



Electronic Transaction Manual for
Arkansas Blue Cross and Blue Shield
FEDERAL EMPLOYEE PROGRAM (FEP)
Dental Claims
HIPAA Transaction Companion Document Guide

Refers to the X12N Implementation Guide:
004010X097A1: (837D) Health Care Claim Dental



Introduction

The ASC X12N Implementation Guides were adopted under HIPAA as the official guides to use for the exchange of electronic transactions. This Electronic Transaction Manual contains the Companion Documents for 837 Health Care Claim Dental. The Companion Documents provide further clarification and specifies the data content when exchanging electronic transactions with Arkansas Blue Cross. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are compliant with both the X12 syntax and those guides. These Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides, adopted for use under HIPAA. The Companion Guides are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides. The Companion Guides on the next few pages describe the requirements and recommendations of implementing the 837 Health Care Dental Claim transactions.

Establishing a Trading Partner Agreement

Overview:

In order to take advantage of the transaction and communication services offered by Arkansas Blue Cross a Trading Partner Agreement (TPA) must be completed. The TPA can be downloaded at:

<http://www.arkansasbluecross.com/doclib/forms/providers/edi/20091029tpa.pdf>.

We suggest that you distribute these forms as:

- The TPA to an Officer of the Corporation empowered to enter a contract on behalf of the Corporation.
- The Trading Partner Enrollment Form is most likely a collaboration of your Billing Office and Information Technology area.

As the Provider the TPA is a legal document, if you want a copy for your records, please sign **two** hard copies and we will sign one and mail it back to your office.

EDI Services – 4BC/S

PO Box 2181, Little Rock, AR 72203-2181

FedEx or UPS: 601 South Gaines St., Little Rock, AR 72201

You may e-mail the Trading Partner Enrollment Form to: EDI_enrollment@arkbluecross.com

Testing the 837 Dental Claim

ABCBS requires testing for all sites submitting HIPAA claim submissions for the first time, prior to actual submission to the production environment. To help you achieve a successful test, please follow the appropriate format specifications (listed in the ABCBS **Specific Data Elements** section of this companion guide) and submission directions. To receive approval to move from test to production you must receive a minimum 95% “correct rate” for the test file submitted.

Claims Testing Process Overview:

Testing consists of the following stages:

1. File Submission

For testing, the claims in your test file should simulate claims from normal business. Submit your test file to the Arkansas Blue Cross EDI Gateway or Secure FTP Server. Refer to the instructions in the EDI User Guide which can be downloaded at

<http://www.arkansasbluecross.com/doclib/forms/providers/edi/x12usrguide9-10-09.pdf>.

2. Test Results

An Arkansas Blue Cross EDI Support representative will contact you by phone with results of your most recent test. Additionally, you must retrieve your reports from the EDI Gateway, Arkansas Blue Cross Secure FTP server, or AHIN. Reviewing reports is the only way to ensure claims have been accepted by FEP.

Note: Stages One and Two will repeat until you achieve a minimum 95% “correct rate” for the most recent file submitted.

3. Approval

When your latest test iteration has achieved the “correct rate,” you may contact EDI via phone at 501-378-2419 or e-mail at edi@arkbluecross.com to move your claims to the production environment.

Failure to complete this step will result in your claims not being paid. You may then submit files to the production EDI Gateway or Secure FTP Server. Reports can be retrieved from the EDI Gateway, Secure FTP server or AHIN.

Batch and Claim Submission Guidelines

Claim files submitted for testing/production must meet the following criteria:

- Test Claim files should contain a minimum of 25 claims and not exceed 50 in any one file.
- The claims in your test file should simulate claims for normal business, using real FEP member’s ID’s.
- Production Claim files cannot exceed 5000 claims in any transaction.
- Transaction must be submitted in continuous string and contain 1 GS-GE and 1 ST-SE per ISA-IEA segment.

The following section describes the reports that are available for you from Arkansas Blue Cross. The reports are stored for up to fourteen (14) days for retrieval.

