Independence Blue Cross

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 Implementation Guides, version 005010

December 2013

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Preface

This Companion Guide (“Companion Guide”) refers to the v5010 ASC X12 Implementation Guides and associated errata adopted under HIPAA and clarifies and specifies the data content when exchanging electronically with Independence Blue Cross (IBC). Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. This Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE:
This page is blank because major sections of a book should begin on a right-hand page.

Table of Contents

1. Introduction

This section describes the ASC X12 Implementation Guides (IGs) adopted under HIPAA and is detailed using tables. The tables contain a row for each segment where IBC has something additional, over and above the information in the IGs. This information can:

1. Limit the repeat of loops or segments;
2. Limit the length of a simple data element;
3. Specify a subset of the IGs internal code listings;
4. Clarify the use of loops, segments, composite, and simple data elements;
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with IBC.

In addition to the row for each segment, one or more additional rows are used to describe IBC'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 suggested use of the rows for the detailed description of the Companion Guide:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row indicates that a new segment has begun. It is shaded at 10%. Notes or comments about the segment are entered in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row limits the length of the specified data element.
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by IBC.
			Plan Network Identification Number	N6		This type of row is used when a note for a particular code value is required. For example, this note could state that value N6 is the default. Not populating the first three columns indicates that the code value belongs to the row immediately above it.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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

IBC is migrating claims processing activities to a new platform managed and maintained by Highmark, Inc., formerly referred to as Highmark Health Services, ("Highmark platform"), an independent company. This change began in the fourth quarter of 2013. During this migration period, some claims will be processed on IBC's current platform, and some claims will be processed on the Highmark platform.

As part of this migration to the Highmark platform, IBC migrated X12 transactions from its current gateway to the gateway managed and maintained by Highmark ("Highmark Gateway"). The purpose of this Companion Guide is to provide guidance when submitting standard electronic transactions for IBC business through the Highmark Gateway as well as to explain the transactions that trading partners will receive during and after the migration.

This Companion Guide addresses how providers, or their business associates, conduct the following HIPAA standard electronic transactions: Health Care Claim: Professional (837P), Health Care Claim: Institutional (837I), Health Care Claim Acknowledgment (277CA), and Health Care Claim Payment/Advice (835) with IBC through the Highmark Gateway. In addition, it addresses the proprietary Unsolicited 277 - Claim Acknowledgment Transaction (U277).*

This Companion Guide also applies to the above referenced transactions that are being transmitted to IBC through the Highmark Gateway by a health care clearinghouse.

005010X IBC Unsolicited 277 Claim Acknowledgment Transaction (U277) is the IBC proprietary functional acknowledgment for ANSI 837 claims transactions. A separate Specification Guide for this transaction is available at U277 Trading Partner Specification (Claim Status Notification). IBC through the Highmark Gateway supports all listed transactions in batch mode.

An Electronic Data Interchange (EDI) trading partner is defined for this Companion Guide as any entity (provider, billing service, software vendor, employer group, or financial institution) that utilizes the Highmark Gateway to send or receive electronic data to or from IBC.

The Highmark Gateway supports standard electronic transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and additional supporting transactions as described in this Companion Guide. Highmark EDI Operations supports transactions for multiple payers, including IBC.

1.2 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with IBC through the Highmark Gateway. This information is organized into the following sections:

- **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 about trading partner authorization and an overview of the trading partner testing process is also included in this section.
- **Testing with the Payer:** This section includes detailed transaction testing information and other relevant information needed to complete transaction testing with IBC on the Highmark Gateway, if applicable.
- **Connectivity with the Payer/Communications:** This section includes information on the Highmark Gateway transmission procedures and communication and security protocols.
- **Contact Information:** This section includes telephone numbers and email addresses for support from Highmark EDI Operations.
- **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.
- **Payer-Specific Business Rules and Limitations:** This section contains information describing IBC's business rules.
- **Acknowledgments and Reports:** This section contains information on all transaction acknowledgments. These include the Interchange Acknowledgment (TA1), Health Care Claim Acknowledgment (277CA), Unsolicited 277 - Claim Acknowledgment Transaction (U277), and the Implementation Acknowledgment for Health Care Insurance (999).
- **Trading Partner Agreements:** This section contains general information about and links to Provider and Clearinghouse/Vendor Trading Partner Agreements (collectively referred to herein as "Trading Partner Agreements").
- **Transaction-Specific Information:** This section describes how IGs adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that has additional information that might supplement the IGs.

