HIPAA Transaction Standard

AZ Blue Companion Guide

azblue.com/providers

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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DISCLOSURE STATEMENT

Health Insurance Portability and Accountability Act (HIPAA) requires Blue Cross Blue Shield of Arizona AZ Blue) and all health insurance payers to comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Department of Health and Human Services. The Accredited Standards Committee (ASC) X12N/005010 versions of the Technical Report Type 3 (TR3) Implementation Guides have been established as the standards for compliance of healthcare transactions. The TR3s for each transaction are available electronically at http://store.X12.org/store/.

This companion guide is to be used with, not as a replacement for, the suite of version 005010 ASC X12N TR3s.

This companion guide refers to:

1. The Technical Report Type 3 (TR3) Implementation Guides, based on ASC X12 Version 005010
2. The Core v5010 Companion Guide

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PREFACE

This companion guide to the ASC X12N TR3s adopted under HIPAA, clarifies, and specifies the data content when exchanging electronically with AZ Blue. Transmissions based on the AZ Blue companion guide, used in tandem with the ASC X12N TR3s, are compliant with both ASC X12 syntax and those guides.

The AZ Blue companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. It is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3s.

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1. INTRODUCTION

This companion guide lists AZ Blue -specific guidelines needed to process certain scenarios on transactions that the TR3 does not provide. The clarifying information is listed in a table format with a separate row for each segment that AZ Blue has something additional, over and above the information in the TR3. That information can:

- Specify a sub-set of the TR3 internal code listings
- Clarify the use of loops, segments, composite, and simple data elements
- Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with AZ Blue

In addition to the row for each segment, one or more additional rows are used to describe AZ Blue's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and the suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that AZ Blue has something additional, over and above this information in the TR3s. The following is just an example of the type of information that would be spelled out or elaborated on in Section 10 – Transaction-specific Information.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 15% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to indicate if AZ Blue processes only utilize a specific number of characters of the submitted.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by AZ Blue.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the reference column and also how to specify that only one code value is applicable.

1.1 Scope

This document is to be used for the implementation of the ASC X12N transactions as mandated under HIPAA and is not intended to replace the TR3s.

1.2 Overview

This companion guide clarifies what AZ Blue looks for in specific loops/segments under specific scenarios on any listed HIPAA compliant electronic transaction set.

This companion guide will replace, in total, the previous AZ Blue companion guide versions for electronic transactions and must be used in conjunction with the TR3 instructions. This companion guide is intended to assist you in implementing electronic transactions that meet AZ Blue's processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide will occur periodically and new documents will be posted on the provider portal at azblue.com/providers under "Electronic Business."

1.3 References

For more information regarding the ASC X12N standards for EDI and to purchase copies of the TR3 documents, consult the ASC X12 store web site at http://store.x12.org/store.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12N committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ASC X12N standards are recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

2. GETTING STARTED

2.1 Working with AZ Blue

If you have questions about the information in this companion guide, please contact Integrated Customer Solutions (ICS) at ICS@azblue.com. AZ Blue supports the following transactions:

- ASC X12N/005010X231 Implementation Acknowledgement (999)
  - Referred to as the **999** in the rest of the document
- ASC X12N/005010X214 Healthcare Claim Acknowledgement (277CA)
  - Referred to as the **277CA** in the rest of the document
- ASC X12N/005010X279 Healthcare Eligibility Benefit Inquiry and Response (270/271)
  - Referred to as the **270 and the 271** in the rest of the document
- ASC X12N/005010X212 Healthcare Claim Status Inquiry and Response (276/277)
  - Referred to as the **276 and the 277** in the rest of the document
- ASC X12N/005010X217 Healthcare Services Review Request for Review and Response (278)
  - Referred to as the **278 or 278-13** for the inquiry and **278-11** for the response in the rest of the document
- ASC X12N/005010X218 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
  - Referred to as the **820** in the rest of the document
- ASC X12N/005010X220 Benefit Enrollment and Maintenance (834)
  - Referred to as the **834** in the rest of the document
- ASC X12N/005010X221 Healthcare Claim Payment/Advice (835)
  - Referred to as the **835** in the rest of the document
- ASC X12N/005010X224 Healthcare Claim: Dental (837)
  - Referred to as the **837D** in the rest of the document
- ASC X12N/005010X223 Healthcare Claim: Institutional (837)
  - Referred to as the **837I** in the rest of the document
- ASC X12N/005010X222 Healthcare Claim: Professional (837)
  - Referred to as the **837P** in the rest of the document

2.2 Trading Partner Registration

Start your registration by contacting Integrated Customer Solutions at ICS@azblue.com.

2.3 Certification and Testing Overview

A business analyst will monitor and review your testing and certification status with you through every step of implementation. Detailed testing requirements will be provided to you at the start of your testing and certification process.

3. TESTING WITH AZ Blue

The testing process covers both compliance and connectivity validation as detailed below.

3.1 Compliance: AZ Blue Payer Specific Validation

HIPAA validation testing including AZ Blue edits:

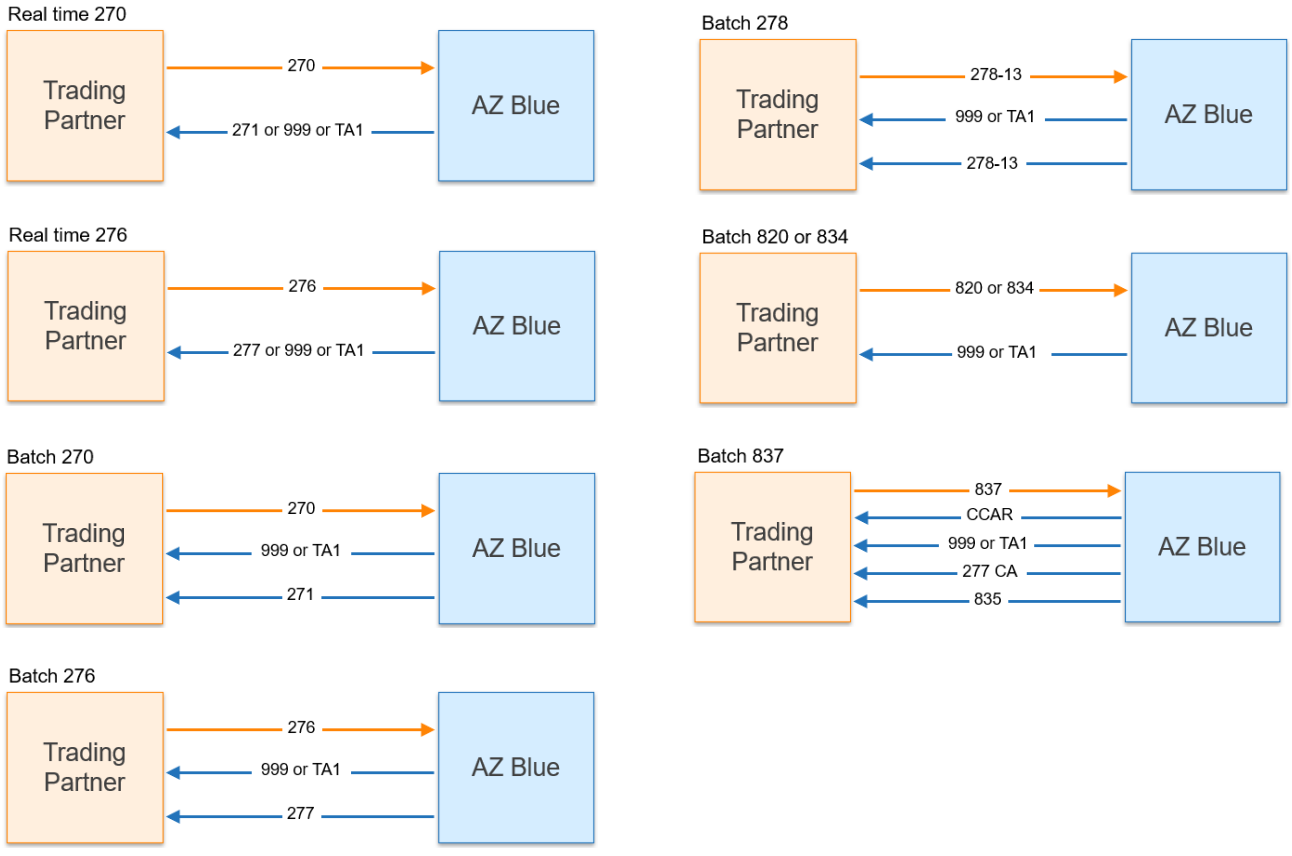
- Transactions will be processed through the AZ Blue edits and the following reports may be sent to you:
  - Interchange Acknowledgement (TA1): File failure for invalid envelope structure
  - 999: Acknowledgment of file passed or failed
  - AZ Blue Custom Claims Acknowledgment Report (CCAR): Pass or fail information at the claim level
  - 277CA: Pass or fail information at the claim level
- Once your test file passes AZ Blue validation, you are ready for phase III.