Report Overview

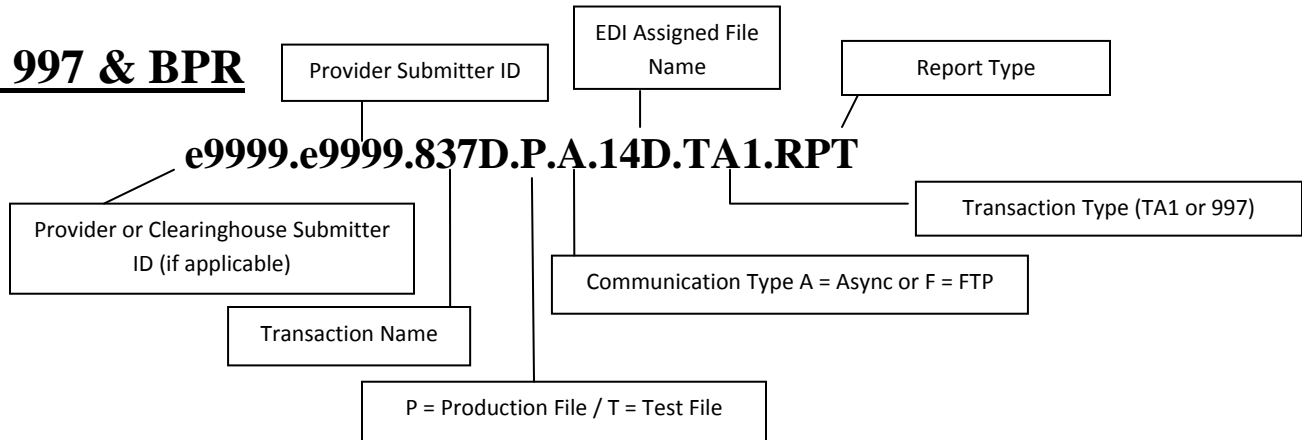
The following table lists the reports generated by ABCBS. The quick reference table is followed by a description and sample of each report. For questions about any of the reports, contact Arkansas Blue Cross using the information provided in the Contact Names section of this companion guide.

Report Name	This Report
<p style="text-align: center;">TA1 e9999.e9999.837D.P.A.14D.TA1.RPT</p>	<p>The TA1 or Interchange Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only.</p> <p>This report allows us to notify you of problems that were encountered in the interchange control structure.</p>
<p style="text-align: center;">997 e9999.e9999.837D.P.A.14D.997.RPT</p>	<p>The 997 Functional Acknowledgment is a means of replying to the functional group and transaction set that has been submitted in any one interchange or transmission.</p> <p>This report notifies you of our ability or inability to process the entire transaction based on ASC X12 syntax and structure rules.</p>
<p style="text-align: center;">RPT e9999.e9999.837D.P.A.14D.RPT</p>	<p>In addition to the ANSI transactions available to you, we prepare a “user-friendly” Submitter Batch Processing Report. There are two sections – a Summary and a Detail.</p> <p>Totals are presented in the Summary for each transmission.</p> <p>Information about each claim is available in the Detail section.</p>
<p style="text-align: center;">835 e9999_10235_103310_fp_p.835</p>	<p>If you have elected to receive your remittance advices electronically, then subsequent to claim adjudication, this transaction will be available in your mailbox.</p>
<p style="text-align: center;">REJ.EMSG e9999.e9999.A.14D.REJ.EMSG</p>	<p>We have developed this report to communicate to you any “special” circumstances that may affect our EDI environment. We anticipate infrequent use of this reject messaging; however, should you see a report with the TXT extension, we ask you to download and review it. If you “script” your servers, we ask that you include the TXT extension in your script.</p>

Reporting

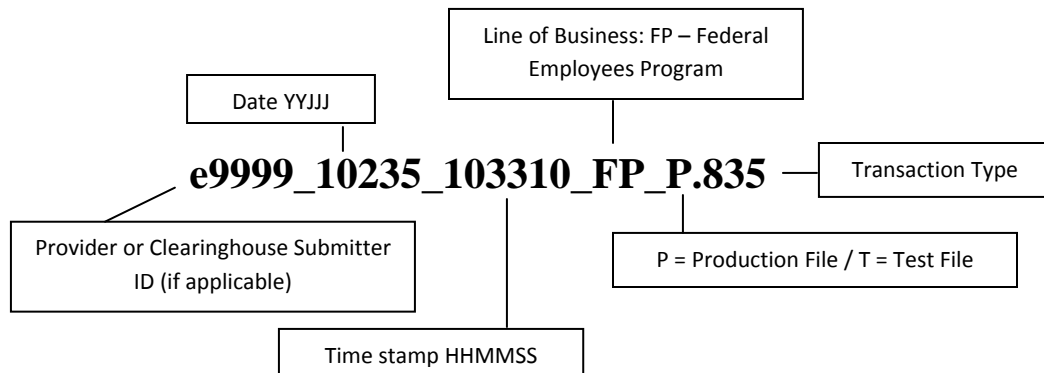
Report Identification (Naming Convention)

