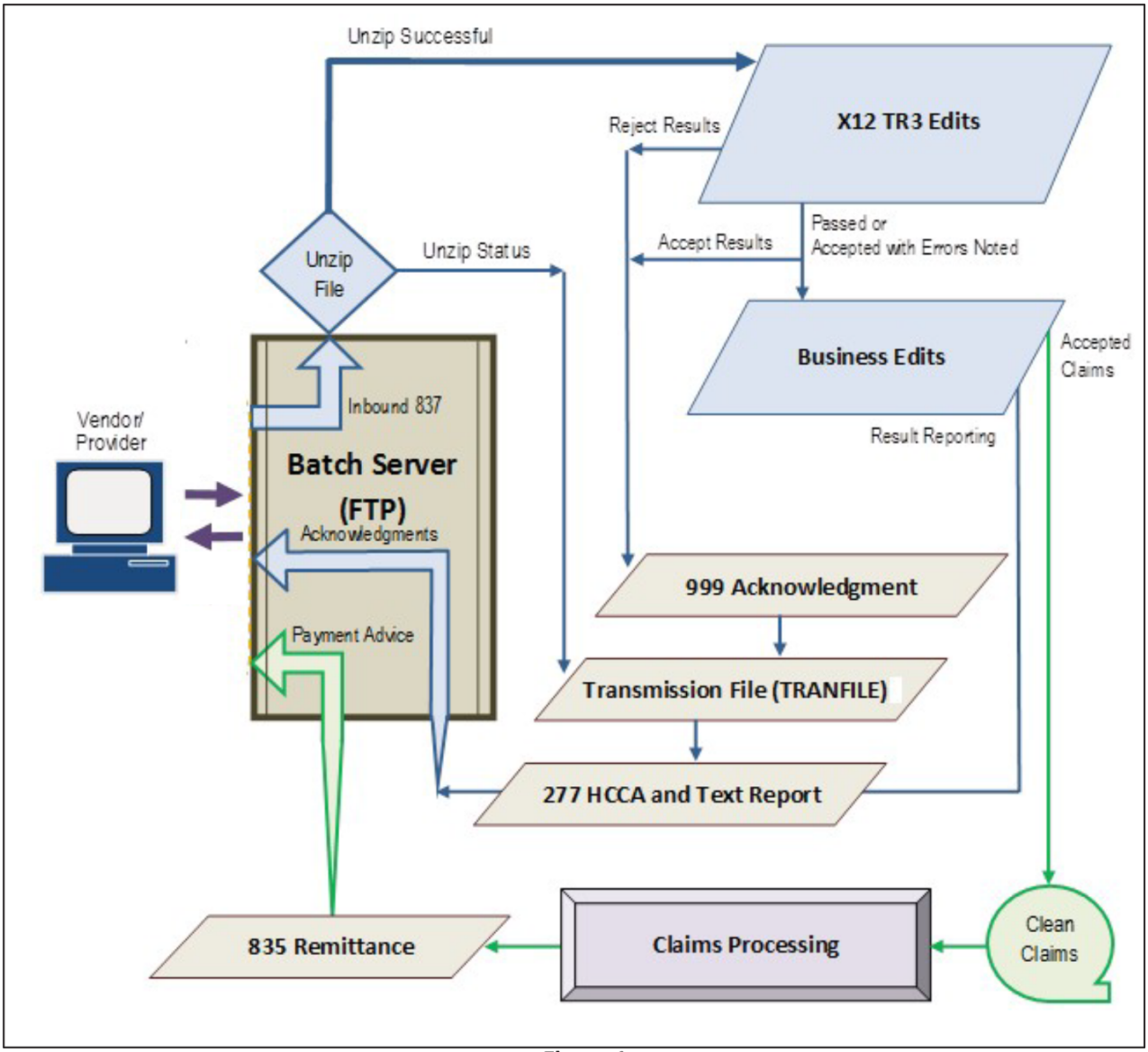


Figure 1.

4.2 Transmission Administrative Procedures

This section contains information regarding when claim files can be submitted and when the different types of acknowledgments will be available for retrieval. Refer to **TPI Section 7** for more information about the acknowledgments returned during this process.

4.2.1 Re-transmission Procedures

To prevent processing of batches that are accidently transmitted multiple times, all batches are analyzed to reject if the batches are exact duplicates. A duplicate batch is defined as the exact same group and claims within an Interchange envelope (ISA-IEA) that was previously submitted. If an exact batch file must be legitimately resubmitted, the file must be resubmitted with the value of 18 in the BHT02 to bypass duplicate batch file checking. If the BHT02 is not submitted correctly the file will reject as a duplicate file. This duplicate batch file bypass should only be used if the entire batch file was rejected. Another way to bypass the duplicate batch file logic is to add one claim or remove one claim from the file.

4.2.2 Claim Collection and Acknowledgment Schedule

- **837** claim files can be submitted to the batch server 7 days a week, 24 hours a day. However, the cut-off time to ensure clean claims are passed to the processor for adjudication the same day they are submitted is 3:30 p.m. Central Time, Monday through Friday. Late submissions may have the TRANFILE and 999 available during the next process cycle, however, the 277 HCCA will not be available until the second business day after submission.
- After receiving a claim file its associated **TRANFILE** and **999** will generally be available within two hours during regular daytime hours, seven days a week. NOTE: Files passing TR3 edits are then gathered from the batch server throughout the day until 3:30 p.m. Central Time Monday through Friday and held for business edit processing which occurs nightly Monday through Friday.
- **277 HCCA and TAR** files are downloaded to the FTP Server at 11:00 p.m. Central Time Monday through Friday for all claims received before 3:30 p.m. Central Time Monday through Friday. These two acknowledgments are only generated upon successful completion of TR3 edit checking. Therefore, if the 999 rejects the claims batch, a 277 HCCA will not be created.

4.2.3 Inbound File Drop-off and Outbound File Pickup Location

- Inbound batch transaction files should be dropped off in the root directory.
- Outbound acknowledgement/report files are available for pickup in the \Inbox sub directory.

4.3 Communication/Network Protocols

All batch file submission and retrieval functions are performed through secure communication with an FTP server. There are multiple communication options and FTP Protocols available for connection to Blue Cross for batch transaction submission and retrieval. The batch server is the location all claim file submissions are sent and where acknowledgments and remittances are retrieved. Available connectivity options are: 1) Mozilla Firefox, Mozilla Firefox ESR , Google Chrome (latest release and future fix packs) or 2) Secure FTP clients over the Internet. Connection to the FTP server via the Internet using SFTP is the preferred method for file transfer.

4.3.1 Connections Protocols

The FTP server (bctransfer.bcbsal.org) is accessible via the Internet and is the preferred method for file transfers. Data/payload encryption is necessary when using this method due to no encryption of the Internet connection. Any of the three supported secure FTP protocols (SFTP, FTPS, and HTTPS) must be used in order to ensure data encryption.