1.3 References

Trading partners must use the IGs adopted under the HIPAA Administrative Simplification Electronic Transaction rule and this Companion Guide for development of the EDI transactions. These documents will be made available through the EDI Trading Partner Business Center:

www.highmark.com/edi-ibc

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:

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])
- Claim Status Category Codes and Claim Status Codes (005010X214 Health Care Claim Acknowledgment [277CA])
- Provider Taxonomy Codes (ASC X12/005010X222A1Health Care Claim: Professional [837P] and ASC X12/005010X223A2 Health Care Claim: Institutional [837I])

1.4 Additional Information

There is no additional information at this time.

2. Getting Started

2.1 Working with Highmark, Inc. (“Highmark”)

System Operating Hours

Highmark is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

It is highly recommended that trading partners transmit any test data during the hours that Highmark EDI Operations is available, 8:00 a.m. through 5:00 p.m. EST, Monday through Friday.

Audit Procedures

For purposes of conducting an audit for itself and/or IBC, Highmark may require access to the medical records used by the trading partner for submitting claims in accordance with the Trading Partner Agreement. The trading partner must ensure that input documents and medical records are retained and available for every automated claim for purposes of an audit. Copies of trading partner documents are acceptable. The trading partner, not the billing agent, is held accountable for accurate records.

The audit conducted by Highmark consists of verifying a sample of automated claim input against medical records. Retention of records might also be checked. Compliance with reporting requirements is sample-checked to ensure proper coding technique is employed. Signature(s) on file records may also be verified.

In accordance with the Trading Partner Agreement, Highmark can request for itself and IBC, 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. Use of these characters can cause problems if encountered in the transaction data.

As described in the ASC 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 are 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/Security/Privacy

Trading partners, including health care clearinghouses, must comply with the HIPAA Electronic Transaction and Code Set standards and HIPAA Privacy and Security standards for all EDI transactions and confidentiality requirements as outlined in the Trading Partner Agreement.

Authorized Release of Information

When contacting Highmark EDI Operations concerning any EDI transactions, you will be required to confirm your trading partner information.

2.2 Trading Partner Registration

An Electronic Data Interchange (EDI) trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution)

utilizing the Highmark Gateway to transmit or receive electronic standard transactions to or from IBC.

While Highmark EDI Operations accepts HIPAA-compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure is established to secure access to data. As a result, Highmark has a process in place to establish a trading partner relationship. That process has the following steps:

- The trading partner must identify Trading Partner Administrator and Delegate roles (see page 13 of this Companion Guide). IBC uses role-based security for transactions related to the maintenance of a trading partner relationship.
- The Trading Partner Administrator must complete an online application to receive from Highmark a DataStream Trading Partner ID associated with submitting transactions on behalf of IBC.
- The Trading Partner Administrator must agree to and electronically accept or otherwise submit the Trading Partner Agreement to Highmark. The Trading Partner Agreement establishes the legal relationship and requirements. This is separate from a participating provider agreement.

Once the Trading Partner Agreement is received by Highmark, the trading partner is sent a logon ID and password combination associated with the DataStream Trading Partner ID for use when accessing the Highmark Gateway for submission or retrieval of IBC transactions ("DataStream logon ID and password"). This DataStream logon ID is also used within EDI Interchanges as the ID of the trading partner. The Confidentiality/Security/Privacy section of this Companion Guide provides more detail about the maintenance of the DataStream logon ID and password by the trading partner.

Authorization Process

New trading partners that want to submit EDI transactions must submit an EDI Transaction Application to Highmark EDI Operations.

The EDI Transaction Application and the Trading Partner Agreement must be completed, electronically accepted and submitted by the Trading Partner Administrator who is an authorized representative of the organization submitting the EDI Transaction Application.

Highmark can terminate the Trading Partner Agreement after a sixty (60) day suspension period, without notice, if the trading partner's account is inactive for a period of six (6) consecutive months, pursuant to the terms of the Trading Partner Agreement.

Complete and accurate reporting of information on the EDI Transaction Application ensures that the authorization process is completed 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 Highmark EDI Operations.

Upon completion of the authorization process, a DataStream logon ID and password are assigned to the trading partner. Highmark EDI Operations will authorize, in writing, the trading partner to submit production IBC EDI transactions.