3.2 Connectivity: End-to-end Connectivity Testing

- Submit your test file to AZ Blue through your established connectivity method.
- For each test file submitted, download and review your reports for accuracy.
- Once connectivity testing is complete, contact your dedicated test team to discuss a production date.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

4.1 Process Flows



4.2 Transmission Administrative Procedures

Providers have two options to connect to AZ Blue.

4.2.1 Direct connect to AZ Blue

If your software vendor offers the ASC X12N transactions and can connect directly to AZ Blue, contact ICS at ICS@azblue.com to initiate the set up process to submit electronic transactions directly to AZ Blue.

Note: AZ Blue requires an executed trading partner agreement prior to testing for all trading partners connecting direct to AZ Blue. A business analyst will verify if one is already on file for your organization.

4.2.2 Connect through a third party clearinghouse

If your software vendor cannot connect directly, the following information will assist you with connecting through a third party clearinghouse:

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

4.3 Retransmission Procedure

4.3.1 Real time

- If a real-time response message is not received within the 60-second response period, do not resubmit sooner than 90 seconds after the original attempt.
- If no real-time response is received after the second attempt, submit no more than five duplicate transactions within the next 15 minutes.
- If additional attempts result in the same timeout, contact AZ Blue Integrated Customer Solutions for production support at ICS@azblue.com.

4.3.1 Batch

AZ Blue duplicate checking logic prevents the same batch file from being processed more than once. If you suspect that your file was not received by AZ Blue, contact AZ Blue Integrated Customer Solutions for production support at ICS@azblue.com before retransmitting the file.

4.3.2 Report repost request

For missing 999, 835, 277CA, or CCAR reports, contact AZ Blue Integrated Customer Solutions for production support at ICS@azblue.com to request a file to be reposted.

4.4 File Size and Volume Limits

- Real-time volume limit is 25 transactions per minute by a single trading partner.
- Maximum size of batch files for 27x is 99 individual requests.

4.5 System Availability

- For both batch and real time, AZ Blue's system is available Monday-Saturday, 12:00am through 11:59pm (MST), excluding the following holidays:
  - New Year's Day
  - Memorial Day
  - Independence Day
  - Labor Day
  - Thanksgiving Day
  - Christmas Day
- Downtime may be scheduled on Sunday to perform system maintenance.
  Note: In most circumstances, batch submission will be available during Sunday system maintenance times.

4.6 Communication Protocol Specifications

AZ Blue offers 4 connectivity options as described below.

4.6.1 CORE II web service

AZ Blue implemented a web service that conforms to CORE 153 and CORE 270.

- AZ Blue uses version 2.2.0 of the CORE connectivity rule.
- Supports batch and real-time 270/271 and 276/277.
- Login/password authentication is as defined in CORE 270.
- Responses for batch files are concatenated.
- For batch files, the interchange control number found in the ISA 13 must be unique.
- Batch responses will be available for pick up for 14 days.
- Complete technical specifications can be found online at:
  - caqh.org/sites/default/files/core/phase-i/policy-rules/153-v5010.pdf
  - caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf

Production and test URLs (copy and paste these URLs into your Web Service Application):

- SOAP + WSDL
  - Production: https://CORE2.services.azblue.com/Soap/COREIISoapService.svc
  - Test: https://stage.CORE2.services.azblue.com/Soap/COREIISoapService.svc
- HTTP + MIME
  - Real time
    - Production: https://CORE2.services.azblue.com/mime/COREIIMimeService.svc/realtime
    - Test: https://stage.CORE2.services.azblue.com/mime/COREIIMimeService.svc/realtime
  - Batch
    - Production
      - For submitting transactions: https://CORE2.services.azblue.com/mime/COREIIMimeService.svc/batchsubmit
      - To pick up acknowledgements (TA1 or 999): https://CORE2.services.azblue.com/mime/COREIIMimeService.svc/batchsubmitackretrieval

- To pick up the 271 or 276:
  https://CORE2.services.azblue.com/mime/COREIIMimeService.svc
  /batchresultsretrieval
- To send an acknowledgement:
  https://CORE2.services.azblue.com/mime/COREIIMimeService.svc
  /batchresultsacksubmission

- Test
  - For submitting transactions:
    https://stage.CORE2.services.azblue.com/mime/COREIIMimeService.svc/batchsubmit
  - To pick up acknowledgements (TA1 or 999):
    https://stage.CORE2.services.azblue.com/mime/COREIIMimeService.svc/batchsubmitackretrieval
  - To pick up the 271 or 276:
    https://stage.CORE2.services.azblue.com/mime/COREIINimeService.svc/batchresultsretrieval
  - To send an acknowledgement
    https://stage.CORE2.services.azblue.com/mime/COREIIMimeService.svc/batchresultsacksubmission

4.6.2 AZ Blue hosted SFTP

- Supports batch 834, 835, 837, 270, and 276 transactions.
- Production and testing URLs (copy and paste these URLs into your file transfer application or FTP/SFTP client):
  - Production: filegateway.bcbsaz.com:11233
  - Testing: filegateway.bcbsaz.com:12233
- Trading partners must supply AZ Blue with the IP address they will use to connect to the AZ Blue SFTP server.
- Trading partners are required to either:
  - Encrypt the files using PGP
  - Authenticate with an SSH UID key

4.6.3 Trading partner hosted FTP

AZ Blue can connect to a trading partner's FTP server to pick up and/or drop off files.