SFTP
Host Name: bctransfer.bcbsal.org
Listening port: 22
Supported FTP Clients: WS_FTP PRO

FTPS (explicit)
Host Name: bctransfer.bcbsal.org
Listening port: 990
Supported FTP Clients: WS_FTP PRO

HTTPS – via *myFileGateway* portal (Refer to **TPI Section 4.3.4** for portal instructions)
Host Name: https://bctransfer.bcbsal.org
Listening port: 443
Supported Browsers: Chrome

*NOTE: It is strongly recommended that the FTP service be accessed via the Internet using the hostname **bctransfer.bcbsal.org** instead of using an IP address. Using the host name will provide the greatest level of availability and redundancy in the event of server maintenance or unplanned downtime. Using an IP address would require vendors to make changes on their system during server maintenance before file transfers can continue.*

4.3.2 File Compression

Optional compression of files is supported for transmissions between the submitter and Blue Cross. Any compression software compatible with PKZIP by PKWARE, Inc. is supported (e.g. PKZIP, WinZip). It is recommended that claim files be compressed but not required. Refer to **TPI Section 3.1.1** for filename listing.

4.3.3 Password Resets

Password resets can be done via *myFileGateway* web interface via https://bctransfer.bcbsal.org . After successfully logging into the system, click the Change Password link. You will be prompted for the old password and the new one.

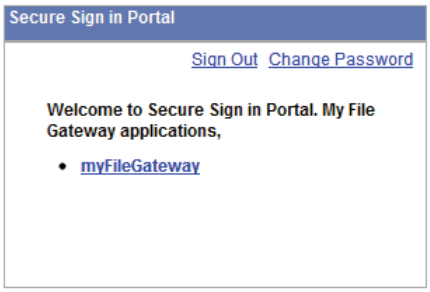
We request all vendor change their passwords upon receiving their bctransfer/qabctransfer credentials from their Blue Cross and Blue Shield of Alabama representative.

4.3.4 Instructions for using *myFileGateway* Portal via HTTPS

Logging Into *myFileGateway*

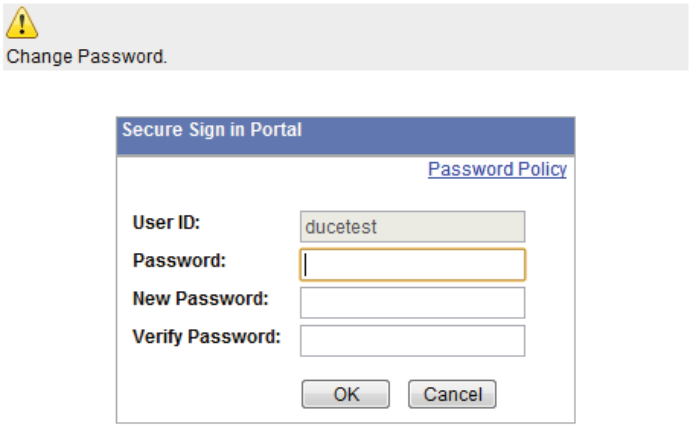
Use a web browser to point to https://bctransfer.bcbsal.org. If you attempt to connect to the non-SSL site, you'll be automatically redirected to the secure one. The initial page is below:

Enter the user ID and password assigned to you. Click the **Sign In** button to complete the login process.



Changing Your Password Through *myFileGateway*

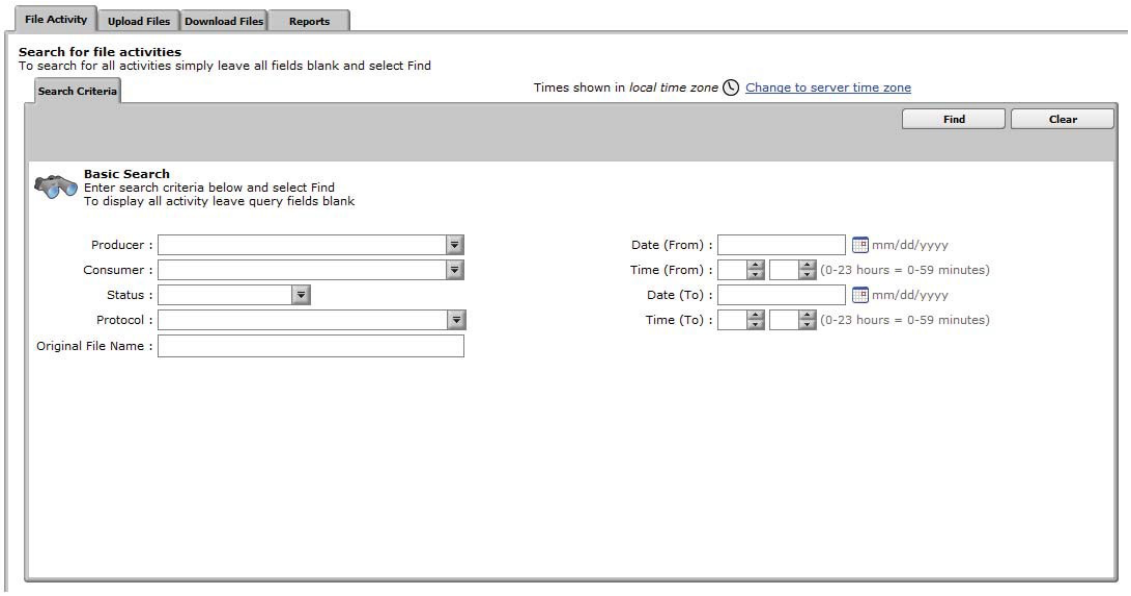
To change your password, you must be logged in. After logging in, click **Change Password**



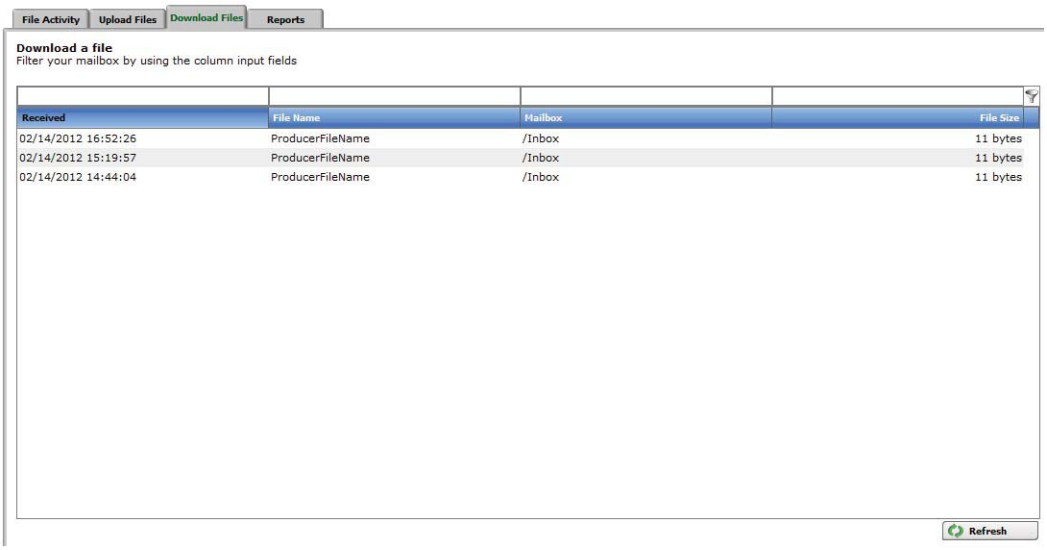
In the boxes provided, enter your old password, your new password and then retype your new password. Click **OK** to change your password.