Trading Partner Administrator and Trading Partner Delegate Roles

This section explains the Trading Partner Administrator ("Administrator") and Trading Partner Delegate ("Delegate") roles. Highmark EDI Operations will only make changes to the trading partner record if the change request is received from the authorized Administrator or Delegate.

- The "Administrator" is the primary representative of the trading partner entity (provider office, billing service, clearinghouse, etc.) that is authorized by the trading partner to conduct all electronic business on behalf of the trading partner, including entering into Trading Partner Agreements, modifying trading partner capabilities, and conducting inquiries about electronic transactions.
- The "Delegate" is a representative of the Trading Partner Administrator that has been authorized by the trading partner/Trading Partner Administrator to conduct certain activities on behalf of the trading partner such as, requesting the addition or deletion of affiliated providers or conducting inquiries about electronic transactions.
- The provider is a physician or allied health care provider credentialed and approved by IBC to provide covered services to IBC members and submit standard electronic transactions for such services to IBC for processing.
- The Administrator is required to submit a security question and an answer to this question when registering. The security answer is used to confirm and verify the identity of the Administrator prior to Highmark making any form changes on behalf of the trading partner.

The following table lists the rights that an Administrator, a Delegate, and a provider are authorized to perform:

IBC Trading Partner Role-Based Security Matrix

Rights	Administrator	Delegate	Provider
EDI Trading Partner Business Center Permissions			
New trading partner registration	✓		
New trading partner request	✓		
Update a trading partner's address information	✓		
Delete a trading partner	✓		
Update claim transactions	✓		
Update Administrator	✓		

Rights	Administrator	Delegate	Provider
Establish Delegate	✓		
Update Delegate	✓	✓	
Request for production	✓	✓	
Provider changes	✓	✓	✓
Update software vendor	✓	✓	
Other Permissions			
Receive EDI transaction support	✓	✓	✓
Request password change	✓	✓	

Where to Get Authorization Forms to Request a DataStream Trading Partner ID

To receive a DataStream Trading Partner ID, you must complete an online New DataStream Trading Partner Application and electronically agree to the terms of the Trading Partner Agreement. The New DataStream Trading Partner Application and all other EDI request forms are available through the *Sign Up* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-ibc

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

To receive Health Care Claim Payment/Advice (835 remittance transactions) generated from the payment cycle in a batch process, trading partners need to request 835 remittance transactions by completing an *Update Claims Transactions* form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-ibc

Adding a New Provider to an Existing Trading Partner

Trading partners currently using electronic claims submission who wish to add a new provider to their DataStream Trading Partner ID should complete the *Provider Changes* form in the *Update Trading Partners* section of the EDI Trading Partner Business Center website, and select the option to *Add Provider*.

www.highmark.com/edi-ibc

Deleting Providers from an Existing Trading Partner

Trading partners who wish to delete an existing trading partner from their DataStream Trading Partner ID should complete the *Provider Changes* form in the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-ibc

Reporting Changes in Status

If trading partners need to change any other trading partner information, they must inform Highmark EDI Operations by completing the appropriate trading partner update form through the *Update Trading Partners* section of the EDI Trading Partner Business Center website.

www.highmark.com/edi-ibc

2.3 Certification and Testing Overview

IBC through Highmark Transactional Testing

Detailed payer testing requirements and procedures to be determined.

Claims Transactions

Detailed payer testing requirements and procedures to be determined.

3. Testing with the Payer

Detailed payer testing requirements and procedures to be determined.