- AZ Blue supports FTP, SFTP, and FTPS protocols.
- Batch 834, 835, 837, 270, and 276 transactions.
- AZ Blue requires trading partners that use the FTP protocol to PGP encrypt files.

4.7 Connectivity Summary

	MyFileGateway	AZ Blue-hosted SFTP	Trading Partner-hosted FTP	CORE II Web service
270/271	Batch	Batch	Batch	Real time/Batch
276/277	Batch	Batch	Batch	Real time/Batch
278	Batch	Batch	Batch	Batch
820	Batch	Batch	Batch	Batch
834	Batch	Batch	Batch	Batch
835	Batch	Batch	Batch	Batch
837	Batch	Batch	Batch	Batch

If you have questions about methods of connectivity, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

4.8 Passwords

Passwords for trading partners will be supplied during the trading partner connectivity process. For questions regarding passwords, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

5. CONTACT INFORMATION

5.1 EDI Customer Service and Technical Assistance

For customer support or technical assistance with electronic transactions, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

5.2 Provider Service Numbers

- For assistance concerning claims processing and payments, contact:
  - Provider Assistance: (602) 864-4320, 1 (800) 232-2345 ext. 4320
- For assistance from your assigned network contract specialist (NCS), contact:
  - Provider Partnerships: (602) 864-4231, 1 (800) 232-2345 ext. 4231
- For assistance concerning member enrollment information and questions, contact:
  - Member Enrollment: (602) 336-7444, 1 (800) 232-2345 ext. 4400 or email ElecEnrl@azblue.com

5.3 Applicable Websites

- **Blue Cross Blue Shield of Arizona**: azblue.com/providers
- **Centers for Medicare & Medicaid Services (CMS) Transaction & Code Sets Standards:** https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AdoptedStandardsandOperatingRules.html
- **WPC:** http://wpc-edi.com/
- **CORE Specifications**: caqh.org/core/operating-rules
- **X12**: x12.org

6. CONTROL SEGMENTS/ENVELOPES

6.1 ISA-IEA Interchange Control

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission and provides sender and receiver identification.

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	**None**	**ISA**	**ISA Interchange Control Header**		
C.4		ISA05	Interchange ID Qualifier	ZZ	
C.4		ISA06	Interchange Sender ID		Supplied by AZ Blue
C.5		ISA07	Interchange ID qualifier	33	
C.5		ISA08	Interchange Receiver ID	53589	

6.2 GS-GE Functional Group

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope.

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**		
C.7		GS02	Application Sender's Code		Supplied by AZ Blue
C.7		GS03	Application Receiver's Code	53589	

6.3 ST-SE Transaction Set

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real-time transactions, there will always be only one ST and SE combination.

7. PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

See tables under *Section 10: Transaction-specific Information*.

8. ACKNOWLEDGEMENTS AND REPORTS

8.1 Acknowledgement Transactions

AZ Blue will acknowledge all inbound HIPAA batch transactions with either a TA1, 999, or 277CA.

8.2 TA1

For either batch or real-time transactions, a TA1 will be sent for compliance failures at the ASC X12 Interchange Envelope level [within the Interchange Control Header (ISA) and Trailer (IEA) segments], resulting in rejection of the entire Interchange.

8.3 999

If a valid interchange is received, a 999 will be sent which provides the results of the compliancy status of the electronic file.

8.3.1 Batch transactions

- A 999 will be generated for all batch files received indicating whether the file was accepted, partially accepted, or rejected.

8.3.2 Real-time transactions

- For real-time transactions, a 999 will only be generated if the transaction is rejected.

8.4 277CA

A 277CA will be generated for all claim files received.

8.5 Custom Claim Acknowledgement Report (CCAR)

A CCAR is a 'human-readable' report that contains information on all claims within a batch and includes a detailed status of rejected and accepted claims.

9. TRADING PARTNER AGREEMENTS

EDI trading partner agreements accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The trading partner agreement is related to the electronic exchange of information between each party to the agreement and may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

AZ Blue requires an executed trading partner agreement prior to testing for all trading partners (providers, billing services, software vendors, employer groups, financial institutions, clearinghouses, etc.) that transmits to and/or receives electronic data directly with AZ Blue. A business analyst will verify if one is already on file for your organization.

To find out how to become a AZ Blue trading partner, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

10. TRANSACTION-SPECIFIC INFORMATION

10.1 Sender ID

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

10.2 Transmission Guidelines

- Do not concatenate multiple ISA/IEA interchanges within a file.
- You may submit multiple GS/GE functional groups within one ISA/IEA interchange envelope structure (except 834 transactions).
- Transaction responses for batch transactions will be available for electronic pickup by the submitter.
- Submit data in uppercase.
- For batch transactions, the file naming convention is "0000SSSS.###."
  Note: ''0000SSSS'' indicates the 8-digit sender ID number assigned by AZ Blue. "###" defines the transaction number. i.e. 837.

10.3 Delimiters

- Inbound delimiters
  - AZ Blue will accept any delimiter for inbound transactions as defined in Section B of the TR3.
  - **Important!** The use of (*), (:), (^) and (~) other than as a delimiter is expressly prohibited.
- Outbound delimiters
  - AZ Blue will use the following delimiters on outbound transactions:

Delimiters Character	Purpose
Asterisk (*)	Used to separate elements within a segment
Colon (:)	Used for composite elements
Tilde (~)	Represents the end of a segment
Carat (^)	Used as a repetition separator

10.4 270/271

The 270/271 transactions are used to electronically transfer healthcare eligibility and benefit information:

- 270: Request eligibility and benefit information.
- 271: Respond with eligibility and benefit information.

These transactions are used to determine an individual's eligibility and benefit information, but do not provide a benefit history.

Guidelines

- The 270/271 can be conducted for AZ Blue, FEP (Federal Employee Program) and BlueCard (out-of-area) members.
- Member ID requirements to submit BCBS eligibility inquiries are as follows:
    - AZ Blue members: Three-character prefix followed by 9 numbers.
    - FEP members: The letter 'R' followed by 8 numbers.
    - BlueCard (out-of-area) members: Minimum of a three-character prefix followed by a combination of 4 to 17 numbers and/or letters.

  NOTE: Embedded spaces for any of the above listed member ID requirements are **not allowed.**
- If an incorrect member ID prefix is submitted on a 270 for a AZ Blue member, the 271 will contain the corrected prefix.
- The NPI is required on all electronic transactions unless the provider of services cannot obtain an NPI or does not meet the definition of a healthcare provider.
- Batch transactions will be broken down and processed by AZ Blue as individual inquiries. You will receive individual responses for each inquiry.
- The 270/271 is capable of responding to past, present, and future inquiries. Future inquiries must be less than or equal to 31 days in the future. Past inquiries are limited up to no more than 36 months in the past.
- For Corporate Health Service (CHS) eligibility and benefit inquiries, contact the CHS group or applicable third party administrator (TPA) located on the back of the member's card.
- Eligibility and benefit information for Medicare Advantage members (prefix XBU) is not supported by AZ Blue. Visit azbluemedicare.com for online eligibility inquiries.

