Blue Cross Blue Shield of Delaware

Standard Companion Guide

Instructions related to Provider Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 4.0

May 2011

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Preface

This Companion Guide (CG) contains two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for Highmark while ensuring compliance with the associated ASC X12 Implementation Guide (IG).

The Communications/Connectivity component is included in the CG to convey the information needed to commence and maintain communication exchange with Highmark.

The Transaction Instruction component is included in the CG to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Highmark

Communications/Connectivity

April 2011

Communications/Connectivity Information (CCI)

1. Communications/Connectivity Introduction

1.1 Scope

The Provider EDI Companion Guide addresses how Providers, or their business associates, conduct Professional Claim, Institutional Claim, Claim Acknowledgment, Claim Payment Advice, HIPAA standard electronic transactions with Highmark. This guide also applies to the above referenced transactions that are being transmitted to Highmark by a clearinghouse.

An Electronic Data Interchange (EDI) Trading Partner is defined as any Highmark customer (Provider, Billing Service, Software Vendor, Employer Group, Financial Institution, etc.) that transmits to, or receives electronic data from, Highmark.

Highmark's EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide. Highmark EDI Operations supports transactions for multiple payers; each transaction chapter lists the supported payers for that transaction.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Highmark. This information is organized in the sections listed below.

- Getting Started: This section includes information related to system operating hours, provider data services, and audit procedures. It also contains a list of valid characters in text data. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.
- Transaction Testing: This section includes detailed transaction testing information as well as other relevant information needed to complete transaction testing with Highmark.
- Connectivity/Communications: This section includes information on Highmark's transmission procedures as well as communication and security protocols.
- Contact Information: This section includes telephone and fax numbers for Highmark's EDI support.

- Control Segments/Envelopes: This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to Highmark.
- Acknowledgments and Reports: This section contains information on all transaction acknowledgments sent by Highmark. These include the TA1, Health Care Claim Acknowledgment (277CA) and An Implementation Acknowledgment for Health Care Insurance (999).
- CCI Change Summary: This section lists the changes made to this companion guide since the last version
- CCI Additional Information: This section contains links to Highmark's Trading Partner Agreements and Other Resources

1.3 References

Trading Partners must use the ASC X12 National Implementation Guides adopted under the HIPAA Administrative Simplification Electronic Transaction rule and Highmark's EDI Companion guidelines for development of the EDI transactions. These documents may be accessed through Highmark's EDI Trading Partner Portal:

https://www.highmark.com/edi-bcbsde

Trading Partners must use the most current national standard code lists applicable to the EDI transactions. The code lists may be accessed at the Washington Publishing Company website:

http://www.wpc-edi.com

The applicable code lists and their respective X12 transactions are as follows:

- Claim Adjustment Reason Codes and Remittance Advice Remark Codes (ASC X12/005010X221A1 Health Care Claim Payment/Advice (835))
- Provider Taxonomy Codes (ASC X12N/005010X222A1 Health Care Claim: Professional (837P) and ASC X12N/005010X223A2 Health Care Claim: Institutional (837I))

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working Together

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day seven days a week, except during scheduled system maintenance periods.

We strongly suggest that Highmark EDI Trading Partners transmit any test data during the hours that Highmark EDI Operations support is available.

Audit Procedures

The Trading Partner ensures that input documents and medical records are available for every automated claim for audit purposes. Highmark may require access to the records at any time.

The Trading Partner's automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Trading Partner documents are acceptable. The Trading Partner, not his billing agent, is held accountable for accurate records.

The audit consists of verifying a sample of automated claim input against medical records. Retention of records may also be checked. Compliance to reporting requirements is sample checked to ensure proper coding technique is employed. Signature on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark may request, and the Trading Partner is obligated to provide, access to the records at any time.

Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", Highmark can accept characters from the basic and extended character sets with the following exceptions:

Character	Name	Hex value
!	Exclamation point	(21)
>	Greater than	(3E)
^	Caret	(5E)
		Pipe	(7C)
~	Tilde	(7E)

These five characters are used by Highmark for delimiters on outgoing transactions and control characters for internal processing and therefore would cause problems if encountered in the transaction data.

As described in the X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be

significant characters. In the actual data stream trailing spaces should be suppressed. The representation for this data element type is AN.

Confidentiality

Highmark and its Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the Highmark EDI Trading Partner Agreement.

Authorized Release of Information

When contacting EDI Operations concerning any EDI transactions, you will be asked to confirm your Trading Partner information.

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.

While Highmark EDI Operations will accept HIPAA compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure be established in order to secure access to data. As a result, Highmark has a process in place to establish an Electronic Trading Partner relationship. That process has two aspects:

- A Trading Partner Agreement must be submitted which establishes the legal relationship and requirements. This is separate from a participating provider agreement.
- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing Highmark's EDI system for submission or retrieval of transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner. Maintenance of the ID and password by the Trading Partner is detailed in the security section of this document.