Retrieve a File Using *myFileGateway*

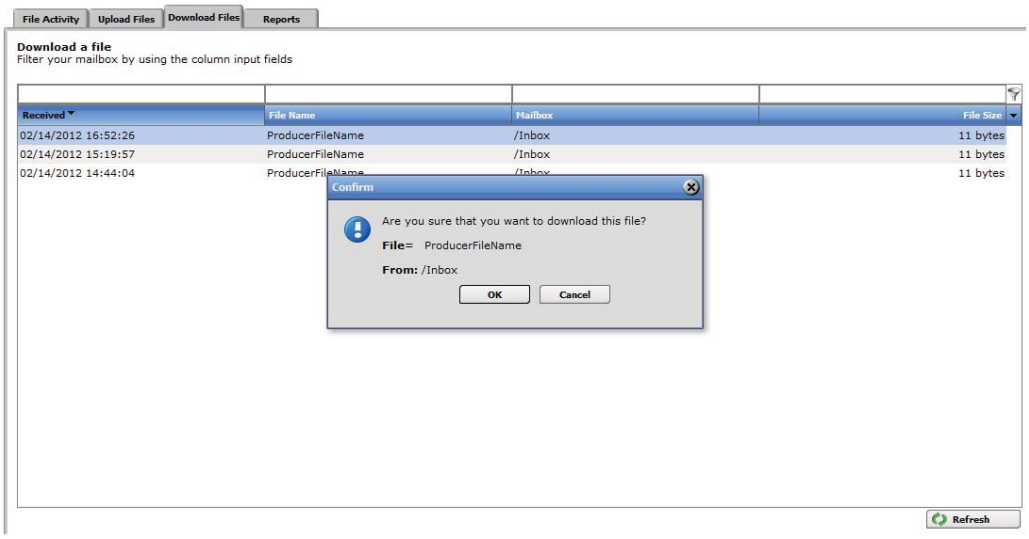
After successfully logging in, click on ***myFileGateway***



Click the **Download Files** tab.



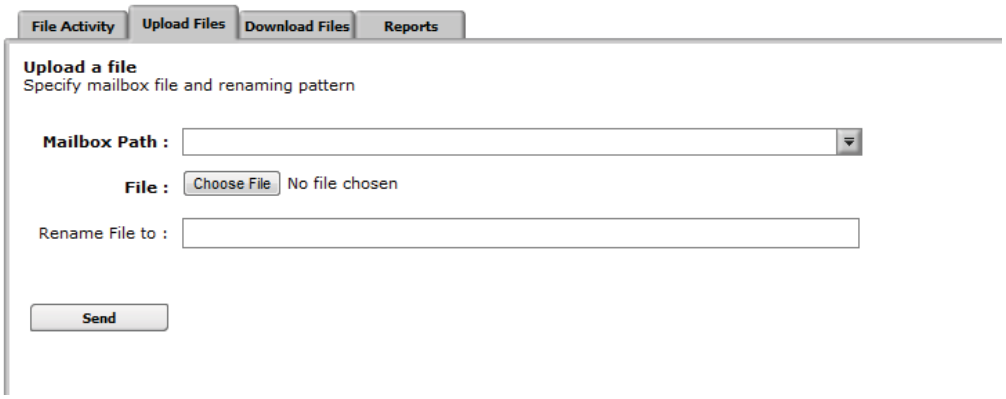
Select a file from the list of files by clicking the filename. Confirm the file download by selecting **OK** in the pop up window.



*Note: During the file transfer, if you click **Cancel**, the transfer may or may not be stopped, depending on the size of the file and rate of transfer. Click **Refresh** to see if the file is still available for download.*

Send a File Using *myFileGateway*

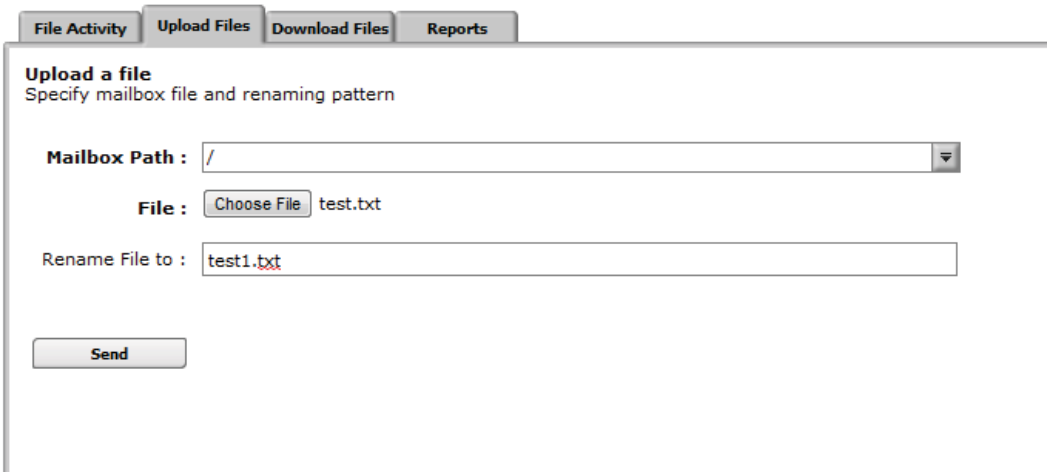
To send a file in *myFileGateway*, click on the **Upload Files** tab



Select the mailbox path where the file should be dropped off.

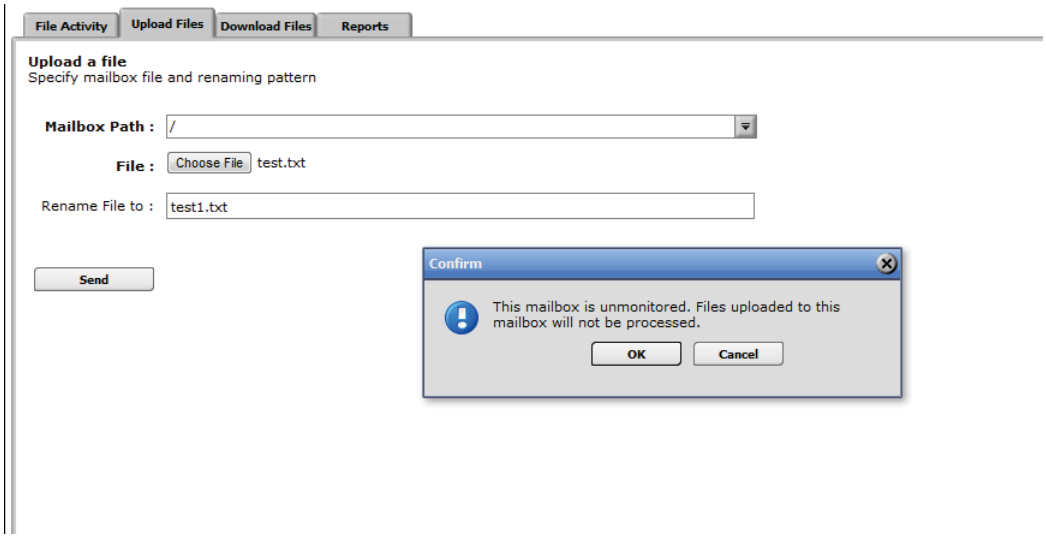
Enter the name and location of the file or browse to the file to be uploaded.