AAA Segments

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

- System time-out
- Future date of service greater than 31 days
- Membership validation
- Provider ID validation

270/271 Data Elements

Page #	Loop ID	Reference	Name	Codes	Comments
69	2100A	NM1	Information Source Name		
69	2100A	NM101	Entity Identifier Code	PR	Insert 'PR' (Payer)
71	2100A	NM108	Identification Code Qualifier	NI	Insert 'NI' (NAIC)
71	2100A	NM109	Information Source Identifier	53589	Insert '53589'
95	2100C	NM1	Subscriber Name		
95	2100C	NM109	Subscriber Primary Identifier		AZ Blue requires the subscriber's primary identifier to support a TR3 search option
108	2100C	DMG	Subscriber Demographic Information		
108	2100C	DMG01	Date Time Period Format Qualifier		AZ Blue requires the subscriber's date of birth to support a TR3 search option
108	2100C	DMG02	Subscriber Date of Birth		AZ Blue requires the subscriber's date of birth to support a TR3 search option
165	2100D	DMG	Dependent Demographic Information		
165	2100D	DMG01	Date Time Period Format Qualifier		AZ Blue requires the date of birth to support a TR3 search option if the patient is a dependent
165	2100D	DMG02	Dependent Date of Birth		AZ Blue requires the date of birth to support a TR3 search option if the patient is a dependent

270/271 Service Type Guide

The following table provides information regarding the service types that will be included in the response based on the service type present in the inquiry.

Service Type Guidelines

Service Type	Included Service Types on Responses	Comments
1	1, 2, 42, 45, 69, 76, 83, AG, BT, BU, DM	
2	2, 7, 8, 20	
3		Use service type 98
4	4	
5	5	Do not use service type 66
6	6	
7	7	
8	8	
9	Baseline response*	
10	Baseline response*	
11		Use service type 12
12	12	Do not use service type 11, 75
13	13	
14		Use service type 42
15	Baseline response*	

Service Type	Included Service Types on Responses	Comments
16	Baseline response*	
18	18	
19		Use service type 80
20	20	
21	Baseline response*	
22	22	
23	23, 24, 25, 26, 35, 36, 38, 39, 41	
24	23, 24, 25, 26, 35, 36, 38, 39, 41	
25	23, 24, 25, 26, 35, 36, 38, 39, 41	
26	23, 24, 25, 26, 35, 36, 38, 39, 41	
27	Baseline response*	
28	23, 24, 25, 26, 35, 36, 38, 39, 41	
30	Baseline response*	
32	Baseline response*	
33	4, 33	
34		Use service type 33
35	23, 24, 25, 26, 35, 36, 38, 39, 40, 41	Service type 35 is the dental baseline
36	23, 24, 25, 26, 35, 36, 38, 39, 41	
37		Use service type 30 for medical coverage; Use 35 for dental coverage
38	23, 24, 25, 26, 35, 36, 38, 39, 41	
39	23, 24, 25, 26, 35, 36, 38, 39, 41	
40	40	
41	23, 24, 25, 26, 35, 36, 38, 39, 41	
42	42, 43, A3	Do not use service type 14
43	42, 43, A3	
44	Baseline response*	
45	45	
46	Baseline response*	
47	47, 51, 52, 53	
48	48, 99	
49		Use service 48
50	50, 51, 52, A0	
51	51	
52	52	
53	53	
54	54	
55	Baseline response*	
56		Use service type 59
57		Use service type 59
58		Use service type 59
59	59	
60	60	Returns active/non-covered only
61	61	
62	62	
63	63	
64	64	

Service Type	Included Service Types on Responses	Comments
65	65	
66		Use service type 5
67	67	
68	68, 80, BH	
69	69	
70	70	
71	Baseline response*	
72	Baseline response*	
73	4, 5, 62, 73	
74	74	
75		Use service type 12
76	76	
77	Baseline response*	
78	78	
79	Baseline response*	
80	80	
81	81	
82	82	
83	61, 83	
84	84	
85	Baseline response*	
86	51, 52, 86, 98	
87	Baseline response*	
88	88	Service type 88 is the pharmacy baseline
89		Use service type 88
90		Use service type 88
91		Use service type 88
92		Use service type 88
93	93	
94	Baseline response*	
95	Baseline response*	
96	Baseline response*	
97	Baseline response*	
98	98, BZ	
99	99	
A0	A0	
A1	Baseline response*	
A2	Baseline response*	
A3	A3	
A4	Baseline response*	
A5	Baseline response*	
A6	A6	
A7	A7	
A8	A8	
A9	Baseline response*	
AA	Baseline response*	

Service Type	Included Service Types on Responses	Comments
AB	AB	
AC	Baseline response*	
AD	AD	
AE	AE	
AF	AF	
AG	AG	
AH	Baseline response*	
AI	AI	
AJ		Use service type AI
AK		Use service type AI
AL	AL, AN, AO	Service type AL is the vision baseline
AM	AM	Post-cataract only
AN		Use service type AL
AO		Use service type AL
AQ	Baseline response*	
AR	AR	
BA	Baseline response*	
BB	BB	
BC	BC	
BD	Baseline response*	
BE	Baseline response*	
BF	Baseline response*	
BG	BG	
BH	BH	
BI	Baseline response*	
BJ	Baseline response*	
BK	Baseline response*	
BL	Baseline response*	
BM	Baseline response*	
BN	Baseline response*	
BP	Baseline response*	
BQ	Baseline response*	
BR		Use service type AL
BS	Baseline response*	
BT	BT	
BU	BU	
BV	BT, BU, BV	
BW		Use service type 88
BX		Use service type 88
BY	BY	
BZ	BZ	
B1	Baseline response*	
B2		Use service type 88
B3		Use service type 88
CA	CA	
CB	CB	

Service Type	Included Service Types on Responses	Comments
CC	2, 7, 8, 20	
CD	Baseline response*	
CE	CE	
CF	CF	
CG	CG	
CH	CH	
CI	CI	
CJ	CJ	
CK	CK	
CL	CL	
CM	CM	
CN	CN	
CO	CO	
CP	AL, AN, AO	
CQ	CQ	
C1	Baseline response*	
DG	Baseline response*	
DM	12, 18, DM	
DS	DS	
GF		Use service type 88
GN		Use service type 88
GY	Baseline response*	
IC	Baseline response*	
MH	MH, CE, CF, CG, CH	
NI	Baseline response*	
ON	Baseline response*	
PT	PT	
PU	Baseline response*	
RN	Baseline response*	
RT	RT	
TC	Baseline response*	
TN	Baseline response*	
UC	UC	

* Baseline includes the following service types: 1***, 33, 35**, 47***, 48, 50, 51, 52, 86***, 88**, 98***, AL**, BZ, MH***, UC

** Active/inactive required

*** Active/inactive only; 98 also return MSG: Specialist

10.5 276/277

The 276/277 transactions are used to electronically transfer a subscriber's and/or dependent's healthcare claim status information.

- 276: Request claim status.
- 277: Respond with claim status information.

Guidelines

- Member ID requirements to submit BCBS claim status inquiries are as follows:
  - AZ Blue members: Three-character prefix followed by 9 numeric characters.
  - FEP members: The letter 'R' followed by 8 numbers.
  - BlueCard (out-of-area) members: Minimum of a three-character prefix followed by a combination of 4 to 17 numbers and/or letters.