Authorization Process

New Trading Partners wishing to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application process includes review and acceptance of the appropriate EDI Trading Partner Agreement. Submission of the EDI Transaction Application indicates compliance with specifications set forth by Highmark for the submission of EDI transactions. This form must be completed by an authorized representative of the organization.

Highmark may terminate this Agreement, without notice, if participant's account is inactive for a period of six (6) consecutive months.

Complete and accurate reporting of information will insure that your authorization forms are processed in a timely manner. If you need assistance in completing the EDI Transaction Application contact your company's technical support area, your software vendor, or EDI Operations.

Upon completion of the authorization process, a Logon ID and Password will be assigned to the Trading Partner. EDI Operations will authorize, in writing, the Trading Partner to submit production EDI transactions.

Where to Get Enrollment Forms to Request a Trading Partner ID

To receive a Trading Partner ID, you must complete an online EDI Transaction Application and agree to the terms of Highmark's EDI Trading Partner Agreement. The EDI Transaction Applications and all other EDI request forms are available through the Enrollment Center on our Internet website. You may access the online Application from the page accessed by the link below.

Resource Center https://www.highmark.com/edi-bcbsde/index.shtml

Receiving ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) Transactions Generated from the Payment Cycle (Batch)

If you are not currently receiving Health Care Claim Payment/Advice (835) remittance transactions generated from the payment cycle in a batch process and wish to, you will need to complete a new Add/Remove Transactions Application on the Update Your Profile section of the site.

Adding a New Provider to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add a new provider to their Trading Partner Number should complete a Provider Affiliations Application on the Update Your Profile section and select the option to “Add a provider to an existing Trading Partner”.

Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should complete a Provider Affiliations Application on the Update Your Profile section and select the option to "Delete a provider from an existing Trading Partner”.

Reporting Changes in Status

Trading Partners changing their information must inform EDI Operations by completing an EDI Transaction Application and including all information that is to be updated.

https://www.highmark.com/edi-bcbsde

2.3 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

Testing Policy

All Trading Partners must be approved to submit 5010 transactions. Practice Management Software (PMS) Vendors may test their software for 5010 readiness on behalf of all of their clients. After a PMS Vendor has been tested and approved by Highmark, any Trading Partner that uses their software may submit a request for production 5010 access. If a software vendor has not tested and been approved a Trading Partner can do their own testing.

Web Based

Highmark offers Web-based syntax and validation testing using a Highmark-customized version of Foresight Corporation's Community Manager® product. Web-based testing is available for claims where the Interchange Receiver ID (ISA08) is Blue Cross Blue Shield of Delaware (00070, 00570). This testing includes the following types of edits:

- Transaction syntax testing (5010 transaction standards),
- HIPAA data requirements testing (5010 Implementation Guides),
- Front-end acceptance (payer) business rules.

This Web-based testing is available free of charge to our Trading Partners who have submitted a request to update to 5010. This functionality is designed to make EDI HIPAA syntax and validation testing for Highmark fast, simple, and secure by using a Web-based environment. Testing partners will receive detailed error analysis reports or a notice of successful validation. For more information on Foresight's Community Manager®, please visit their Web site describing the product at http://foresightcorp.tibco.com.

If you need assistance during your Community Manager® testing, you may call EDI Operations at 800-992-0246 or e-mail us at edisupport@highmark.com. A member of our support staff will be available Monday through Friday 8:00 a.m. to 5:00 p.m. ET to assist with any Community Manager® Trading Partner Testing questions you may have.

To get started, you need a Highmark Trading Partner ID. This requires completion of an EDI Transaction Application and execution of an EDI Trading Partner Agreement as explained in section 2.2. The

Transaction Application includes a place to request access to the Web based testing function.

Highmark Transactional Testing

Highmark does not allow Trading Partners to connect and send test batch transaction files in our production environment. A rejected 999 will be generated for any transaction file that has “test” indicated in the ISA segment.