If you want to rename the file, enter the new file name. This field isn't required.

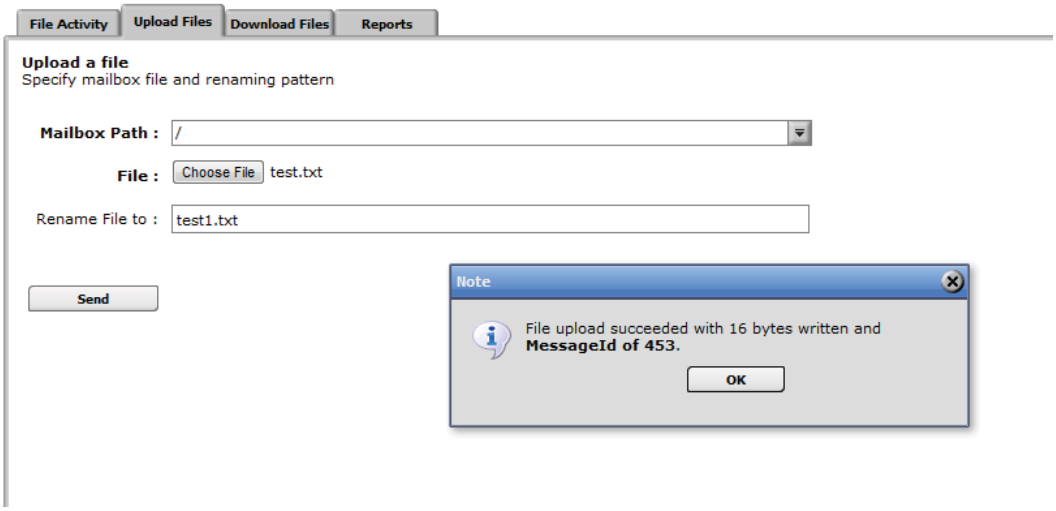


Click **Send**.

If you encounter the following message, continue the upload by selecting **OK**. Depending on the setup of your account, this message could be expected. It implies an internal process will run separately.



You should see the following file upload status after a successful upload.

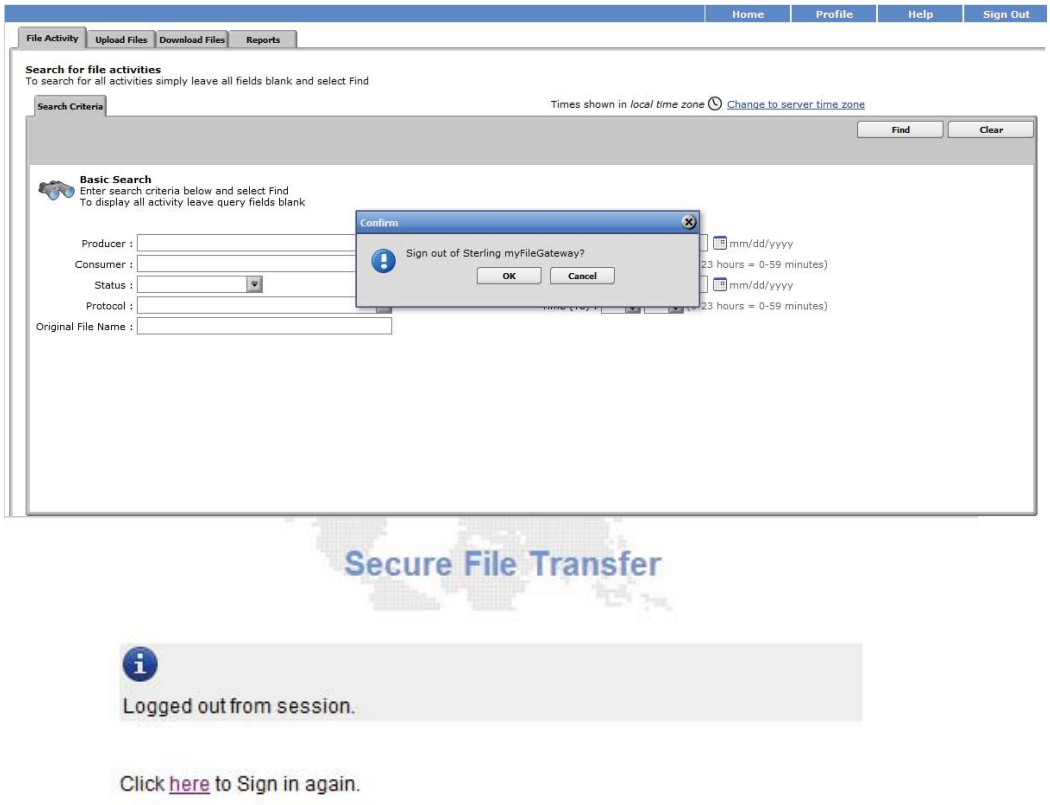


NOTE: Depending on the size of the file and the rate of transfer, you may have to wait for the file transfer to complete.

Logging Off of *myFileGateway*

When you've completed your work, click **Sign Out** in the upper right hand menu.

Confirm that you wish to sign out by clicking **OK**



You will see confirmation that you have successfully signed out

5. Contact Information

5.1 EDI Customer Service

EDI Services Support is the general support area for EDI questions. Vendors and providers may contact this area with questions regarding their electronic submissions and retrievals. Submit questions to **Ask-EDI@bcbsal.org** or telephone 205-220-6899.

5.2 EDI Technical Assistance

EDI Services Support is the technical support area for EDI questions. Typically these types of questions are received from vendors unless providers have their own IT area that supports their own billing application. Submit questions to **Ask-EDI@bcbsal.org** or telephone 205-220-6899.

5.3 Provider Services

Vendors and providers can contact EDI Services Support with questions regarding their electronic submissions and retrievals. However, if a provider is experiencing EDI issues, it is recommended that they initially contact their vendor for support. It may be possible the issue is already being researched between the vendor and Blue Cross.

When questions expand beyond the scope of EDI and reach into content related information providers should contact Customer Service. For example, Why did a specific claim pay a certain way in a remittance? versus. Why didn't I receive my remittance?

For information about provider networks and education contact Network Services.