  NOTE: Embedded spaces for any of the above listed member ID requirements are **not allowed.**
- If an incorrect member ID prefix is submitted on a request for a AZ Blue member, the 277 response will contain the corrected prefix.
- Batch transactions will be broken down and processed by AZ Blue as individual inquiries. You will receive individual responses for each inquiry.
- Provider claim status inquiries for all services provided in Arizona on behalf of any AZ Blue plan must be submitted to AZ Blue.
- For CHS claim status inquiries, contact the CHS plan or applicable TPA located on the back of the member's card.

276/277 Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
41	2100A	NM103	Payer Name		Insert 'AZ Blue'
42	2100A	NM109	Payer Identifier		Insert '53589'

10.6 278

The 278 transaction is used to electronically transfer a subscriber's and/or dependent's healthcare referral, precertification, and prior authorization review request and response between providers and review entities.

It processes information from primary participants such as providers and utilization management organizations (UMOs), where the entity inquiring is the primary provider and the servicing provider.

- 278-13: Request information related to precertification, and prior authorization.
- 278-11: Respond to referral, precertification, and prior authorization inquiries.

Guidelines

- **278-13: Request**
  - AZ Blue will accept batch 278-13 transactions.
  - Batch inquiries will be broken down and processed by AZ Blue as individual transactions. You will receive individual responses.
  - Urgent and non-urgent 278-13 transactions should be submitted with separate level-of-service codes, per patient event.
  - Member ID requirements to submit BCBS eligibility inquiries are as follows:
    - AZ Blue members: Three-character prefix followed by 9 numbers.
    - FEP members: The letter 'R' followed by 8 numbers.
    - BlueCard (out-of-area) members: Minimum of a three-character prefix followed by a combination of 4 to 17 numbers and/or letters.

    NOTE: Embedded spaces for any of the above listed member ID requirements are **not allowed.**
  - AZ Blue will accept default values of all 9s on TRN02 and TRN03.
  - For CHS group plans, contact the CHS group or applicable TPA listed on the back of the member's ID card.

- **278-11: Response**
  - 278-11 transactions sent from other Blue plans may not be considered final and can be followed up with a letter, phone call, etc. Contact the appropriate BCBS plan for status.
  - If an incorrect member ID prefix is submitted on an 837-13 for a AZ Blue member, the 278-11 will contain the corrected prefix.
  - **Important!** When the 278-11 is returned, the HCR02 certification number may or may not be present. This number only confirms the return response and does not confirm approval of the 278-13. Therefore, it is imperative to check each service line for the appropriate HCR01 action code (A1, A3, A4, A6, CT or NA).

AAA Segments

Potential scenarios which result in the failure of the request transaction and creation of the 278-11 AAA segment responses are:

- System time-out
- Membership validation
- Provider ID validation

278 Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
71	2010A	NM1	Utilization Management Organization (UMO) Name		
73	2010A	NM108	ID Code Qualifier	PI	Insert 'PI' (payer identification)
73	2010A	NM109	ID Code		Insert '860004538'
84	2010B	PER	Requestor Contact Information		
85	2010B	PER02	Name		For quicker turnaround time, AZ Blue requests the direct contact information for the person handling this request
85	2010B	PER04	Communication Number		For quicker turnaround time, AZ Blue requests the direct contact information for the person handling this request
87	2010B	PRV	Requestor Provider Info		AZ Blue requires the requestor's role and specialty for processing
112	2010D	DMG	Dependent Demographic Information		
113	2010D	DMG02	Date of Birth		AZ Blue requires the date of birth to support a TR3 search option if the patient is a dependent

10.7 820

The 820 is used to initiate group premium payment transactions with or without remittance detail.

Guidelines

- Depository financial institution ID number and receiver bank account number will be provided after execution of the trading partner agreement.
- ACH payment dollars must include remittance detail with group section number and will be processed through the ACH network and financial institutions.
- AZ Blue expects premium payments to be made in the same currency as billed (United States dollar).

820 Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
48		REF	Premium Receivers ID Key		
48		REF01	Reference Identification Qualifier	14	Insert '14'
49		REF02	Reference Identification		Insert AZ Blue group section number
56	1000A	REF	Premium Receiver's Name		
56	1000A	N102	Name		Insert 'AZ Blue'
57	1000A	N103	Identification Code Qualifier	FI	Insert 'FI'
57	1000A	N104	Identification Code		Insert '860004538'
59	1000A	N3	Premium Receiver's Address		
59	1000A	N301	Address Information		Insert 'PO BOX 81049'
60	1000A	N4	Premium Receiver's City, State and ZIP Code		
60	1000A	N401	City Name		Insert 'PHOENIX'
61	1000A	N402	State or Providence Code		Insert 'AZ'
61	1000A	N403	Postal Code		Insert '850691049'
64	1000B	N1	Premium Payer's Name		
65	1000B	N103	Identification Code Qualifier	FI,24	Insert 'FI' or '24'
87	2300A	RMR	Organization Summary Remittance Detail		
87	2300A	RMR01	Reference Identification Qualifier	1L	Insert '1L'
88	2300A	RMR02	Reference Identification		Insert the AZ Blue group section number
107	2100B	NM1	Individual Name		
107	2100B	NM101	Entity Identifier Code	EY	Insert 'EY'
109	2100B	NM108	Identification Code Qualifier	EI	Insert 'EI'
112	2300B	RMR	Individual Premium Remittance Detail		
112-113	2300B	RMR01	Reference Identification Qualifier	AZ, IK	Insert 'AZ' when invoice has not been received Insert 'IK' when invoice has been received

10.8 834

The 834 is used to request and receive information, and to transfer subscriber and/or dependent enrollment information from the sponsor of the insurance coverage, benefits, or policy, to a payer.

Guidelines

- It is required that loop 2000 INS segment (member-level detail) is sent with a termination maintenance type code (024) when Health Coverage Maintenance Type Code 024 (2300-HD segment) is present. If the member being terminated is the subscriber, then all dependents linked to the subscriber will also be terminated.
- It is recommended that full file audits (verify) be used for regular weekly processing. A maintenance file contains "adds," "changes," or "termination" requests for members. Full file audits would be identified when the BGN08 segment is equal to '4' (verify). A maintenance file is identified when the BGN08 segment is equal to '2' (change/update).