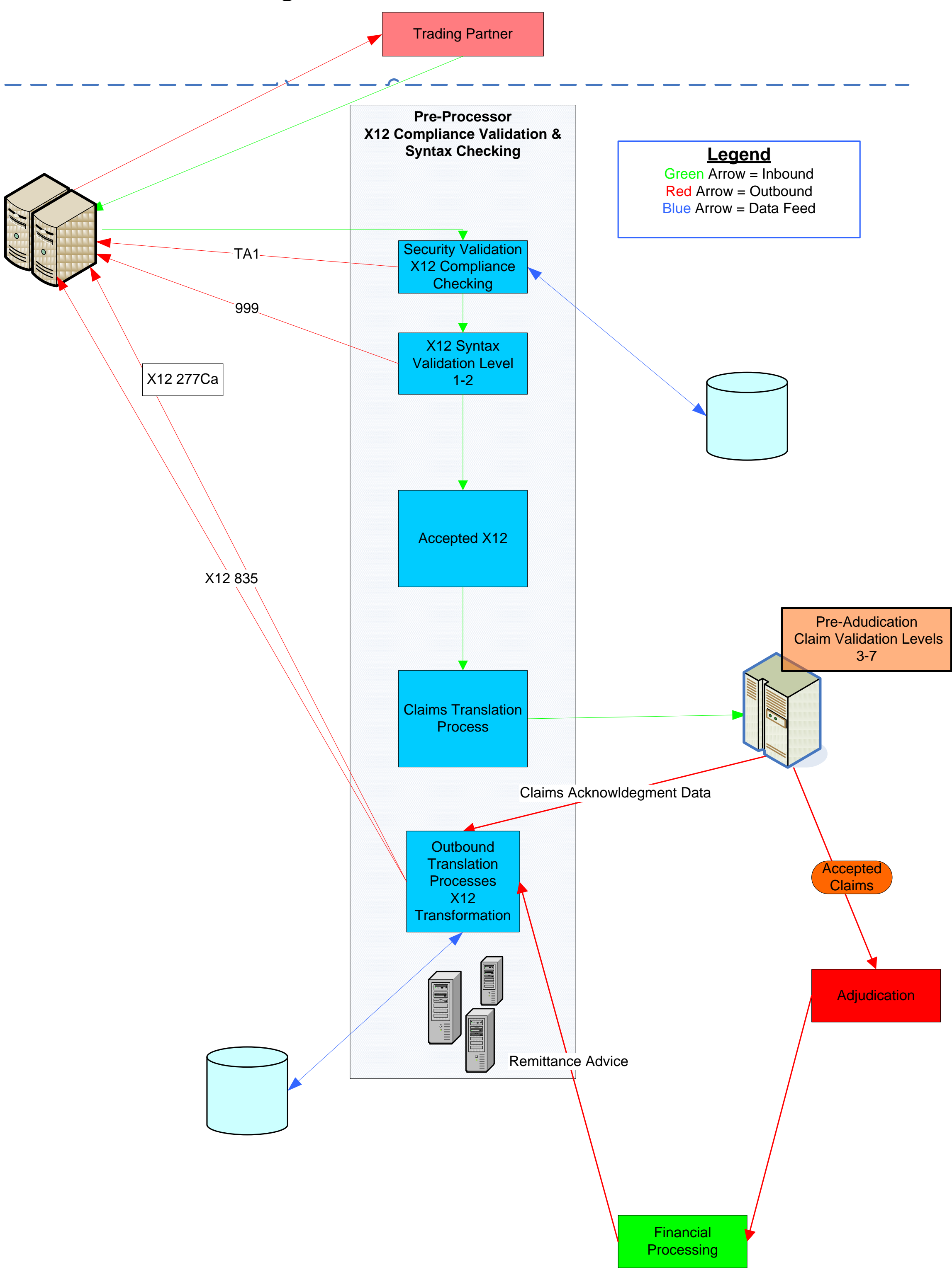
3. Testing with the Payer

Trading Partners should submit a test file containing a minimum of 25 test claims. Test files should contain claims that accurately represent the type of claims that will be submitted in production (ex. taxonomy/specialty, inpatient, outpatient, member & dependent claims). After a successful test file has been validated through the Community Manager® testing tool, the Trading Partner must request production capabilities by submitting a 5010 production request form to Highmark. Upon approval, 5010-ready Practice Management Software Vendors, Clearinghouses and Billing Services will be added to Highmark's 5010 Approved Trading Partner list. Any questions may be directed to EDI Operations at 800-992-0246.

4. Connectivity with the Payer / Communications

Highmark offers its Trading Partners File Transfer Protocol (FTP) through a secure Internet connection (eDelivery) for transactions in batch mode.

Process Flow



4.1 Transmission Administrative Procedures

4.2.1 Re-transmission procedures

Highmark does not have specific re-transmission procedures. Submitters can retransmit files at their discretion.

4.2 Communication Protocols

Internet

Highmark offers secured File Transfer Protocol (FTP) through "eDelivery" for Trading Partners who submit or receive any HIPAA-compliant EDI transactions in batch mode.

Internet File Transfer Protocol (FTP) through "eDelivery"

The Highmark Secure FTP Server ("eDelivery") provides an FTP service over an encrypted data session providing "on-the-wire" privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple FTP process in an encrypted and private manner.

Any state of the art browser can be used to access the Highmark Secure FTP Server. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser.

2. Connect to the FTP servers at: https://ftp.highmark.com

3. The server will prompt for an ID and Password. Use the ID/ Password that Highmark has provided you for accessing this service. Enter the ID, tab to password field and enter the password, then hit enter or click on OK.

4. The server will then place you in your individual file space on the FTP server. No one else can see your space and you cannot access the space of others. You will not be able to change out of your space.

5. You will need to change into the directory for the type of file you are putting or getting from the server.

6. By default, the file transfer mode will be binary and this mode is acceptable for all data types. However, you may change between ASCII and Binary file transfer modes by clicking the "Set ASCII"/ "Set Binary" toggle button.