Please refer to the following link to locate the appropriate telephone number for your question: **AlabamaBlue.com/providers/contacts/index.cfm.**

5.4 Applicable EDI Websites/Email

Website Name	URL
Blue Cross and Blue Shield of Alabama - Providers	**AlabamaBlue.com/providers/**
Blue Cross and Blue Shield of Alabama - Software Vendors	**AlabamaBlue.com/providers/vendors/**
Blue Cross and Blue Shield of Alabama Customer Service (non-EDI questions).	**AlabamaBlue.com/providers/contacts/**
WEDI	www.wedi.org/
X12	www.x12.org

Who Do You Want to Contact?	Email address
Blue Cross and Blue Shield of Alabama EDI Services Support All EDI questions should be sent to this email address with the exception of the 2 instances listed below.	**Ask-EDI@bcbsal.org**
Only **new** vendors prior to passing the testing process should use this email. Once a new vendor is approved for production all EDI questions should be sent to the **Ask-EDI** mailbox.	**EDIVendorTesting@bcbsal.org**
Established vendors should use this email address when they have questions regarding enrollment paperwork for their clients (Refer to **TPI Section 2.2.1**).	**EDIEnrollment@bcbsal.org**

6. Control Segments/Envelopes

6.1 ISA-IEA

The Interchange Control Header Segment (ISA) contains information regarding the identification of an interchange and related control segments. The ISA is always the first segment in an interchange. Because every data element within the ISA must be filled to the maximum length, the ISA has a fixed length.

6.1.1 Claims

Below are the envelope requirements for 837D, 837I and 837P submissions. Refer to **TPI Section 8.2** to view sample ISA and IEA segments.

- The Interchange Sender ID (ISA06) must contain the assigned 8-character submitter ID followed by seven spaces to meet the data element requirement of 15 bytes.

  Note: The Submitter ID reported in ISA06 must match the Submitter ID reported in GS02.

- The Interchange ID Qualifier (ISA07) should be the mutually defined code of ZZ.
- The Interchange Receiver ID (ISA08) must contain the 7-character receiver ID (left justified) followed by eight spaces to meet the data element requirement of 15 bytes. Receiver IDs are applicable to line-of-business.

  00010BC (institutional claims)
  00510BS (professional claims)
  00510DN (dental claims)

- If a vendor submits more than one interchange to the same directory on the same day for the same submitter ID, it is advisable that there be unique interchange control numbers in the ISA13 for each.

6.1.2 Remittances

- The Authorization Information Qualifier (ISA01) will be 03 and the Authorization Information (ISA02) will be the Payee's Tax Identifier.
- The ISA-IEA interchange will represent a single remittance for the unique combination of Payee NPI, Tax Identifier and line-of-business per payroll date. Therefore, an organization that uses the same Organizational NPI and tax ID combination to submit both professional and institutional claims, the organization will receive two separate remittances. One with Blue Cross adjudication information and one with Blue Shield/Dental adjudication information.
- Separate remittances will be created for separate types of adjudication. Possible remittances are Regular, FEP, Domestic. Refer to the *Remittance Filename Legend* in the **TPI Section 3.1.1** regarding filenames.
- All remittance data will be in uppercase regardless of the case submitted in the 837 claim.

6.1.3 Delimiters

Preferred delimiters are:

***** (asterisk) for **data element** separators.
^ (caret) for **repetition separator**.
: (colon) or **>** (greater than) for **component** data element separators.
~ (tilde) for **segment** separators.

Blue Cross sends a caret (^) in ISA11 for 005010X214 and 005010X221 transmissions.

6.1.3.1 Text Fields

The only special characters that should be used in free-formatted text data elements are the hyphen (-) and the apostrophe (').

The usage of other special characters within text data elements in the incoming 837 transaction may cause problems with creation of subsequent transactions, including the outbound 837 and the 835. For instance, if a colon is used within a text field the translator may interpret the colon in the text as a delimiter which would cause the transaction to reject back in the 999.

6.1.4 Character Sets

This general information on character sets is applicable to all transactions.

- Blue Cross will convert all lowercase characters submitted on an inbound 837 file to uppercase when sending data to the processing system.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix B of the 837 TR3 documents. In addition to the basic character set, you may choose to submit lowercase characters, the apostrophe (') and the @ symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange to be rejected in the TRANFILE. Refer to **TPI Section 7** for more information about acknowledgments.

6.2 GS-GE

The Functional Group Header (GS) is intended to group similar transaction sets within the same interchange. If multiple functional groups are submitted in the same interchange they should all hold the same transaction type.

6.2.1 *Claims*

Below are the functional group requirements for 837D, 837I and 837P submissions. Refer to **TPI Section 8.2** to view sample GS and GE segments.

- Use the 8-character Submitter ID assigned by Blue Cross or vendor in the Application Sender's Code (GS02) data element. The Submitter ID reported in this segment must match the Submitter ID submitted in ISA06.

- The Application Receiver's Code (GS03) should contain the applicable receiver id: 00510BS for professional claims, 00010BC for institutional claims and 00510DN for dental claims. Refer to **TPI Section 8.2** to view a sample GS segment.

- If a vendor submits more than one functional group to the same directory on the same day, it is advisable that there be unique functional control numbers in the GS06 in those submissions.

6.2.2 *Remittances*

- The Application Sender's Code (GS02) will be 00510BS for Dental/Professional data and 00010BC for Institutional data.

- The Application Receiver's Code (GS03) will contain the Payee National Provider Identifier (NPI).

6.3 ST-SE

Refer to **TPI Section 8.2** to view a sample ST segment.

- If a vendor submits more than one transaction set to the same directory on the same day for the same type of transaction, it is advisable that there be unique transaction set control numbers in the ST02 of those transactions. This is to allow for ease in matching the specific 277 HCCA back to its 837 counterpart since a separate 277 HCCA will be created for each 837.

- If multiple transaction sets are submitted in a functional group they must be of the same type. If different types (for example, 837P and 837I) are submitted the error will be indicated in a 999.

- Chargeable claims must contain CH in the BHT06. Encounter claims must contain RP in the BHT06.

7. Acknowledgements and Reports

Below is a complete list of acknowledgments (both proprietary and ASC X12 formats) that may be generated within the process of submitting an 837 file. ASC X12 transactions are explained in **TPI Section 7.1** and proprietary reports are explained in **TPI Section 7.2**.

This list demonstrates the order in which these acknowledgments will be created as 837 files continue through the editing process. If files reject during the process of translating, validating or editing, the reporting process may not continue to generate the reports that are produced later in the process. For instance, if a transaction is rejected for compliance errors in the 999 there will not be a 277 HCCA created for that file.

- TRANFILE (Transmission File – Proprietary)
- TA1 (Interchange Acknowledgment – ASC X12)
- 999 (Implementation Acknowledgment – ASC X12)
- 277 HCCA (Health Care Claim Acknowledgment – ASC X12)
- TAR (Text Audit Report – Proprietary)

7.1 ASC X12 Acknowledgments

The following ASC X12 acknowledgments may be created during the process of translating, validating and editing 837 claim files.

TA1 This segment acknowledges the interchange structure only. The 837 file does not progress to the next step if a rejection occurs at this level. When the ISA in the 837 is in error a TA1 will be created with only an envelope (interchange) to hold the structure errors (ISA, TA1, IEA segments only) if the 837 ISA14=1.

If the ISA passes envelope structure edits, the TA1 will be included in the envelope of the 999 acknowledgment (instead of by itself) IF the ISA14 in the 837 contains the value of 1 (1=Interchange Acknowledgment Requested).

999 The 999 contains TR3 compliance information. The 999 will be generated for **Rejected** (IK5*R and/or AK9*R), **Accepted** (IK5*A and/or AK9*A) and **Accepted with errors noted** (IK5*E or AK9*E) status.