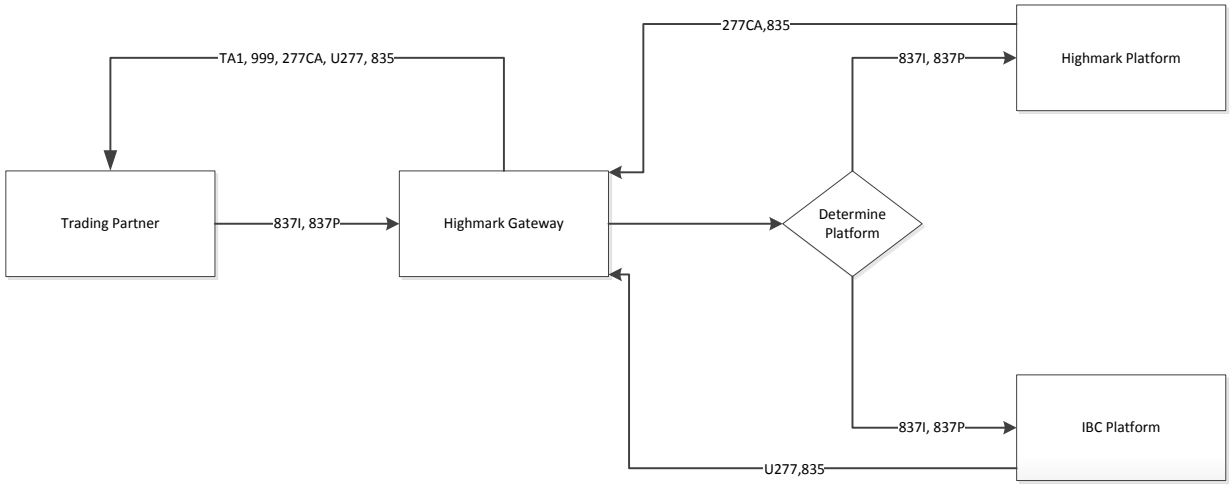
4. Connectivity with the Payer/Communications

Highmark offers IBC trading partners the following communication method for transferring data electronically:

- A secure https Internet connection is available for transactions in batch mode.

4.1 Process Flows

In the fourth quarter of 2013, IBC started migrating claims processing activities to the Highmark platform. During this migration period, some claims will be processed on IBC's current platform, and some claims will be processed on the Highmark platform, as illustrated in the following diagram:



837 institutional and professional claims transactions submitted to IBC via the Highmark Gateway may be processed on either IBC's current platform or the new Highmark platform. If an 837 claim transaction is processed at IBC, it will generate a U277 Claim Acknowledgment transaction and an 835 Health Care Claim Payment/Advice transaction from the IBC platform. If an 837 claim transaction is processed at Highmark, it will generate a 277CA Health Care Claim Acknowledgment transaction and an 835 Health Care Payment/Advice transaction from the Highmark platform.

Trading partners will submit and receive all transactions through the Highmark Gateway. The 999 Implementation Acknowledgment for Health Care Insurance transaction, TA1 Transaction Acknowledgment transaction, 277CA Health Care Claim Acknowledgment transaction, U277 Claim Acknowledgment transaction, and 835 Health Care Payment/Advice transaction are all returned to trading partners through the Highmark Gateway.

4.2 Transmission Administrative Procedures

This information will be communicated to the trading partner upon Highmark's receipt of the agreed-to Trading Partner Agreement.

4.3 Re-Transmission Procedures

IBC does not have specific re-transmission procedures. Trading partners can retransmit files at their discretion.

4.4 Communication Protocol Specifications

Internet

Highmark offers a secure File Transfer Protocol (SFTP) through "eDelivery" for conducting business with IBC. "eDelivery" is available for trading partners who submit or receive any HIPAA-compliant EDI transactions in batch mode.

Internet File Transfer Protocol (SFTP) through "eDelivery"

The Highmark Secure FTP Server ("eDelivery") provides an SFTP 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 SFTP process in an encrypted and secure 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 SFTP server at https://ftp.highmark.com.
3. The server prompts you for your DataStream logon ID and password. Use the DataStream logon ID/password that Highmark provided you as part of the

trading partner authorization process for accessing this service. Enter the ID, tab to password field and enter the password.

4. Press “Enter” or click “OK”.
5. The server places you in an individual file space on the SFTP server. Other users cannot access your space and you cannot access the space of other users. You cannot change your space.
6. You need to change into the directory for the type of file you are uploading or downloading from the server.
7. By default, the file transfer mode is binary. This mode is acceptable for all data types. However, you can change between ASCII and binary file transfer modes by clicking the “Set ASCII”/“Set Binary” toggle button.
8. Send Highmark a file. The following is an example of the submission of an electronic claim[1] transaction file:
    a. Click the “hipaa-in” folder to change into that directory.
    b. Click the **browse** button to select a file from your system to send to Highmark. A file finder box appears listing the files available on your system.
    c. Select the file you want to send to Highmark and click **OK**. This returns you to the browser with the file name you selected in the filename window.
    d. Click the **Upload File** button to transfer the file to Highmark. Once completed, the file appears in your file list.
9. Retrieve a file from Highmark. The following is an example of retrieval of an Implementation Acknowledgment For Health Care Insurance (999) file:
    a. Click the “hipaa-out” directory. Your browser lists all the files available to you.
    b. Click the “ack” directory.
    c. Click the file you want to download. Your browser downloads the file. If your browser displays the file instead of downloading, click the **browser back** button and click the tools next to the file you want to receive. Select application/ octet-stream. You might be prompted with the **Save As** file location window. Select a file location and click **Save** to download the file.