7. Send Highmark a file. The following is an example of the submission of an electronic claim[1] transaction file:

a. Click on the “hipaa-in” folder to change into that directory.

b. Click on the browse button to select a file from your system to send to Highmark. This will pop open a file finder box listing the files available on your system.

c. Select the file you wish to send to Highmark and Click on OK.

d. This will return you to the browser with the file name you selected in the filename window. Now click on the “Upload File” button to transfer the file to Highmark. Once completed, the file will appear in your file list.

Note: The file naming convention for all FTP transactions should be 31 bytes or less and should not contain a '.' (dot) in the file name during transmission.

8. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:

a. Click on the “hipaa-out” directory.

b. Your browser will list all the files available to you.

c. Click on the “ack” directory.

d. Click on the file you wish to download. Your browser will download the file. If your browser displays the file instead of downloading, click the browser back button and click on the tools next to the file you wish to receive. Select application/ octet-stream. Your system may then prompt you for a “Save As” file location window. Make the selection appropriate for your system and click on Save to download the file.

Scripting Internet File Transfer Protocol transmissions

The following is an example of how to script a Secure FTP transmission.

Create a file that contains:

open -u userid,password sftp://ftp.highmark.com

cd /foldername

put filename

quit

then, to call linux command

lftp -f name-of-file

Or, if preferred, you can put it all on one line. lftp is free and comes with linux. For additional questions about scripting FTP transmissions, please consult your technical support area.

4.3 Security Protocols

Highmark EDI Operations personnel will assign Logon IDs and Passwords to Trading Partners. EDI Transactions submitted by unauthorized Trading Partners will not be accepted by our Highmark EDI Operations system.

Trading Partners should protect password privacy by limiting knowledge of the password to key personnel. Passwords should be changed regularly; upon initial usage and then periodically throughout the year. Also, the password should be changed if there are personnel changes in the Trading Partner office, or at any time the Trading Partner deems necessary.

Password requirements include:

- Password must be 8 characters in length.
- Password must contain a combination of both numeric and alpha characters.
- Password cannot contain the Logon ID.
- Password must be changed periodically.

5. Contact information

5.1 EDI Customer Service

Contact information for EDI Operations:

Address: EDI Operations
P.O. Box 890089
Camp Hill, PA 17089-0089
or

TELEPHONE NUMBER: (717) 302-5170 or (800) 992-0246

EMAIL ADDRESS: edisupport@highmark.com

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for EDI Operations:

Address: EDI Operations
P.O. Box 890089
Camp Hill, PA 17089-0089
or

TELEPHONE NUMBER: (717) 302-5170 or (800) 992-0246

EMAIL ADDRESS: edisupport@highmark.com

When contacting EDI Operations, have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

EDI Operations personnel are available for questions from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

5.3 Applicable websites / e-mail

EDI specifications, including this companion guide, can be accessed online at:

https://www.highmark.com/edi-bcbsde

6. Control Segments / Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the national implementation guides. Highmark's expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter of the Transaction Information Companion Guide.

Note - Highmark only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

6.1 ISA-IEA

Delimiters

As detailed in the national implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Highmark EDI Operations (inbound transmissions), the following list contains all characters that can be accepted as a delimiter. Note that LineFeed, hex value "0A", is not an acceptable delimiter.

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1 E
!	21
"	22

Description	Hex value
%	25
&	26
‘	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^ *	5E
{	7B
}	7D
~	7E

* “^” may be used as a Data Element Separator, but will not be accepted as Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark will use the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, "!", can not be used in text data (type AN, Sting data element) within the transaction; reference section 2.1 of this document titled Valid Characters in Text Data.

Delimiter Type	Character Used	(hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator	{	(7B)

Data Detail and Explanation of Incoming ISA to Highmark

Segment: ISA Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in Appendix B of the national transaction implementation guides, with the clarifications listed below.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark can only support code 00 - No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark can only support code 00 - No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	ZZ	Use qualifier code value "ZZ" Mutually Defined to designate a payer-defined ID.
	ISA06	Interchange Sender ID		Use the Highmark assigned security Login ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	ZZ	Use qualifier code value “ZZ”.
	ISA08	Interchange Receiver ID	00570 ----- 0070	BCBSD Professional BCBSD Institutional
	ISA14	Acknowledgment Requested		Highmark does not consider the contents of ISA14. Highmark always returns a TA1 segment when the incoming interchange is rejected due to errors at the interchange or functional group envelope.
	ISA15	Usage Indicator		Highmark uses the value in this element to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from Highmark

Segment: ISA Interchange Control Header (Outgoing)

Note: Listed below are clarifications of Highmark's use of the ISA segment for outgoing interchanges.

Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Highmark will send code 00 - No Authorization Information present
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Highmark will send code 00 - No Security Information present
	ISA04	Security Information		This element must be space filled
	ISA05	Interchange ID Qualifier	ZZ	Highmark will send qualifier code value ZZ to designate a payer assigned ID.
	ISA06	Interchange Sender ID	00570 00070	BCBSD Professional BCBSD Institutional
	ISA07	Interchange ID Qualifier	ZZ	Highmark will send qualifier code value "ZZ" Mutually Defined, to designate that a Highmark-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The Highmark-assigned ID will be the trading partner's security login ID. This ID will be left-justified and space filled.
	ISA14	Acknowledgment Requested		Highmark always uses a 0 (No Interchange Acknowledgement Requested).
	ISA15	Usage Indicator		Highmark provides T or P as appropriate to identify the test or production nature of all transactions

Loop ID	Reference	Name	Codes	Notes/Comments
				within the interchange.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS-GE can be found with the related transaction in sections 3 (Instruction Tables) and 5.2 (Payer Specific Rules and Limitations) of the Transaction Information Companion Guide.

6.3 ST-SE

Highmark has no requirements outside the national transaction implementation guides.

7. Acknowledgments and Reports

7.1 Report Inventory

Highmark has no proprietary reports.

7.2 ASC X12 Acknowledgments

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance
277 Acknowledgment	Claim Acknowledgment to the Electronic Claim[1]

Outgoing Interchange Acknowledgment TA1 Segment

Highmark returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA - IEA) must be rejected. TA1 segments are not returned for interchanges that do not have interchange-level errors.

The interchange rejection reason is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the guidelines in Appendix B of the national transaction implementation guides. Each Highmark TA1 will have an Interchange control envelope (ISA - IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is

[1] Electronic claim includes both ASC X12N/005010X222A1 Health Care Claim: Professional (837) and ASC X12N/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

received in a batch mode. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of Implementation Acknowledgment for Health Care Insurance (999) transactions will be returned.

Transaction accepted/rejected status is indicated in IK501. For details on this transaction, please refer to the Implementation Acknowledgment for Health Care Insurance (999) in sections 3.8 and 5.2.8 of the Transaction Information Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The Claim Acknowledgment Transaction is used to return a reply of "accepted" or "not accepted" for claims or encounters submitted via the electronic claim[1] transaction in batch mode. Acceptance at this level is based on the electronic claim[1] Implementation Guides and front-end edits, and will apply to individual claims within an electronic claim[1] transaction. For those claims not accepted, the Health Care Claim Acknowledgement (277CA) will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to the Health Care Claim Acknowledgement (277CA) in sections 3.3 and 5.2.3 of the Transaction Information Companion Guide.

8. CCI Change Summary

9. CCI Additional Information

9.1 Implementation Checklist

Highmark does not have an Implementation Checklist.

9.2 CCI Transmission Examples

No examples at this time.

9.3 Trading Partner Agreement

- Provider Trading Partner Agreement ( )
  For use by professionals and institutional providers.

- Clearinghouse/vendor Trading Partner Agreement ( )
  For use by software vendors, billing services or clearinghouses.

9.4 Frequently Asked Questions

No FAQs at this time.

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Standard Companion Guide

Transaction Information

May 2011

Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 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 health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations 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

1.1.2 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).

1.1.3 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 requirements

- Modifying any requirement contained in the implementation guide

1.2 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.

2. Included ASC X12 Implementation Guides

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

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010X221A1	Health Care Claim Payment/ Advice

3. Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

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

3.1 005010X222A1 Health Care Claim: Professional (837P)

Refer to section 5.2.1 for Highmark Business Rules and Limitations

005010X222A1 Health Care Claim: Professional				
Loop ID	Reference	Name	Codes	Notes/Comments
	GS	Functional Group Header		

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS02	Application Sender's Code		Delaware Trading Partner number. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	00570	BCBSD Professional
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Delaware Trading Partner number.
1000A	PER	Submitter EDI Contact Information		BCBSD will use contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		BCBSD
	NM109	Receiver Primary Identifier	00570	Identifies BCBSD as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2010AA	N3	Billing Provider Address		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		BCBSD will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BB	NM1	Payer Name		
	NM103	Payer Name		BCBSD
	NM109	Payer Identifier	00570	BCBSD Professional
2300	DTP	Admission Date		Reporting of admission dates is required on all inpatient services.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one BCBSD Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2310C	NM1	Service Facility Location	21 (Inpatient Hospital) 22 (Outpatient Hospital) 23 (ER) 31 and 32(Skilled Nursing Facility) 51 (Inpatient Psychiatric Facility) 55 (Residential Substance Abuse Treatment Facility) 61 (Comprehensive Inpatient Rehabilitation Facility)	For this list of Places of Service (Loop 2300, CLM05-1 and/or 2400 SV105), the services were performed inpatient in a facility. Therefore by definition the location of the services cannot be the same as the Billing Provider's address, and the service location must be submitted in this loop.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	SV103	Unit / Basis for Measurement Code		Anesthesia CPT codes (00100-01999) must be reported with minutes, except code 01996 which is reported with units indicating the number of days managing continuous drug administration. Moderate (Conscious) Sedation Codes 99143 - 99145 and 99148 - 99150, and anesthesia modifying unit procedure codes 99100, 99116, 99135, 99140 are reported with UN, Units and not MJ, Minutes.
2410	LIN	Drug Identification		**1.** NDC codes are required when required by government regulations. **2.** BCBSD encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one BCBSD contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.