Data Elements

Page #	Loop ID	Reference	Name	Codes	Comments
36		REF	Transaction Set Policy Number		
36		REF02	Master Policy Number		Insert group policy number supplied by AZ Blue
39	1000A	N1	Sponsor Name		
39	1000A	N102	Plan Sponsor Name		Insert group name
40	1000A	N103	ID Code Qualifier		Insert 'FI' (federal taxpayer's ID number)
40	1000A	N104	Sponsor ID Code		Insert sponsor's federal taxpayer's ID number
41	1000B	N1	Payer		
41	1000B	N102	Name		Insert 'AZ Blue'
42	1000B	N103	ID Code Qualifier	FI	Insert 'FI'
42	1000B	N104	ID Code		Insert '860004538' for AZ Blue
51	2000	INS	Member Level Detail		
51	2000	INS05	Benefit Status Code	A,C	A= Active, C= COBRA (must include INS07)
55	2000	REF	Subscriber Number		
55	2000	REF02	Reference ID		Allowed examples of subscriber ID numbers are as follows: • SS number • Employee ID number • AZ Blue subscriber number
57	2000	REF	Member Supplemental II		
57	2000	REF01	Reference ID Qualifier	DX, ZZ	Insert either DX or ZZ
58	2000	REF02	Reference ID		For DX: Insert the employee's billing location or department For ZZ: Insert the employee ID#
140	2300	HD	Health Coverage		
141	2300	HD03	Insurance Line Code		See the AZ Blue health coverage insurance line codes (HD03) on page 27 of your 834 5010 appendix document
141	2300	HD04	Plan Coverage Description		See the AZ Blue health coverage descriptions (HD04) section of your 834 5010 MASTER mapping/structure Specifications

10.9 835

The purpose of the 835 is to facilitate the electronic transfer of healthcare claim payment information through an electronic remittance advice.

Guidelines

PLB Segment: Provider level adjustments

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

Note: The patient account number will be provided in the offset detail when available.

Offset Type	Data Reported in PLB03-2
IRS Backup Withholding (PLB03-1 Adjustment Reason Code = 'IR')	IRS Backup Withholding
Claim Overpayment Offset (PLB03-1 Adjustment Reason Code = 'WO')	11-digit offset A/R number, space, first 8 letters of the subscriber's last name, space, first 9 characters of the subscriber ID

835 Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
107	1000B	REF	Payee Additional Identification		
108		REF02	Additional Payee Identifier		'Pay to' provider tax ID will be reported

10.10 837

The 837 transactions are used to electronically transfer and exchange healthcare claim billing and encounter information for the following types of claims:

- 837P — (professional claims)
- 837I — (institutional claims)
- 837D— (dental claims)

Guidelines

- When submitting the member ID number, include the ID exactly as shown on the ID card including all letters and numbers.
- Member ID requirements to submit AZ Blue 837 transactions are as follows:
    - AZ Blue members: Three-character prefix followed by 9 numbers.
    - FEP members: The letter 'R' followed by 8 numbers
    - BlueCard (out-of-area) members: Minimum of a three-character prefix followed by a combination of 4 to 17 numbers and/or letters.

  NOTE: Embedded spaces for any of the above listed Member ID requirements are **not allowed.**
- Refer to azblue.com/eTransactions for the list of commercial payers and associated payer IDs that can be submitted to AZ Blue.
- For all CHS claims, submit claims using payer ID 53589. CHS claims must have a valid group number (the format for this AZ Blue -assigned group number is three letters followed by three numbers, e.g., ABC123).

Dental

- When submitting dental claims with loop 2300 DTP*472 (claim level service date) a date range must be used (DTP02=RD8) when loop 2400 DTP*472 (line level service date) is also used and contains date range.
- Dental providers with multiple office locations (POS 11) must include the service facility loop 2310C when services are performed at a location other than the billing address location.

Anesthesia

When submitting anesthesia procedures with loop 2400, use SV103 and SV104 to enter the qualifier MJ. Enter the total minutes for the service along with an anesthesia modifier listed in SV101 (AA, AD, QK, QS, QX, QY or QZ).

Adjustments

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

Use frequency code 7 to indicate that you are making adjustments to replace a prior claim. Use frequency code 8 when you want to void or cancel the original claim and start over with a new clean claim. AZ Blue will return all 837 adjustment requests that do not include a frequency code 7 or 8.

CHS claims are excluded from specific AZ Blue requirements for adjustments.

10.10.1 837P

Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
116	2000B	SBR	Subscriber Information		
117	2000B	SBR03	Subscriber Group Number		For CHS claims, the group number must be submitted
289	2310E	N403	Ambulance Pick-up ZIP Code		AZ Blue requires the ZIP code for ambulance claim processing for all LOBs
294	2310F	N403	Ambulance Drop-off ZIP Code		AZ Blue requires the ZIP code for ambulance claim processing for all LOBs

Adjustment Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
159	2300	CLM	Claim Information		
159	2300	CLM05 – 3	Claim Frequency Type Code	7, 8	Frequency code must be equal to: 7 (replacement); or 8 (voided/canceled)
196	2300	REF	Payer Claim Control Number		
196	2300	REF01 Claim Information	Reference Identifier Qualifier	F8	2/3
196	2300	REF02	Payer Claim Control Number	AN	For BlueCard (out-of-area), the ICN/DCN must be 15-17 numeric characters For AZ Blue and FEP, the ICN/DCN must be 15 numeric characters

10.10.2 837I

Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
109	2000B	SBR	Subscriber Information		
110	2000B	SBR03	Subscriber Group Number		For CHS claims, the appropriate group number must be submitted
143	2300	CLM	Claim Information		
284	2300	HIXX-5	Ambulance Pick-up ZIP Code		Place pick-up ZIP code when HI0X-1 = BE and HI0X-2 = A0 use when rev code is =054x

Adjustment Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
143	2300	CLM	Claim Information		
145	2300	CLM05 – 3	Claim Frequency Type Code	7, 8	Must be equal to 7 = replacement or 8 = voided
166	2300	REF	Payer Claim Control Number		
166	2300	REF02	Payer Claim Control Number		For BlueCard (out-of-area) the ICN/DCN must be 15-17 numeric characters For AZ Blue and FEP the ICN/DCN must be 15 numeric characters

10.10.3 837D

Data Elements

Page #	Loop ID	Reference	Name	Codes	
112	2000B	SBR	Subscriber Information		
112	2000B	SBR03	Insured Group or Policy Number		For CHS claims, the appropriate group number must be submitted

Adjustment Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
145	2300	CLM	Claim Information		
167	2300	CLM05 – 3	Claim Frequency Type Code	7, 8	Must be equal to 7 = replacement or 8 = voided
168	2300	REF	Claim Identifier for Transmission Intermediaries		
168	2300	REF02	Reference Identification		For BlueCard (out-of-area) ICN/DCN must be 15-17 numeric characters For AZ Blue and FEP ICN/DCN must be 15 numeric characters

10.11 Medicare Advantage Provider Billing

Introduction

- Providers treating BlueCard (out-of-area) Medicare Advantage members must ensure that they send in clean claims with all necessary data to AZ Blue according to the Medicare Managed Care Manual. The data elements identified below need to be included on out-of-area Medicare Advantage claims sent to AZ Blue to ensure that claims will be paid accurately and timely.
- Providers treating AZ Blue Medicare Advantage members must submit claims to commercial payer ID 53589. If unable to submit electronically, submit paper claims to AZ Blue Medicare Advantage, P.O. Box 29234, Phoenix, AZ, 85038-9234.