4.5 Passwords

Highmark EDI Operations assigns DataStream logon IDs and passwords to trading partners. EDI transactions submitted by unauthorized trading partners will not be accepted by the Highmark Gateway.

[1]Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

Trading partners should protect password privacy by limiting knowledge of the password to a key Administrator or their Delegates. 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. Trading partners must notify Highmark immediately if there is a violation of these DataStream logon ID and password requirements as required by the Trading Partner Agreement.

Password requirements include:

- Password must be eight characters in length.
- Password must contain a combination of both numeric and lower case alpha characters.
- Password cannot contain the logon ID.
- Password must be changed periodically.

Trading partners are directed to refer to the terms of their Trading Partner Agreement for any additional obligations they may have concerning logon IDs and passwords.

Password Change Requests

EDI Operations only performs a password reset if requested by an Administrator or Delegate.

If an Administrator or a Delegate provides the answer to their security question, EDI Operations can provide temporary passwords over the telephone. If the security answer is not provided, a temporary password is not given during the initial telephone call. In this case, the temporary password can be provided in a follow-up email or return telephone call using existing contact information on file at Highmark.

5. Contact Information

5.1 Highmark EDI Operations

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246
- Email Address: edisupport@highmark.com

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

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.2 EDI Technical Assistance

Contact information for Highmark EDI Operations:

- Telephone Number: 1-800-992-0246
- Email Address: edisupport@highmark.com

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

Highmark EDI Operations is available for questions from 8:00 a.m. to 5:00 p.m. EST, Monday through Friday.

5.3 Provider Services

Non-EDI related inquiries should be handled through your existing channels of communication with IBC.

5.4 Applicable Websites/Email

EDI specifications, including this Companion Guide, will be accessible online in the *Resources* section of the EDI Trading Partner Business Center website:

www.highmark.com/edi-ibc

6. Control Segments/Envelopes

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the IGs. IBC'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 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.

For 5010 claim files, the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days, the file is considered a duplicate and rejected with a TA1 Duplicate Interchange.

6.1 ISA-IEA

Delimiters

As detailed in the IGs, 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 Line Feed, hex value “0A”, is 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
%	25
&	26
‘	27
(	28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F
@	40
[	5B
]	5D
^	5E
{	7B
}	7D
~	7E

Note: "^"can be used as a Data Element Separator, but is not accepted as a Component Element Separator, Repeating Element Separator, or Segment Terminator.

Highmark uses the following delimiters in all outbound transactions. Note that these characters as well as the Exclamation Point, "!", cannot be used in text data (type AN, Sting data element) within the transaction; refer to Section 2.1 Valid Characters in Text Data in this document.

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 IBC

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 IGs with the clarifications as follows:

Table 1: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	IBC can only support code 00 - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	IBC 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 IBC assigned security logon ID. The ID must be left justified and space filled. Any alpha characters must be upper case.
	ISA07	Interchange ID Qualifier	33	Use qualifier code value "33". IBC only supports the NAIC code to identify the receiver.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA08	Interchange Receiver ID	54704	IBC
	ISA13	Interchange Control Number		For 5010 claim files the ISA13 Control number must be unique for each submitted interchange. If the content of an interchange matches another interchange submitted within the last 14 days the file will be considered a duplicate and rejected with a TA1 Duplicate Interchange.
	ISA 14	Acknow-ledgment Requested	1	A TA1 segment is always returned when the incoming interchange is rejected due to errors at the interchange or functional group envelope.
	ISA15	Usage Indicator		The value in this element is used to determine the test or production nature of all transactions within the interchange.

Data Detail and Explanation of Outgoing ISA from IBC

Segment: ISA Interchange Control Header (Outgoing)

Note: The following table lists clarifications of IBC's use of the ISA segment for outgoing interchanges.