3.2 005010X223A2 Health Care Claim: Institutional (837I)

Refer to section 5.2.2 for Highmark Business Rules and Limitations

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Delaware Trading Partner number.
	GS03	Application Receiver's Code	00070	BCBSD Institutional
	GS08	Version/Release/ Industry Identifier Code		Use 005010X223A2
	ST	Transaction Set Header		
	ST03	Version/Release/ Industry Identifier Code		Use 005010X223A2
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Delaware Trading Partner number.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		BCBSD
	NM109	Receiver Primary Identifier	00070	Identifies BCBSD as the receiver of the transaction and corresponds to the value in ISA08 Interchange Receiver ID.
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one BCBSD Contracted Specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2010AA	N3	Billing Provider Address		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	N403	Zip Code		The full 9 digits of the Zip+4 Code are required. The last four digits cannot be all zeros.
2100AA	PER	Billing Provider Contact Information		BCBSD will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on BCBSD internal files will be used for mailing of a check or other documents related to the claim.
2010BA	NM1	Subscriber Name		
	NM109	Subscriber Primary Identifier		This is the identifier from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only and are not part of the identification code and therefore should not be submitted in this transaction.
2010BB	NM1	Payer Name		
	NM103	Payer Name		BCBSD
	NM109	Payer Identifier	00070	BCBSD Institutional
2300	CLM	Claim Information		
	CLM05-1	Facility Type Code	84	BCBSD considers Free Standing Birthing Center to be Outpatient when applying data edits. Note that this is a variation from the Inpatient indication in the NUBC Data Specifications Manual as of the time of this document.
2300	DTP	Discharge Hour		
	DTP03	Discharge Time		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	DTP	Admission Date/Hour		

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP03	Admission Date and Hour		Hours (HH) are expressed as '00' for midnight, '01' for 1 a.m., and so on through '23' for 11 p.m. A default of '99' will not be accepted. Minutes (MM) are expressed as '00' through '59'. If the actual minutes are not known, use a default of '00'.
2300	K3	File Information		Present on Admission (POA) codes are not reported in the K3. Claims with POA codes in the K3 will not be accepted for processing. POA codes are reported in the appropriate HI segment along with the appropriate diagnosis code.
2300	HI	Principal Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Admitting Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future.
2300	HI	Patient's Reason for Visit		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Other Diagnosis		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Principal Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future
2300	HI	Other Procedure Information		ICD-10-PCS Procedure Codes will not be accepted at this time. Further information addressing BCBSD's implementation of the ICD-10 mandate will be issued in the future
	HI01-1	Code List Qualifier Code		Until further notification from BCBSD, Advanced Billing Concepts (ABC) codes will not be accepted.
2300	HI	Occurrence Information		An Assessment Date is submitted as an Occurrence Code 50 with the assessment date in the corresponding date/time element.

005010X223A2 Health Care Claim: Institutional				
Loop ID	Reference	Name	Codes	Notes/Comments
2310A	PRV	Attending Provider Specialty Information		When the Attending Provider's National Provider Identifier (NPI) is associated with more than one BCBSD contracted specialty, the Provider Taxonomy Code correlating to the contracted specialty must be submitted in addition to the NPI. This enables the accurate application of the provider's contractual business arrangements with Highmark.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.

3.3 005010X214 Health Care Claim Acknowledgment

3.4 (277CA)

Refer to section 5.2.3 for Highmark Business Rules and Limitations

005010X214 Health Care Claim Acknowledgment				
Loop ID	Loop ID	Loop ID	Codes	Notes/Comments
	GS	Functional Group Header		
	GS02	Application Sender's Code	00070 00570	This will match the payer id in the GS03 of the claim transaction BCBSD Institutional (00070) BCBSD Professional (00570)
	GS03	Application Receiver's Code		This will always be the BCBSD assigned Trading Partner Number for the entity receiving this transaction.
2100A	NM1	Information Source Name		
2100A	NM109	Information Source Identifier	00070 00570	This will match the payer id in the GS03 of the claim transaction BCBSD Institutional (00070) BCBSD Professional (00570)
2100B	NM1	Information Receiver Name		
2100B	NM109	Information Receiver Identifier		This will always be the BCBSD assigned Trading Partner Number for the entity that submitted the original 837 transaction.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
2200B	STC	Information Receiver Status Information		Status at this level will always acknowledge receipt of the claim transaction by the payer. It does not mean all of the claims have been accepted for processing. We will not report rejected claims at this level.
2200B	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
2200B	STC01-2	Health Care Claim Status Code	19	Default value for this status level.
2200B	STC01-3	Entity Identifier Code	PR	Default value for this status level.
2200B	STC03	Action Code	WQ	This element will always be set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
2200B	STC04	Total Submitted Charges		In most instances this will be the sum of all claim dollars (CLM02) from the 837 being acknowledged. In instances where the claim dollars do not match, an exception process occurred. **Details on exception processes to follow**.
2200C		Provider of Service Information Trace Identifier		The 2200C loop will not be used. Status or claim totals will not be provided at the provider level.
2200D	STC	Claim Level Status Information		Relational edits between claim and line level data will be reported at the service level
2200D	STC01-2	Health Care Claim Status Code	247	Health Care Claim Status Code '247 - Line Information' will be used at the claim level when the reason for the rejection is line specific.
2200D	DTP	Claim Level Service Date		
2200D	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used.
2200D	DTP03	Claim Service Period		The earliest and latest service line dates will be used as the claim level range date for professional claims. When the service line is a single date of service, the same date will be used for the range date.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
2220D	STC	Service Line Level Status Information		Relational edits between claim and line level data will be reported at the service level
2220D	DTP	Service Line Date		.
2220D	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used
2220D	DTP03	Service Line Date		When the service line date is a single date of service the same date will be used for the range date