TA1, 997 & BPR

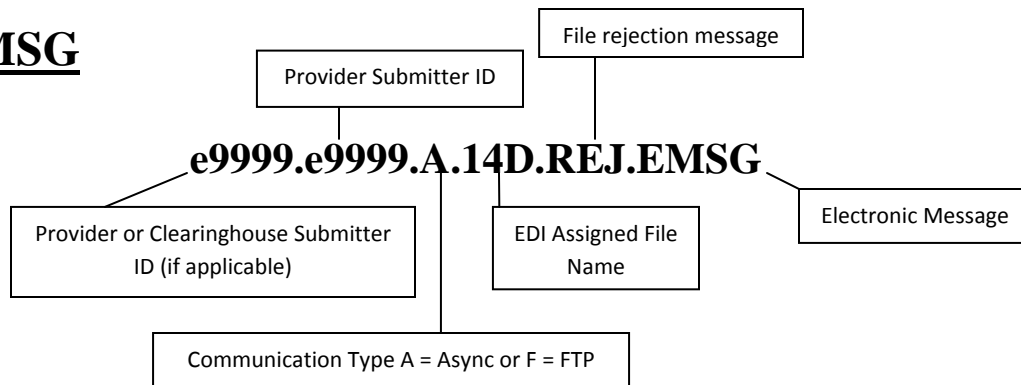


Note: The Batch Processing Report (BPR) will follow the same naming convention, omitting the Transaction Type.

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REJ.EMSG



Arkansas Blue Cross Specific Conditional Requirements

Dental Claim Data Requirements

General

The information in this section is to be used in conjunction with the 4010A1 837 Dental Implementation Guide. This document specifies the required values for FEP dental claims submitted to Arkansas Blue Cross.

Control Segments

837D Implementation Guide Data				Payer Specific Data
Page	Segment ID	Description	837 Requirements	ABCBS Instructions
B.3	ISA	Interchange Control Header	To start and identify an interchange of zero or more functional groups and interchange - related control segments	
B.3	ISA01	Authorization Information Qualifier	Required	Use: 00 (No Authorization Information Present / No Meaningful Information in 102)
B.3	ISA02	Authorization Information	Required	Use: 10 Spaces
B.4	ISA03	Security Information Qualifier	Required	Use: 00 (No Security Information Present / No Meaningful Information in 104)
B.4	ISA04	Security Information	Required	Use: 10 Spaces
B.4	ISA05	Interchange ID Qualifier	Required, qualifies the Sender in ISA06	Use: ZZ (Mutually Defined)
B.4	ISA06	Interchange Sender ID	Required	Use your Submitter ID (This is for entity who is sending the file, provider or clearinghouse)
B.4	ISA07	Interchange ID Qualifier	Required, qualifies the Receiver in ISA08	Use: ZZ (Mutually Defined)
B.5	ISA08	Interchange Receiver ID	Required	Use: 00200 (ABCBS)

Professional Claims (837P) Data Requirements - Continued

837D Implementation Guide Data				Payer Specific Data
Page	Segment ID	Description	837 Requirements	ABCBS Instructions
B.8	GS	Functional Group Header	To indicate the beginning of a functional group and to provide control information	
B.8	GS02	Application Sender Code	Required	Use your Submitter ID (the same code used in ISA06 provider if direct or clearinghouse)
B.8	GS03	Application Receiver Code	Required	Use: 00200 (ABCBS)
B.9	GS08	Version / Release / Industry ID Code	Required	Use: 004010X097A1 (Dental Implementation Guide plus Addenda)

Dental Claims (837D) Data Requirements (continued)

837D Implementation Guide Data				Payer Specific Data
Page	Segment ID	Description	837 Requirements	ABCBS Instructions
59	Loop 1000A	SUBMITTER NAME		
59	NM1	Submitter Name	To supply the full name of an individual or organizational entity	
59	NM109	Identification Code	Required	Use Submitter ID of the Dentist Office (if direct submitter, the same code as used in ISA06 and GS02. If a clearinghouse is sending, use provider's ABCBS submitter number)
66	Loop 1000B	RECEIVER NAME		
66	NM1	Receiver Name	To supply the full name of an individual or organizational entity	
66	NM109	Identification Code	Required	Use: 00200 (ABCBS)
69	Loop 2000A	BILLING / PAY-TO PROVIDER SPECIALTY INFORMATION		
71	PRV	Provider Information	To specify the identifying characteristics of a provider	
71	PRV02	Reference Identification Qualifier	Required when Taxonomy Code is submitted in PRV03	Use the code "ZZ" to indicate the Health Care Provider Taxonomy Code list.
71	PRV03	Reference Identification	Required when adjudication is known to be impacted by the Provider Taxonomy Code.	In general, Provider Taxonomy Code is <i>not</i> required for ABCBS claims. However, if you have been instructed by ABCBS to submit your Provider Taxonomy Code in order to crosswalk your NPI, it is required.
76	Loop 2010AA	BILLING PROVIDER NAME		
76	NM1	Individual or Organizational Name	To supply the NPI	
76	NM103	Provider's Name	Required	
80, 81	N301/ N401/ N402/ N403	Provider's Address	Required	City/State/Zip
76	NM108	Identification Code Qualifier	Required	Use: XX (NPI)
76	NM109	Identification Code	Required	Use the <i>Billing</i> Provider's 10-digit NPI