Accepted but with errors noted status is generated when there are non-fatal implementation errors. These will be listed as rejections in the 277 HCCA. However, permitting these 'E's to pass the 999 edit checking will allow partial acceptance in the 277 HCCA vs. rejecting the entire batch.

277 HCCA The Health Care Claim Acknowledgment 277 transaction will be created when an 837 file has received an **Accepted** and **Accepted but with errors noted** status in its 999. Only **Accepted** claims move immediately on to business editing.

The 277 HCCA will contain specific edit information in STC segments. STC segments will be generated to indicate acceptance or rejection at the Information Receiver, Billing Provider,

Claim or Line Level. There may be one STC or a combination of STCs to help clarify the status of applicable information.

ACCEPTED CLAIMS:

- Claims accepted for adjudication will include a REF segment with a 1K value that will contain the assigned Blue Cross claim number(s). This claim number may be used to submit a real-time claim status request to receive status on that specific claim.
- Accepted claims will only have claim status information in the STC01 data element.
    - An STC segment for an accepted claim will be created as follows:

      STC*A2:20*ccyymmdd***WQ***$$~**
      Where: **ccyymmdd** is the effective date of the status information
      $$ is the numeric amount of the original submitted charges

- Accepted corrected bills will only have claim status information in the STC01 data element.
    - An STC segment for an accepted corrected bill will be created as follows:

      STC*A0:19:PR*ccyymmdd***WQ***$$~**
      Where: **ccyymmdd** is the effective date of the status information.
      $$ is the numeric amount of the original submitted charges.

REJECTED CLAIMS:

- Claims that reject in the 999 level will not generate a 277 HCCA. Claims that receive a 999 edit that reflects **Accepted but with errors noted** will be included in the 277 HCCA; however, they will be rejected claims in the 277 HCCA. Allowing **Accepted but with errors noted** to pass beyond the 999 edit level will accommodate partial acceptance of an entire batch of claims.

  Claims rejected in the 277 HCCA may contain more than one STC data element within an STC segment or perhaps even multiple STC segments to help clarify the rejection.

  Although the 277 HCCA is not yet listed as a covered transaction under HIPAA legislation, it is of the same standard format and is compatible with all HIPAA requirements.

7.2 Report Inventory

The following proprietary reports may be created during the process of translating, validating and editing 837 claim files.

TRANFILE This proprietary transmission file (TRANFILE) will list pre-edit status information regarding your transmission. Validation of the filename convention, file format

authentication and decompression status will be in this file. If any of these high-level errors occur for instance, if the UNZIP was unsuccessful, or the file is not in ASC X12 format the file will not continue processing.

TAR

The Text Audit Report (TAR) is a text file that contains information that has been interpreted from the 277 HCCA into a human readable file. This file is not intended to be used for auto-reconciliation within software systems. Refer to the 277 HCCA for the purpose of using a formatted file to post to a software system.

8. Additional Trading Partner Information

8.1 Implementation Checklist

A checklist is intended to aide in technical, testing and/or enrollment processes. Refer to **Appendix A** for documents that can be printed as stand-alone forms to assist in the various aspects of setup, testing and enrollment. The checklist titles are:

- Communications/Connectivity and Testing Checklist
- Enrollment Checklist

8.2 Transmission Examples

This section contains samples of the envelope and control segments to be submitted in transmissions containing 837 files. For more information regarding the use of these segments, refer to the applicable TR3 and **TPI Section 6** of this document.

- ISA/IEA segments are related to the entire interchange, GS/GE segments are related to the functional group and the ST/SE segments are pertinent to the transaction.

Sample 837P ISA and Matching IEA Segments:

```
Position:                                                                                                                  1         1
         1         2         3         4         5         6         7         8         9         0         1
         0         0         0         0         0         0         0         0         0         0         0
----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

ISA*00*          *00*          *ZZ*ABCTEST1       *ZZ*00510BS       *010509*0930*^*00501*123456789*1*T*:~
```

Add spaces to the ISA data elements that do not meet length requirements. *TEST*

IEA*1*123456789~ **Interchange 123456789 contains 1 Functional Group.** *(PRODUCTION=P)*

Sample 837P GS and Matching GE Segments:

```
GS*HC*ABCTEST1*00510BS*20091231*0930*432*X*005010X222A1~
```

GE*1*432~ **Functional Group 432 contains 1 transaction set.**

Sample 837P ST and Matching SE Segments:

```
ST*43789*005010X222A1~
```

SE*117*43789~ **Transaction Set 43789 contains 117 segments including the ST and SE.**

8.3 Trading Partner Agreement

EDI Trading Partner Agreements, such as the **Blue Cross EDI Vendor/Clearinghouse Agreement**, ensures the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is with an individual or an entity representing each party to the agreement.

For example, a Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

Refer to **TPI Section 2.2** for the trading partner process necessary to enroll in data exchange with Blue Cross, including the appropriate forms and their location on the Blue Cross website**.**

8.4 Frequently Asked Questions

Questions related to TPI, such as general EDI processes, connectivity, electronic communications and enrollment were combined with Transaction Information (TI) questions to contain all FAQs in one area for easier reference. All FAQs are contained in **TI Section 13.3**.

8.5 Other Resources

Refer to **TI Section 13.4** for other resource information pertinent to both the TPI and TI.

9. Trading Partner Information Change Control Summary

Change and version information regarding both the TPI Section and the TI Section of this document are contained in a single Change Control Summary Table located immediately following the Table of Contents for easy reference.

Transaction Instruction (TI)

This section contains transaction guidance including clarification of situational rules, business rules, frequently asked questions and additional related information.

10. TI Introduction

10.1 Background

10.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial healthcare transactions primarily between healthcare providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

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

10.1.2 Compliance According to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s)
- Change the meaning or intent of the standard’s implementation specification(s)

10.1.3 Compliance According to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

10.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

11. Included ASC X12N Implementation Guides

This table lists the ASC X12N Implementation Guides for which specific transaction instructions apply and which are included in **TI Section 3** of this document.

Unique ID	Title	Submitter
005010X222A1	Health Care Claim: Professional (837)	Vendor/Provider
005010X223A2	Health Care Claim: Institutional (837)	Vendor/Provider
005010X224A2	Health Care Claim: Dental (837)	Vendor/Provider
005010X231A1	Implementation Acknowledgment for Health Care Insurance (999)	Blue Cross
005010X214	Health Care Claim Acknowledgment (277)	Blue Cross
005010X221A1	Health Care Claim Payment/Advice (835)	Blue Cross

12. Instruction Tables

These tables contain one or more rows for each segment for which only supplemental instruction is needed. When the notes are applicable to a data element only, a shaded row naming the segment for which the data element belongs will precede the note for the data element. Instruction regarding the enveloping of the transactions is located in **TPI Section 6**.

Legend:

SHADED rows represent "**segments**" in the X12N implementation guide.
NON-SHADED rows represent "data elements" in the X12N implementation guide.