3.5 005010X221A1 Health Care Claim Payment/ Advice (835)

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	00070 00570	This will match the payer id in the GS03 of the claim transaction "00570" – Professional Claim "00070" – Institutional Claim
	GS03	Application Receiver's Code		This will always be the BCBSD assigned Trading Partner Number for the entity receiving this transaction.
	REF	Receiver Identification		
	REF02	Receiver Identification		This will be the electronic Trading Partner Number assigned by Highmark's EDI Operations for transmission of Health Care Claim Payment/ Advice (835) transactions
1000A	REF	Additional Payer Identification		
1000A	REF01	Reference Identification Qualifier	NF	This value will always be used.
1000A	REF02	Additional Payer Identification	00070 00570	BCBSD
1000B	REF	Additional Payee Identification		
1000B	REF01	Additional Payee Identification Qualifier	TJ	The Provider's Tax Identification Number will be sent when the Provider's NPI is sent in the 1000B Payee Identification N104.
2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.
2000	LX01	Assigned Number	1	All claims except BCBSD Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period.
2000	LX01	Assigned Number	2	BCBSD Identified Overpayment reversal and correction claims where refund offset is delayed for 60 day review period.

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
2100	CLP	Claim Payment Information		
2100	CLP01	Claim Submitter's Identifier		The actual Patient Account Number may not be passed from paper claim submissions.
2100	CLP02	Claim Status Code	2	**Health Care Spending Account use:** This status code will be used on all claims within a Health Care Claim Payment/ Advice (835) that contains claim payments from members' Health Care Spending Accounts.
2100	CAS	Claim Adjustment		
2100	CAS01	Claim Adjustment Group Code	OA	**Health Care Spending Account use**: This Group Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.
2100	CAS02	Claim Adjustment Reason Code	23	**Health Care Spending Account use:** This Reason Code will be used for all adjustment dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.
2100	NM1	Corrected Priority Payer Name		
2100	NM108	Identification Code Qualifier	PI	BCBSD will always use this value
2100	NM109	Identification Code		Other payer IDs are not currently retained therefore a default value of **99999** will be used in this element.
2100	REF	Other Claim Related Identification		
2100	REF01	Reference Identification Qualifier	CE	
2100	REF02	Other Claim Related Identifier		Professional claims - This value will be utilized to provide the payer's Class of Contract Code and code description. Institutional claims - This value will be utilized to provide the Reimbursement Method Code.

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
2110	SVC	Service Payment Information		
2110	SVC01-2	Adjudicated Procedure Code		The applicable Unlisted Code will be returned in this data element when a paper professional or institutional claim was submitted without a valid procedure or revenue code: 99199 - Unlisted HCPCS Procedure code (SVC01-1 qualifier is HC) 0949 - Unlisted Revenue code (SVC01-1 qualifier is NU)
	PLB	Provider Adjustment		
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	CS	This value will be used for financial arrangement adjustments such as Bulk Adjustments, Cost Rate Adjustments, etc. Supporting identification information will be provided in the Reference Identification element.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	FB	This value will be used to reflect balance forward refund amounts between weekly Health Care Claim Payment/ Advice (835) transactions.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	L6	This value will be used to reflect the interest paid or refunded for penalties incurred as a result of legislated guidelines for timely claim processing.
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	WO	This value will be used for recouping claim overpayments and reporting offset dollar amounts
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Provider Adjustment Reason Code is "FB" the Provider Adjustment Identifier will contain the applicable 835 Identifier as defined in the ASC X12/005010X221 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing

005010X221A1 Health Care Claim Payment/ Advice				
Loop ID	**Loop ID**	**Loop ID**	**Codes**	**Notes/Comments**
	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the Adjustment Reason Code is "WO", the Provider Adjustment Identifier will contain the BCBSD Claim Number for the claim associated to this refund recovery.

3.6 005010X23A1 Implementation Acknowledgment For Health Care Insurance (999)

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		BCBSD has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		BCBSD has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time.
2110	IK4	Implementation Data Element Note		
	IK404	Copy of Bad Data Element		The 005010 version of the 999 transaction does not support codes for errors in the GS segment, therefore, when there are errors in the submitted GS, “TRADING PARTNER PROFILE” will be placed in this element to indicate that one or more invalid values were submitted in the GS.
2110	CTX	Element Context		BCBSD has implemented levels 1 and 2 edits only. This CTX segment will not be used at this time

4. TI Additional Information

This section may contain one or more of the following appendices.