837I: Medicare Advantage Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
80	2000	PRV	Billing Provider Specialty Information		
80	2000A	PRV03	Reference Identification		The facility taxonomy code is required
164	2300	REF	Prior Authorization		
165	2300	REF02	Reference Identification Prior Authorization Number		AZ Blue requires the prior authorization number for claim processing
284	2300	HI	Value Code		
284	2300	HIXX-1	Height and Weight		AZ Blue requires the weight for ESRD patients
284	2300	HIXX-1	CORE Based Statistical Area (home health claims)		AZ Blue requires this information to process home health claims

837P: Medicare Advantage Data Elements

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
273	2310C	N4	Service Facility Location		
274	2310C	N403	Ambulance Pick Up ZIP Code		AZ Blue requires the ZIP code for ambulance claim processing
288	2310E	N4	Ambulance Pick Up Location City, State, ZIP Code		
289	2310E	N403	Ambulance Pick-up ZIP Code		AZ Blue requires the ZIP code for ambulance claim processing for all LOBs
294	2310F	N403	Ambulance Drop-off ZIP Code		AZ Blue requires the ZIP code for ambulance claim processing for all LOBs

APPENDICES

Appendix 1: Frequently Asked Questions (FAQs)

General

Q: How do I begin the testing process for HIPAA transactions?

A: Contact Integrated Customer Solutions (ICS) at ICS@azblue.com to initiate the set up process.

Q: What will happen during the testing process?

A: See page 5.

Q: How much time will testing require?

A: The time line may vary depending on the support and coordination you establish with your software vendor, clearinghouse, and health plans. The accuracy of the test file, based on the TR3 and the AZ Blue companion guide requirements, will also help accelerate the testing process.

Q: When can I begin to submit 'live' transactions in production?

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

Q: Do I have to submit a AZ Blue specific sender ID number?

A: The AZ Blue specific sender ID must be sent in the interchange control header ISA06 and the functional group header GS02 application sender's code.

Q: Does AZ Blue have special requirements for HIPAA transactions?

A: There are situational data elements AZ Blue needs in order to conduct business and process your transactions. AZ Blue has developed the AZ Blue companion guide to supplement the TR3. The guide contains specific data elements required for transactions and clarifies some of the standard uses of the transaction elements.

Q: If I am only sending 837s now, can I send other HIPAA transactions too?

A: Yes. If you want to send additional types of HIPAA transactions, contact Integrated Customer Solutions (ICS) at ICS@azblue.com to begin testing for these additional transactions.

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

A: Batch is one or more transactions sent with the expectation that a response will not be available immediately. AZ Blue typically provides responses within 24 hours or the next business day.

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

Q: Who is the contact for HIPAA transaction testing technical support?

A: Contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

270/271 Transaction

Q: What is the 270/271 transaction?

A: This transaction provides a member's eligibility and benefit information.

Q: What information will I receive from AZ Blue in a 271 response?

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

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

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

Q: Can I send 270 batch inquiries?

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

Q: Can I submit BlueCard (Out-of-area) and FEP 270 requests to AZ Blue?

A: Yes, providers should submit BlueCard and FEP 270 requests to AZ Blue. AZ Blue will forward your inquiry to the appropriate Blue plan or FEP for processing.

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

A: Providers typically receive a real-time 271 response BlueCard and FEP request within 20 seconds. Batch response for BlueCard and FEP request are typically received within a maximum of 24 hours.

Q: Why are multiple service types returned in the same EB segment on the 271?

A: Eligibility requests for individual service types will include the member's health benefit plan coverage. They will be returned in the same EB03 using the EB03 separator.

Q: How do I know which benefits apply to a specific network?

A: The TR3 provides values for the EB12 segment. A "W" will be returned when the benefit information being conveyed in the EB segment is not specific to a network. A "Y" will be returned if the benefit applies to in-network only. An "N" will be returned if the benefit applies to out-of-network only.

Q: What does an EB01 = R mean?

A: AZ Blue will return EB01 = R (other or additional payer) if we show any other payer liability information in our records. The provider should contact the member to find out if this information is still applicable and get the other payer information.

Q: Why did I receive a group number on my 271 response when I did not submit one?

A: The TR3 requires the group number on 837 transactions if published on the ID card. AZ Blue prints the group number on the ID card and will return the group number on the 271 response for the provider's convenience.

276/277 Transaction

Q: What is the purpose of the 276/277 transaction?

A: This transaction provides a member's claim status information.

Q: What information will I receive from AZ Blue in a 277 response?

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

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

A: Yes, AZ Blue accepts real-time transactions. Real-time response transactions are typically sent within 20 seconds.

Q: Can I send 276 batch inquiries?

A: Yes, AZ Blue accepts and processes batch 276 inquiries. Batch responses are generally provided within 24 hours or the next business day.

Q: Can I submit BlueCard (out-of-area) and FEP 276 requests to AZ Blue?

A: Yes, providers should submit BlueCard and FEP 276 requests to AZ Blue.

Q: How long will it take to receive an answer for BlueCard (out-of-Area) request?

A: Providers will typically receive a 277 response for BlueCard requests for real-time inquiries within 20 seconds. Batch responses will be received generally within a maximum of 48 hours.

278 Transaction

Q: What is the purpose of the 278 transaction?

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

Q: What information will I receive from AZ Blue in a 278 response? A :

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

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

A: AZ Blue accepts only batch 278 transactions at this time.

Q: How long will it take to receive a response for a 278 request?

A: AZ Blue returns responses within Department of Labor standards.

Q: Can I submit 278 requests for other BCBS Plans?

A: Yes, providers should submit BlueCard (out-of-area) requests to AZ Blue.

Q: How long will it take to receive an answer for BlueCard (Out-of-area) request?

A: AZ Blue returns responses within Department of Labor standards.

Q: How will I know if my 278 request has been received for processing?

A: AZ Blue acknowledges all inbound HIPAA transactions with either a TA1 or a 999 transaction.

820 Transaction

Q: What is the purpose of the 820 transaction?

A: This transaction is used to initiate premium payment with or without remittance detail from employer groups to AZ Blue.

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

A: For information on electronic premium payment, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

834 Transaction

Q: What is the purpose of the 834 transaction?

A: This transaction is used by employer groups to transfer benefit enrollment and maintenance information to AZ Blue.

Q: If I cannot send an 834, how else can I send enrollment and maintenance information to AZ Blue?

A: An employer group can submit an 834 flat file. For information regarding submission of a flat file, contact Member Enrollment at (602) 336-7444 or 1 (800) 232-2345 x 7444.

835 Transaction

Q: What is the purpose of the 835 transaction?

A: This transaction provides an electronic remittance advice (ERA) in a HIPAA compliant format to healthcare providers.

Q: What information will I receive from AZ Blue on an 835?

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

Q: Will the 835 work with all practice management software systems?

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

Q: Must we participate in electronic funds transfer (EFT) in order to get the 835?

A: No, EFT is not required to receive the 835; however, utilizing the EFT and the 835 generally makes your accounts receivable reconciliation more efficient.

Q: Will I be able to associate the EFT to the 835?

A: There will be an EFT trace number present on the 835 file for ease in reconciliation. The same EFT trace number will be placed in the CCD+ Addenda record of the EFT that goes to the bank.

Q: Will the patient account number be present in the 835?

A: Yes, if the patient account number is received on the claim it will populate on the ERA.

Q: Will I be able to identify the accounting adjustments?

A: Yes, there will be an adjustment reason code to identify the type of offset.

Q: Can we print the 835?

A: No, it is in an electronic file format and is considered as machine readable, not human readable. Check with your software vendor for printing capability through your practice management system. Also, you can view or print remittance advice notices online in the secure provider portal at azblue.com/providers. Go to "Practice Management > Claims > Online Remits."