12.1 Health Care Claim: Professional - 005010X222A1

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	**NM1**	Submitter Name		
1000A	NM109	Submitter Identifier		Use the 8-character Submitter ID.
1000B	**NM1**	Receiver Name		
1000B	NM109	Receiver Primary Identifier		Use 00510BS in NM109 as the Receiver Name Code.
2000A	**PRV**	Billing Provider Specialty Information		The Health Care Provider Taxonomy Code is necessary when: 1) the provider submitting the claim practices under multiple specialties within the same billing entity – for example, an orthopedic surgeon who also bills as a DME supplier under the same NPI; 2) the provider is a VA , military, or children's rehabilitation employee.
2010BA	**NM102**	Entity Type Qualifier	1	Per TR3 Notes, state of Alabama requires "1," Person.
2300	**CLM**	Claim Information		
2300	CLM05-3	Claim Frequency Type Code	1, 7 or 8	1 = Original 7 = Replacement/Corrected 8= Voided
2300	CLM07	Assignment or Plan Participation Code		Medicare should be considered the Payer when submitting Blue Advantage claims.
2300	PWK01	Report Type Code	CK	CK= Consent Form (Surprise Billing Consent Form – Only)
2300	PWK02	Attachment Transmission Code	FX	FX = Fax (Surprise Billing Consent Form - Only) Fax Number: 205-220-2146
2300	PWK06	Identification Code		Attachment Control Number – Unique attachment control number linking to claim

	2310B	**PRV**	Rendering Provider Specialty Information		The Health Care Provider Taxonomy Code is necessary when: 1) the provider submitting the claim practices under multiple specialties within the same billing entity – for example, an orthopedic surgeon who also bills as a DME supplier under the same NPI; 2) the provider is a VA , military, or children's rehabilitation employee.

12.2 Health Care Claim: Institutional - 005010X223A2

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	**NM**	Submitter Name		
1000A	NM109	Submitter Identifier		Use the 8-character Submitter ID.
1000B	**NM**	Receiver Name		
1000B	NM109	Receiver Primary Identifier		Use 00010BC in NM109 as the Receiver Name Code.
2010BA	**NM102**	Entity Type Qualifier	1	Per TR3 Notes, state of Alabama requires "1," Person.
2300	**PWK**	Claim Supplemental Information		Any data submitted in this segment will not be considered for processing.
2400	**SV2**	Institutional Service Line		
2400	SV202	Procedure Modifier		Although four modifiers may be submitted, only the first two are considered in processing.
2400	**PWK**	Line Supplemental Information		Any data submitted in this segment will not be considered for processing.

12.3 Health Care Claim: Dental - 005010X224A2

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	**NM1**	Submitter Name		
1000A	NM109	Submitter Identifier		Use the 8-character Submitter ID.
1000B	**NM1**	Receiver Name		
1000B	NM109	Receiver Primary Identifier		Use 00510DN in NM109 as the Receiver Name Code.
2010BA	**NM102**	Entity Type Qualifier	1	Per TR3 Notes, state of Alabama requires "1," Person.
2300	**CLM**	Claim Information		
2300	CLM05-3	Claim Frequency Type Code	1 or 7	1 = Original 7 = Replacement/Corrected

12.4 Implementation Acknowledgment for Health Care Insurance (999)-005010X231A1

Loop ID	Reference	Name	Codes	Notes/Comments
There are no clarifying instructions for this transaction. However, please carefully review the ST, AK1, and AK2 segments in the 999 TR3 to understand how files will be identified. If multiple files are submitted to your directory, these segments will be of importance in order to match the 999 to its corresponding 837.				

12.5 Health Care Claim Acknowledgment (277) - 005010X214

Loop ID	Reference	Name	Codes	Notes/Comments
2000A	**NM1**	Information Receiver Name		
	NM101	Entity Identifier Code	41	
	NM108	Identification Code Qualifier	46	
	NM109	Identification Code		The information in this segment will mimic what was submitted in the 837 1000A loop, **Submitter Name** segment (NM101=41)
2200C	**REF**	Provider Secondary Identifier		
	REF01	Reference Identification Qualifier	TJ or SY	
	REF02	Billing Provider Additional Identifier		The Employer's Identification Number or Social Security Number submitted in the 837 2010AA, **Billing Provider Tax Identification** segment (REF01=EI or SY) will be returned.
2200D	**REF**	Payer Claim Control Number		
	REF01	Reference Identification Qualifier	1K	
	REF02	Payer Claim Control Number		The claim number assigned by Blue Cross for an ACCEPTED claim. Claims that reject due to implementation or pre-adjudication business edits will not be assigned a claim number. *A valid Blue Cross claim number is a 9-digit number where digits 4-6 are the Julian date of receipt.*

Claims Status Category Codes and **Claim Status Codes** are standardized code sets located on the Washington Publishing Company (EDI) site: **www.wpc-edi.com.**

12.6 Health Care Claim Payment/Advice (835) - 005010X221A1

Loop ID	Reference	Name	Codes	Notes/Comments
2000	**LX**	Header Number		• For professional/dental remits, the LX will be present for each provider NPI within a Payee NPI. • For institutional remits one iteration of loop 2000 will be present for paying claims and a second iteration for rejected claims.
	LX01	Assigned Number		Numeric value '4'
2100	**CLP**	Claim Payment Information		
	CLP01	Claim Submitter's Identifier		Although the 837 allows for a maximum of 38 characters for the Patient Control Number in 2300-CLM01, only positions 1 through 20 will be returned in the 835 CLP01 due to system limitations.

13. TI Additional Information

13.1 Business Scenarios

At this time there are no other business scenarios explicit to Blue Cross transmissions that are not addressed in another section of this document or in the TR3 documents for the 837, 835 or 277 HCCA transactions.

13.2 Payer Specific Business Rules and Limitations

13.2.1 Scheduled Maintenance

The batch server should be available 24 hours a day, seven days a week for delivery and retrieval of files. The routine maintenance window that may impact server availability is between 6 p.m. and midnight each Thursday, and on Sunday midnight to 6 a.m. and 6 p.m. to midnight. The schedule of when acknowledgments and remittances are placed on the server for retrieval is discussed in **TPI Section 4.2.2**

13.3 Frequently Asked Questions

This section contains questions that are commonly asked by vendors and providers relating to general EDI, communications, connectivity and specific electronic batch transactions in both HIPAA and proprietary formats.

Q1: **How does one know Blue Cross received a particular submission?**

A: TRANFILE and 999 acknowledgments should be available within one to two hours after submission during normal daytime hours. If there are no acknowledgments available within a couple of hours after submission, it may be due to one of these most common reasons:

1. Blue Cross did not receive the file. Check your directory name, sign-on, transmission history, etc., to troubleshoot the cause.
2. Blue Cross was unable to open the file you submitted. Check the file naming convention to ensure it follows the appropriate syntax. If the file is unrecognizable it will most likely still be in the directory in which it was placed.
3. Blue Cross was not able to identify the submitter ID within the ISA and GS to determine in which directory the TRANFILE should be placed.

The presence of an acknowledgment indicates the file was received. Please check the content of the acknowledgment to verify it was accepted and moved forward in the process. An acknowledgment does not always indicate acceptance.

Q2: When are acknowledgments of the claims submitted available for retrieval?

A: Transmission file (TRANFILE) and implementation acknowledgments (999) should be available within two hours of an 837 submission if it was sent during normal daytime hours. Health Care Claim Acknowledgments (277 HCCA) will be available the next **business** day if the claim file was received before 3:30 p.m. Central Time, and the 999 does not report a TR3 rejection.