4.1 Business Scenarios

No business scenarios at this time

4.2 Payer Specific Business Rules and Limitations

4.2.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 Implementation Guide, as modified by the June 2010 Type 1 Errata Document, is the primary source for definitions, data usage, and requirements.

This section and the corresponding transaction data detail make up the companion guide for submitting Health Care Claim: Professional (837P) claims for patients with BCBSD benefit plans. Accurate reporting of Highmark's NAIC code is critical for claims submitted to Highmark EDI.

Claims Resubmission
Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a "prior claim" or "finalized claim". An 837 is not an appropriate response to a payer's request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

4.2.2 005010X223A2 Health Care Claim: Institutional (837I)

The 837 transaction is used for institutional claims. The May 2006 ASC X12 005010X223 Implementation Guide, as modified by the August 2007 and June 2010 Type 1 Errata document, is the primary source for definitions, data usage, and requirements. Transactions must be submitted with the revisions in the errata; the transaction version must be identified as 005010X223A2.

Companion guides supplement the national guide and addenda with clarifications and payer-specific usage and content requirements. This section and the corresponding transaction detail make up the companion guide for submitting Health Care

Claim: Institutional (837I) claims for patients with BCBSD benefit plans.

Claims Resubmission

Frequency Type codes that tie to "prior claims" or "finalized claims" refer to a previous claim that has completed processing in the payer's system and produced a final paper or electronic remittance or explanation of benefits. Previous claims that are pending due to a request from the payer for additional information are not considered a "prior claim" or "finalized claim". An 837 is not an appropriate response to a payer's request for additional information. Rather, the instructions contained on the request must be followed for returning that information. At this time, there is not an EDI transaction available to use for the return of the requested information.

4.2.3 005010X214 Health Care Claim Acknowledgment (277CA)

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a Health Care Claim Acknowledgment (277CA) within twenty-four hours after Highmark receives the electronic claims[1], subject to processing cutoffs. In the event system issues are encountered and all claims from a single 837 transaction cannot be acknowledged in a single 277CA, it may be necessary to retrieve multiple 277CA transactions related to an electronic claims transaction. See section 4.3 Communication Protocols of the Communications/Connectivity Companion Guide for information on retrieving the batch Health Care Claim Acknowledgment (277CA).

4.2.4 005010X221A1 Health Care Claim Payment/ Advice (835)

Availability of Payment Cycle 835 Transactions (Batch)

Payment Health Care Claim Payment/Advice (835) transactions are created on a weekly or daily basis to correspond with Highmark’s weekly or daily payment cycles. The Health Care Claim Payment/Advice (835) payment transaction files become available for retrieval after the payment cycle is complete, and remain available for 7 days. If a Health Care Claim Payment/Advice (835) transaction was expected but not available for retrieval on the third day after the payment cycle was complete, contact EDI Operations for assistance.

Limitations

- Paper claims may not provide all data utilized in the Health Care Claim Payment/Advice (835). Therefore, some data segments and elements may be populated with “default data” or not available as a result of the claim submission mode.

- Administrative checks are issued from a manual process and are not part of the weekly or daily payment cycles; therefore they will not be included in the Health Care Claim Payment/Advice (835) transaction. A letter or some form of documentation usually accompanies the check. An Administrative check does not routinely contain an Explanation of Benefits notice.

- The following information will be populated with data from internal databases:

  Payer name and address

4.2.5 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Highmark returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS - GE) envelope that is received in a batch mode.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in IK501.) The location and reason for errors are identified in one or more of the following segments:

IK3 - segment errors
IK4 - data element errors
IK5 - transaction errors
AK9 - functional group errors

Rejection codes are contained in the ASC X12C 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) national Implementation Guide. Rejected transactions or functional groups must be fixed and resubmitted.

Implementation Acknowledgment for Health Care Insurance (999) transactions will have Interchange Control (ISA - IEA) and Functional Group (GS - GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the Implementation Acknowledgment for Health Care Insurance (999) will be "005010", indicating a generic 5010 Implementation Acknowledgment for Health Care Insurance (999) transaction.

Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. This difference is because the Implementation Acknowledgment for Health Care Insurance (999) is generic to the 5010 version and is not unique to each transaction standard

As part of your trading partner agreement, values were supplied that identify you as the submitting entity. If any of the values supplied within the envelopes of the submitted transaction do not match the values supplied in the trading partner agreement, a rejected Implementation Acknowledgment for Health Care Insurance (999) will be returned to the submitter. In the following example the IK404 value 'TRADING PARTNER PROFILE' indicates that one or more incorrect values were submitted. In order to process your submission, these values must be corrected and the transaction resubmitted.

4.3 Frequently Asked Questions

No FAQs at this time.

4.4 Other Resources

No Other Resources at this time.

5. TI Change Summary