Table 2: Data Element Summary

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Code 00 is sent - No Authorization Information present.
	ISA02	Authorization Information		This element must be space filled.
	ISA03	Security Information Qualifier	00	Code 00 is sent - No Security Information present.
	ISA04	Security Information		This element must be space filled.
	ISA05	Interchange ID Qualifier	33	Qualifier code value "33" is sent to designate that the NAIC code is used to identify the sender.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA06	Interchange Sender ID	54704	IBC
	ISA07	Interchange ID Qualifier	ZZ	Qualifier code value “ZZ” is sent. Mutually defined to designate that an IBC-assigned proprietary ID is used to identify the receiver.
	ISA08	Interchange Receiver ID		The assigned ID is the trading partner’s security logon ID. This ID is left-justified and space filled.
	ISA 14	Acknowledgment Requested		IBC always uses a 0 (No Interchange Acknowledgment Requested).
	ISA15	Usage Indicator		IBC provides T or P as appropriate to identify the test or production nature of all transactions 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 Section 7 (Payer-Specific Business Rules and Limitations) and Section 10 (Transaction-Specific Information) of this Companion Guide.

6.3 ST-SE

IBC has no requirements outside the national transaction IGs.

7. Payer-Specific Business Rules and Limitations (837P, 837I, 277CA, U277, 835, and 999)

7.1 005010X222A1 Health Care Claim: Professional (837P)

The Health Care Claim: Professional (837P) transaction is used for professional claims. The May 2006 ASC X12 005010X222 IG, as modified by the July 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 IBC benefits plans, Federal Employees Program (FEP), and BlueCard® Par Point of Service (POS). Accurate reporting of IBC’s NAIC code is critical for claims submitted to IBC through the Highmark Gateway.

Patient with Medicare Advantage PPO (MAPPO) Coverage from another Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, allows IBC to accept Health Care Claim: Professional (837P) claims when the patient has coverage from an out-of-state MAPPO Plan. BlueCard also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the following subsections. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, IBC must be listed as the payer by submitting 54704 in the Application Receiver GS03 and in the loop 2010BB NM109 Payer ID. IBC will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local IBC member, rather than a member with MAPPO coverage through another Plan. Because the eligibility information for the patient would not reside on IBC's system, the claim would be denied for no coverage and any payment due the provider would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows IBC to be an electronic interface for its local providers to out-of-area MAPPO Plans that are licensees of the Blue Cross and Blue Shield Association. Any payment to the provider will be made by IBC.

Family Planning

Effective August 1, 2013, Keystone First, the IBC Medicaid affiliate/subcontractor in Pennsylvania, started processing family planning claims for Medicaid members. Providers should submit family planning claims for Medicaid members to Keystone First for processing. For dates of service prior to August 1, 2013, providers should submit family planning claims to IBC through the Highmark Gateway for processing on the Highmark platform.

www.keystonefirstpa.com

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 professional claim transaction 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.

7.2 005010X223A2 Health Care Claim: Institutional (837I)

The Health Care Claim: Institutional (837I) transaction is used for institutional claims. The May 2006 ASC X12 005010X223 IG, as modified by the August

2007 and the July 2010 Type 1 Errata documents, 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.

This Companion Guide supplements the ASC X12 Implementation 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 IBC benefit plans, including Indemnity, Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Point of Service (POS), Comprehensive Major Medical (CMM), Medicare Advantage, and Medicare Supplemental. Accurate reporting of IBC's NAIC code 54704 in the ISA08 along with associated prefixes and suffixes is critical for claims submission.

Keystone Health Plan East (KHPE)

KHPE-contracted providers should submit all KHPE claims to IBC's NAIC code 54704 in the ISA08 and KHPE's NAIC code 95056 in the GS03.

Family Planning

Effective August 1, 2013, Keystone First, the IBC Medicaid affiliate/subcontractor in Pennsylvania, started processing family planning claims for Medicaid members. Providers should submit family planning claims for Medicaid members to Keystone First for processing. For dates of service prior to August 1, 2013, providers should submit family planning claims to IBC through the Highmark Gateway for processing on the Highmark platform.