Q3: What happens to claims that reject in an acknowledgment?

A: Claims that reject in any of the acknowledgments will not be sent for adjudication processing and will not be claim numbered. That means a claim that rejects in the front-end acknowledgment process may be submitted again as a new claim once the missing or invalid information is added or corrected.

Q4: How does a provider track the status of a claim once it has been submitted for adjudication?

A: Once a claim has passed the acknowledgment process and has been passed on for adjudication, its status can be checked by submitting a real-time HIPAA 276 inquiry transaction. A real-time HIPAA 277 response will contain the status information that was requested. Real-time transactions are covered in a separate companion guide titled **Standard Companion Guide related to Real-Time Processing (eligibility & benefits, claim status, referrals).**

Q5: What is a submitter ID?

A: A submitter ID is an 8-character alphanumeric identifier assigned by a clearinghouse, or practice management software vendors, for their clients. It is used to group information together pertinent to that submitter and is typically assigned by the vendor. However, Blue Cross reserves the right to reject the submitter ID if it does not meet the criteria or is already assigned. The password for the submitter ID is always assigned by Blue Cross and will be appropriately disclosed during the enrollment process. This submitter ID is used as the batch server login as well as the identifier within the **ISA06 – Interchange Header** and the **GS02 – Application Sender's Code** of the interchange.

Q6: When are remittances available for retrieval?

A: Remittances for Blue Cross are generated once per week. Remittances are created on Saturdays. The paper check that corresponds to the remittance is dated for that coming Thursday (EFT payments are typically transmitted on Wednesday evenings). If you have claims that have completed the adjudication process by Friday, those claims should be in a remittance for that coming week. Although the check is dated for Thursday, the remittance information will be available for you to review on the Monday of the same week.

Please note: Adjudication of a claim does not necessarily mean payment of a claim. Claims that reject in the adjudication system or pay $0 are contained in remittances along with paid claims.

Q7: What are the benefits of Electronic Funds Transfer (EFT) payments?

A: Instead of waiting for the printing, mailing and delivery of a paper check, your payment is directly deposited into your checking or savings account. There is no need to make a trip to the bank to deposit the check. You don't have to worry about your check getting lost in the mail, or if there are unforeseen disasters, such as a hurricane, that would delay the delivery of your mail. Plus, EFT deposits are typically sent Wednesday evenings – the evening before the date on a paper check.

Q8: How can a provider sign up for EFT payments?

A: If a provider has an account for the Blue Cross *ProviderAccess* web portal, the provider's administrator may register for EFT online behind *ProviderAccess* at **AlabamaBlue.com/providers.**

Q9: In relation to ASC X12 transactions, what does the term "envelope" mean?

A: "Envelope" is the term used to refer to the combination of the Interchange Control Header Segment (ISA) and the Interchange Control Trailer Segment (IEA). These segments are not actually part of the specific transaction itself but are used to precede and follow a transaction. The interchange information contains high-level information that "informs" a computer system about the type of information contained inside the file so it can prepare for that type of data.

Q10: What type of provider identifiers are needed in the 837 claim file?

A: The National Provider Identifier (NPI) is required as the provider's primary identifier. Depending on the type of provider at a specific level in the transaction, other identifiers may be required. For instance, the tax identification number is required for the Billing Provider loop. Secondary provider numbers such as proprietary location numbers (Blue Cross numbers) or UPINs are not used for processing.

13.4 Other Resources

13.4.1 External Code Sources

An External Code Set is a group of codes with predefined meanings where only the values from that named code set may be used in specific data elements. A code set may be controlled by ASC X12 or by an independent industry group. Information about these code sources is contained in *Appendix A* of the 837 TR3 documents.

14. Transaction Instruction (TI) Change Summary

Change and version information regarding both the TPI Section and the TI Section of this document are contained in a single Change Control Summary Table located immediately following the Table of Contents for easy reference.

Appendix A: Checklist Forms

The forms contained in Appendix A:

- Communications/Connectivity and Testing Checklist
    - This checklist can be used by vendors as a guide to check off the necessary steps to progress through testing with Blue Cross.

- Enrollment Checklist
    - This checklist can be used by vendors as a guide when enrolling clients.

Communications/Connectivity Test Checklist

Detail regarding connectivity to the Blue Cross batch server is contained in **TPI Section 1.4**.

Task	Dates or Annotations
Determine the type of connection for your client (Internet, dial-up, dedicated line/frame relay).	
Inform your EDI Vendor Consultant about the connection option you will be using. • Dial-up will require an additional setup step for the access server. • Frame relay will require coordination with the telecom department.	
Acquire a user ID and password to access the Blue Cross batch server. • If using dial-up, use the same user ID and password that is assigned for the batch (FTP) server to log onto the access server first.	
Establish a connection to the batch server and log in.	

Transmit (put) a test 837 file in the directory.
• Be sure to follow the required naming convention outlined in **TPI Section 1.3.4**.
  ○ All files must be submitted in binary mode
  ○ When compressing your 837 claim file, the filename should be identical to the claim source filename, only the extension should be different.
  • The extension should be **.zip** instead of **.clm**.
  • Files named incorrectly will not be recognized and no further action will occur.	

Retrieve (get) acknowledgments. Allow two hours before checking for transmission (TRANFILE) and 999 files. If claims were placed in directory before 3:30 p.m. Central Time, the 277 HCCA and TAR are typically available after 11 p.m. Central Time Monday through Friday. • All files must be retrieved in binary mode • Retrieve (get) the desired file(s) • UNZIP the file and verify you can view the data within	
Display acknowledgment information to clients. Remote login, print screen or onsite visit are options for EDI Vendor Consultants to authenticate this requirement.	

Enrollment and Test Results Checklist

The forms listed are available at: AlabamaBlue.com/Providers/Vendors/ProEnrollment.cfm

Task	Date or other annotation
1) Are you a new vendor to Blue Cross? NO – Go to question 2. YES – Complete, sign and submit a **New EDI Vendor Enrollment Form and Vendor/Clearinghouse Agreement** forms to Blue Cross. Date Blue Cross notified you that paperwork was completed: Go to **Question 2**.	_____ (mm/dd/yy) _____ (mm/dd/yy)
Only actual Blue Cross data is permissible for testing. *There are no "dummy" submitters, providers or members in the Blue Cross system. Vendors must have at least one client that has a relationship with Blue Cross and Blue Shield of Alabama in order to test.*	
	_____ _____
	_____ _____
Test File Information: **Submitter ID:**_____ Date submitted and total claims: Date of acknowledgment retrieval: Pass or Fail? **Submitter ID:**_____ Date submitted and total claims: Date of acknowledgment retrieval: Pass or Fail? **Submitter ID:**_____ Date submitted and total claims: Date of acknowledgment retrieval: Pass or Fail?	
Minimum criteria to pass testing: **At least three successful test files that do not contain duplicate claims should be submitted before approval process. A successful test file is one with: 1) No negative standard or implementation edits; 2) An 85 percent pass rate on business edits. Each successful file must contain no less than 10 claims with at least one secondary claim.**	