Dental Claims (837D) Data Requirements (continued)

837D Implementation Guide Data				Payer Specific Data
Page	Segment ID	Description	837 Requirements	ABCBS Instructions
76	Loop 2010AA	BILLING PROVIDER SECONDARY IDENTIFICATION		
83	REF	Reference Identification	Use to identify the Tax ID (1099 number) of the billing provider	
83	REF01	Reference Identification Qualifier	Required, used to provide the Tax ID number of the Billing Provider	Use: EI (EIN Number) or SY (SSN Number)
83	REF02	Reference Identification	Required, used to submit the Tax ID number of the Billing Provider	Use the Billing Provider's 9-digit Tax ID number (without dashes)
96	Loop 2000B	SUBSCRIBER INFORMATION		
99	SBR	Subscriber Information	To record information specific to the primary insured and the insurance carrier for that insured	
99	SBR02	Individual Relationship Code	Situational, but <i>required</i> if subscriber is the patient	Use: 18 (Self) if subscriber is the patient <i>Important Note:</i> If subscriber is <i>not</i> the patient, do not use this data element; refer to the appropriate patient segments.
103	Loop 2010BA	SUBSCRIBER NAME		
103	NM1	Individual or Organizational Name	To supply the full name of an individual or organizational entity	
103	NM103	Member Name	Situational, but <i>required</i> if subscriber is the patient	
103	NM109	Identification Code Qualifier	Situational, but <i>required</i> if subscriber is the patient	Use the patient's identification number that was in effect on the date of service, exactly as it appears on the BCBS ID card. You must include the appropriate alpha prefix .
103, 108, 109	NM109 / N301, N402, N403	Subscriber's Address/ City/ State/ Zip	Situational, but <i>required</i> if subscriber is the patient	

Dental Claims (837D) Data Requirements (continued)

837D Implementation Guide Data				Payer Specific Data	
Page	Segment ID	Description	837 Requirements		ABCBS Instructions
117	Loop 2010BB	PAYER NAME			
117	NM1	Individual or Organizational Name	Information about the Payer		
117	NM108	Identification Code Qualifier	Required	Use: PI (Payer Identification)	
117	NM109	Identification Code	Required	Use: 00200 (ABCBS)	
149	Loop 2300	DATE - ACCIDENT			
157	DTP	Date or Time or Period	To specify the date of an accident		
161	DTP01	Date/Time Qualifier	Situational, but <i>required</i> if CLM11-1, CLM11-2, or CLM11-3 = AA (Auto Accident), EM (Employment) or OA (other Accident)	Use: 439 if the service involves an accident Use: 472 for dates of services. Note DOS must be no greater than 6 months from current date, due to timely filing requirements. Claims with DOS not complying with this requirement will be rejected.	
161	DTP02	Reference Identification	Situational, but <i>required</i> if CLM11-1, CLM11-2, or CLM11-3 = AA (Auto Accident), EM (Employment) or OA (other Accident)	Use D8 (Date expressed in format CCYYMMDD)	
161	DTP03	Date Time Period	Situational, but <i>required</i> if CLM11-1, CLM11-2, or CLM11-3 = AA (Auto Accident), EM (Employment) or OA (other Accident)	If you have indicated a diagnosis code value greater than 80000 (injury), the date of the injury or accident is <i>required</i>	

Dental Claims (837D) Data Requirements (continued)

837D Implementation Guide Data				Payer Specific Data
Page	Segment ID	Description	837 Requirements	ABCBS Instructions
265	Loop 2400	SERVICE LINE		
265	LX	Dental Service		
265	LX01	Assigned Number	Required	Accept up to 50 service lines per claim.
266	SV3	Dental Service		
266	SV301	Procedure Code	Required	
266	SV302	Line Charge	Required	
266	SV304	Oral Cavity Designation Code	Required	
273	DTP	Date		
273	DTP03	Service Date	Situational	Required if service date is different than the service date reported at the DTP segment in the 2300 loop.
271	TOO	Tooth Identification		
272	TOO02	Tooth Number	Situational	If procedure code requires tooth surface codes, submit 1 tooth number and up to 5 surfaces per procedure line. Only 1 tooth number per line will be accepted by FEP.
272	TOO03	Tooth Surface Code	Situational, if the procedure code requires tooth service codes.	