Q: Who do I contact for 835 ERA set up and support?

A: Contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

Q: How do I get set up for EFT?

A: To initiate the EFT reimbursement process, download the EFT Enrollment Form found online at azblue.com/EFT. It is very important for you to attach a voided check or provide a letter from your bank with the account information. Activation may take up to 30 days.

837 Transaction

Q: What is the purpose of the 837 transaction?

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

- Professional (P)
- Institutional (I)
- Dental (D)

Q: Do I need to send the subscriber's group number?

A: If the claim is for a member that belongs to a CHS group, the subscriber group number (the format for this number is three letters followed by three numbers) must be sent or the claim will reject back to the submitter.

Q: Do I have to send the prefix of the member's ID number?

A: Yes, the prefix is part of the BCBS member ID number and is used for identification in routing internally, as well as externally.

Q: What is a POA?

A: POA stands for present on admission. It means that the condition was present at the time the inpatient admission occurs. This includes conditions that develop while the patient is in the emergency room, having outpatient testing, while the patient is in observation or during an outpatient surgery.

Q: Who is required to report POA information?

A: POA information is required for all inpatient claims for acute care hospitals.

Q: How do I submit POA information?

A: In a standard 837I format, excluding the admitting diagnosis, a POA indicator is required on every diagnosis code, except exempt codes should be populated in loop 2300, segment HI0X-9. Your vendor or clearinghouse should be able to assist you in creating and including this data in your file. Valid POA indicators are as follows:

- Y – diagnosis was present on admission
- N – diagnosis was not present on admission
- U – it is unknown if the diagnosis was present on admission
- W – it is clinically undetermined if the diagnosis was present on admission.

Q: What is a "never" event?

A: A never event is identified by one of 3 hospital inpatient occurrences.

- ICD-10:
    - Y65.51 – Performance of wrong procedure (operation) on correct patient
    - Y65.52 – Performance of procedure (operation) on patient not scheduled for surgery
    - Y65.53 – Performance of correct procedure (operation) on wrong side or body part

Q: What type of facility would report a never event?

A: Reporting a never event is applicable to all hospital inpatient claims that have the occurrence for at least one of the three diagnoses listed in the above question/answer 'What is a never event?'

Q: How do I submit a claim that includes a never event?

A: For claims submitted in a standard 837I format or on a UB-04 claim form, a surgical never event will be submitted with the following:

- Type of bill "110"
- One of the three above diagnosis codes (ICD-10 or ICD-9) present in the principal diagnosis code or any occurrences of other diagnosis codes excluding the admitting diagnosis
- Claims identified as bills for a surgical never event using TOB 110 are bills for the non-covered services associated with the never event

837 Adjustments

Q: How are 837electronic adjustment requests submitted?

A: The provider follows the same process used to submit electronic claims.

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

A: Yes.

Q: If I have questions about the submission of electronic adjustments, whom should I contact?

A: For information on electronic claim solutions, contact Integrated Customer Solutions (ICS) at ICS@azblue.com.

Q: What kind of adjustments can I send?

A: Providers can submit any adjustments as outlined below. Lines of business (LOBs) and claim types (type of bill) included are:

Included	
AZ Blue members	Professional, institutional, and dental
FEP members	Professional, institutional, and dental
BlueCard (out-of-area) members	Professional and institutional
CHS group members	Professional, institutional, and dental
Excluded	
BlueCard (out-of-area) members	Dental

Q: How do I indicate the electronic claim is an adjustment?

A: The provider indicates the following:

- ***Type of bill*** *for institutional claims*
  The 3rd position of the type of bill (values 7 or 8) indicates the claim is an adjustment.
- ***Facility type code (place of service)*** *for professional and dental claims*
  The 3rd position of the facility type code (values 7 or 8) indicates the claim is an adjustment

Q: How do I communicate what I want to have adjusted?

A: AZ Blue requires that all line item information be submitted on the claim adjustment so that it can be compared to the original. In addition, see specific requirements on the following pages:

- Professional claims – Section 10.10.1
- Institutional claims – Section 10.10.2
- Dental claims – Section 10.10.3

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

A: The portion of the *HIPAA Transaction Standard –AZ Blue Companion Guide* for elements required on an 837 adjustment request (professional, dental, and institutional) can also be found in Sections 10.10.1, 10.10.2 and 10.10.3. Use these requirements when working with your vendor to make the necessary changes to your billing systems.

Q: How will I know the adjustment was received by AZ Blue?

A: Your Custom Claim Acknowledgement Report (CCAR)* contains a record of all received claims, including adjustments.

* A "CCAR" is a "human-readable" report that contains information on all claims within a batch and includes a detailed status of rejected and accepted claims.

Q: Does the Medicare cross-over process include adjustments?

A: Yes, the Medicare contractor will send adjusted 837s to AZ Blue for AZ Blue, and senior product lines of business (excludes FEP).

Q: How should I submit Medicare cross-over adjustments?

A: Adjustments where Medicare is primary **must** be sent directly to Medicare. The adjustment, once processed by Medicare, will be electronically crossed over to AZ Blue (excludes FEP). The provider ***must not*** send these adjustments directly to AZ Blue.

Q: Can I submit claim adjustment requests on paper?

A: ***Only*** use AZ Blue's corrected claim form PDF if you are unable to submit an 837 adjustment request, or if you are correcting a provider NPI number*. All other paper claim corrections will be returned.

* To correct an NPI, you must include medical record documentation verifying the rendering provider.

Medicare Advantage

Q: How do I submit a Medicare Advantage claim?

A: See Section 10.11 for institutional and professional claims or refer to the BlueCard Program Provider Guide (in the secure provider portal at "Provider Resources > Guidelines > National Programs") for more information.

Appendix 2: AZ Blue Glossary

Note: The following glossary section is to assist with defining frequently used words and phrases encountered with HIPAA Transactions.

Term	Definition
BlueCard (Out-of-Area)	BlueCard® is a program coordinated by the Blue Cross Blue Shield Association that enables members of a BCBS plan to obtain healthcare service benefits while traveling or living outside of that plan's service area. The programs links participating healthcare providers in the independent BCBS plans across the U.S. and in many countries and territories worldwide, through a single electronic network for claims processing and reimbursement. The program lets AZ Blue providers conveniently submit claims for patients from other BCBS plans, both domestic and international, to AZ Blue. AZ Blue is your sole contact for claims payment, adjustments, and issue resolution.
CCAR	CCAR stands for Custom Claims Acknowledgment Report.
Corporate Health Services (CHS) Groups	CHS groups are large, self-insured employer groups that have entered into an arrangement with AZ Blue that allows their employees access to a AZ Blue provider network. Under CHS agreements, AZ Blue provides network access and claim pricing only (i.e. does not provide administrative or claims payment services). The group, not AZ Blue, assumes all financial risk with respect to claims. Most groups have opted to use a third party administrator (TPA) for claims processing, verification of eligibility and benefits, precertification, medical records requests, and appeals and grievances. Benefits for CHS groups are likely to vary from AZ Blue standard benefits.
AZ Blue members	AZ Blue members refers to members with ID cards issued by AZ Blue. This excludes FEP, CHS, and BlueCard members.