www.keystonefirstpa.com

Patient with Coverage from an Out-of-Area Blue Cross Blue Shield Plan

The BlueCard operating arrangement among Plans that are licensees of the Blue Cross and Blue Shield Association allows IBC to accept Health Care Claim: Institutional (837I) claims when the patient has coverage from an out-of-state plan. BlueCard also applies in certain situations for patients with coverage from other Pennsylvania Plans, as detailed in the subsection below. To be processed through this arrangement, the Member ID (Subscriber and Patient ID if sent) must be submitted with its alpha prefix. Also, IBC must be listed as the payer by submitting IBC's NAIC code of 54704 in the GS03 Application Receiver's Code and the loop 2010BB NM109 Payer ID. IBC will use the Member ID alpha prefix to identify the need to coordinate processing with another Plan. If the alpha prefix portion of the Member ID is missing, the claim will be processed as if the patient were a local IBC member, rather than a member with coverage through another Plan. Because the eligibility information for the patient would not reside on IBC's system, the claim would be denied for no coverage and any payment due the facility would be delayed until the claim is corrected and resubmitted.

This operating arrangement allows IBC to be an electronic interface for its local providers to out-of-area Plans that are licensees of the Blue Cross Blue Shield Association. Any payment to the provider will be made by IBC.

7.3 005010XIBC Unsolicited 277 - Claim Acknowledgment Transaction (U277)

IBC started moving to a new claims processing platform at Highmark in the fourth quarter of 2013. During the platform transition, trading partners will receive both the Unsolicited 277 - Claim Acknowledgment (U277) and Health Care Claim Acknowledgment (277CA) transactions.

837 institutional and professional claim transactions submitted to IBC via the Highmark Gateway may be processed on either IBC's current platform or the Highmark platform. If an 837 claim transaction is processed at IBC, it will generate a U277 Claim Acknowledgment transaction from the IBC platform. If an 837 claim transaction is processed at Highmark, it will generate a 277CA Health Care Claim transaction from the Highmark platform.

Once the transition to the Highmark platform is complete, trading partners will receive only the 277CA transaction and the IBC U277 Trading Partner Specification Guide will be retired. Detailed transaction information for the U277 transaction as well as business rules and/or limitations can be found in the independent IBC U277 Trading Partner Specification.

7.4 005010X214 Health Care Claim Acknowledgment (277CA)

IBC started moving to a new claims processing platform at Highmark in the fourth quarter of 2013. During the platform transition, trading partners will receive both the Unsolicited 277 - Claim Acknowledgment (U277) and Health Care Claim Acknowledgment (277CA) transactions.

837 institutional and professional claim transactions submitted to IBC via the Highmark Gateway may be processed on either IBC's current platform or the new Highmark platform. If an 837 claim transaction is processed at IBC, it will generate a U277 Claim Acknowledgment transaction from the IBC platform. If an 837 claim transaction is processed at Highmark, it will generate a 277CA Health Care Claim Acknowledgment transaction from the Highmark platform.

Once the transition to the Highmark platform is complete, trading partners will receive only the 277CA transaction.

Timeframe for Batch Health Care Claim Acknowledgment (277CA)

Generally, batch claim submitters should expect a 277CA transaction within 24 hours after IBC 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 transaction, it may be

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

necessary to retrieve multiple 277CA transactions related to an electronic claims transaction. See Section 4.4 Communication Protocol Specifications in this Companion Guide for information on retrieving the batch Health Care Claim Acknowledgment (277CA).

7.5 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on Highmark Platform

IBC started moving to a new claims processing platform at Highmark in the fourth quarter of 2013. During the platform transition, trading partners will receive the 005010X221A1 Health Care Claim Payment Advice (835) transaction from both the current IBC platform and the Highmark platform, depending on where the claim is adjudicated.

837 institutional and professional claim transactions submitted to IBC via the Highmark Gateway may be processed on either IBC's current platform or the new Highmark platform. If an 837 claim transaction is processed at IBC, it will generate an 835 transaction from the IBC platform. If an 837 claim transaction is processed at Highmark, it will generate an 835 remittance transaction from the Highmark platform.

Once the transition to the Highmark platform is complete, trading partners will receive only the 835 remittance transaction generated on the Highmark platform.

This section describes business rules specific to the 835 remittance transaction generated on the Highmark platform. See Section 7.6 for business rules specific to the 835 remittance transaction generated on the current IBC platform.

Availability of Payment Cycle 835 Transactions (Batch)

Health Care Claim Payment/Advice (835) transactions are created on a weekly or daily basis to correspond with IBC'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 seven 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 Highmark EDI Operations for assistance.

