

Companion Document For
ANSI ASC X12N 276 4010A1 (Health Care Claim Status) Request
To Blue Cross and Blue Shield of Alabama
(Institutional, Dental, and Professional)
May 2008

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI ASC X12N 276 implementation guides have been established as the standards of compliance for claim status transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI ASC X12N 276 implementation guides. The table contains specific requirements to be used for processing data in the Blue Cross and Blue Shield of Alabama professional, dental, and institutional claims processing system.

The use of this document is solely for the purpose of clarification. This document, supplements, but does not contradict any requirements in the ANSI ASC X12N implementation guides. Additional companion documents are available for use with other HIPAA standards.

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ITEM #	LOOP	SEGMENT NAME	LANGUAGE
1.	----	----	You must submit incoming 276 transactions using the basic character set as defined in Appendix A of the 276 Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
2.	----	----	The incoming 276 transaction should utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), (pipe), and ^ (carat). Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected. The usage of these characters within text data elements in the incoming 276 transaction may cause problems with creation of subsequent 277 transactions.
3.	----	----	Only loops, segments, and data elements valid for the HIPAA Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
4.	----	----	Only loops, segments, and data elements valid for the HIPAA Implementation Guides will be translated. Non-implementation guide data will not be sent for response consideration.
5.	----	----	All dates that are submitted on an incoming 276 claim status request transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the request or the applicable interchange (transmission).
6.	----	----	Blue Cross will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange); a submitter must only submit one ISA-IEA (interchange) per request.
7.	-----	-----	Blue Cross will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
8.	-----	-----	Blue Cross will only accept one claim status request for one line of business per transaction. Claim status requests submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.

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9.	-----	-----	Blue Cross will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Implementation Guide.
10.	-----	-----	Blue Cross will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
11.	-----	-----	Data Encryption Standard (DES) must be used if the identifiers in the communication header and the interchange (ISA) differ. If encryption is not used, the identifiers in the communication header and the interchange (ISA) must be the same.
12.	-----	-----	For Institutional requests the Billing National Provider Identifier (NPI) must be used for Claim Status requests. For Professional or Dental requests the Rendering NPI must be used for Claim Status requests.
13.	-----	-----	If claim number is requested, then that claim will be returned in the 277 transaction if found.
14.	-----	-----	If submitted charges are requested, then claims within +/- \$100.00 of the requested submitted charges will be returned in the 277 transaction.
15.	-----	-----	For Institutional requests, if revenue code is requested, then claims containing that revenue code will be returned on the 277 transaction.
16.	-----	-----	If procedure code is requested, then claims containing that procedure code will be returned in the 277 transaction.
17.	-----	-----	A request for line item detail will receive a 277 response with the entire claim data.
18.	-----	Communication Header	<u>Socket Interface</u> - User ID should be sent in bytes 17-24 of the header; Vendor ID should be sent in bytes 12-14 of the header. <u>Remote Procedure Call (RPC)</u> - User ID equals 'char prov_nr[9]' in the header; Vendor ID equals 'char vendor_id[4]' in the header.
19.	-----	Interchange Control Header	Sender ID is the submitter ID and should be sent in the ISA06 data element. Password should be sent in the ISA04 data element.
20.	-----	Interchange Control Header	Use ZZ in ISA07 as the Interchange ID Qualifier.

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21.	-----	Interchange Control Header	For Institutional requests use 00010BC followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID. For Dental requests use 00510DN followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID. For Professional requests use 00510BS followed by 8 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID.
22.	-----	Functional Group Header	Sender ID is the submitter ID and should be sent in the GS02 data element.
23.	-----	Functional Group Header	In GS03 as the Application Receiver's Code, use 00010BC for Institutional requests, 00510DN for Dental requests, and 00510BS for Professional requests.
24.	-----	Functional Group Header	Blue Cross will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
25.	-----	Functional Group Header	Use HHMMSSDD as format in the Time data element GS05.
26.	-----	Transaction Set Header	Blue Cross will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
27.	2100A	Payer Name	Use 010 in NM109 (ID Code) for Institutional requests, use 00510 for Dental and Professional requests.
28.	2100B	Information Receiver Name	Use XX in NM108 (ID Code Qualifier) and NPI of the entity requesting information in the NM109 (ID Code).
29.	2100C	Provider Name	Use XX in NM108 (ID Code Qualifier) and Payee NPI in the NM109 (ID Code).