Limitations

- Paper claims might 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
  - Payee name and address

Major Medical

Under certain group contracts, IBC processes major medical benefits concurrently with the “basic” medical-surgical coverage. In those instances, the liabilities for the “basic” coverage and the major medical coverage will be combined and the resulting “net” liabilities reported in the Claim Adjustment Segment at each service line.

Under certain group contracts, IBC processes major medical benefits concurrently with the “basic” medical-surgical coverage. In those instances, the liabilities for the “basic” coverage and the major medical coverage will be combined and the resulting “net” liabilities will be reported in the Claim Adjustment Segment at either the claim level or each service line, depending on the type of claim. Claims that are processed concurrently with major medical coverage will reflect Remittance Advice Remark Code ‘N7’ - Processing of this claim/service has included consideration under Major Medical provisions’ in either the 2100 Loop MIA or MOA Segment or 2110 Loop LQ Segment to alert the provider of this processing arrangement.

Claim Overpayment Refunds

Member Facility Institutional Claims

The Reversal and Correction methodology is used to recoup immediate refunds for overpayments identified by the provider or by IBC. The change in payment details is reflected by a reversal claim (CLP02 = 22) and a corrected claim (CLP02 = 1, 2, 3, or 4). The payment amount of the check/EFT is reduced by the overpayment amount, after any outstanding provider offsets are applied from previous checks/EFTs.

If IBC is unable to recoup all or a portion of the refund money from the current check/EFT, the remaining refund amount to be offset on a future check will be shown as a negative amount in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835) using the Provider Adjustment Reason code of FB – Forward Balance. The negative PLB dollars allow the Health Care Claim Payment/Advice (835) payment to balance and essentially delay or move the refund balance forward to a future Health Care Claim Payment/Advice (835), when money is available to be offset from a check/EFT.

When the refund dollars are eventually offset in a subsequent check/EFT, the money is only reflected in the Health Care Claim Payment/Advice (835) PLB segment with the dollar amount being offset from that specific check/EFT. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835).

IBC claims processed on the Highmark platform use the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.

Professional and Non-Member Facility Claims

When overpayment of a professional claim is identified by the provider, and verified by IBC, the reversal/correction/offset mechanism described above for member facility institutional claims is followed.

When overpayment of a professional claim is identified by IBC, the provider's payment will not be immediately reduced. This delay is intended as an opportunity for the provider to appeal IBC's overpayment determination. Due to the timing of the appeal review and actual check/ EFT reduction, providers are encouraged to NOT wait to appeal the refund request. With the exception of difficult refund cases, this new process will eliminate the form letters.

In the Health Care Claim Payment/Advice (835) transaction, the IBC-identified overpayment reversal and correction claims will be separated to a second LX loop (LX01 = 2). Because the resulting overpayment amounts for the claims in this LX loop are not being deducted from this check/EFT, a negative amount which cancels out the reversal and correction overpayment claims is reported in the Provider Adjustment PLB segment. The PLB segment will have the following codes and information:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim followed by the word "DEFER" with no space. Example: '06123456789DEFER.'

  Claim Interest – If an interest payment was made in connection with the original claim payment, recoupment of the interest corresponding to the overpayment will also be deferred. Deferred Interest will be individually detailed in the PLB segment to assist the provider with account reconciliation. The PLB segment will reflect the following codes and information:

  - Provider Adjustment Reason Code L6, Interest Owed
  - Reference Identification will contain the claim number from the impacted claim followed by the word "DEFER" with no space. Example: '06123456789DEFER.'
  - Both a positive and negative interest (L6) adjustment will be shown in order to not financially impact the current Health Care Claim Payment/Advice (835) payment.

If an appeal is not filed, IBC will assume the provider agrees with the refund request. The overpayment refund will then be deducted from a current check/EFT, and that refund amount will be reflected in a Provider Adjustment PLB segment. Note that the reversal and correction claim detail is not repeated in the Health Care Claim Payment/Advice (835). The following codes and information will be used in the PLB segment for this purpose:

- Provider Adjustment Reason Code WO, Overpayment Recovery.
- Reference Identification will contain the claim number from the reversal and correction claim.
- If Interest related to this claim was previously deferred, the current refund amount being collected will include the interest amount.

In the event the full refund amount cannot be deducted from the current check/EFT, then the remaining balance will be 'moved forward' to a subsequent check/EFT using the Provider Adjustment Reason code of FB – Forward Balance in the Provider Adjustment PLB segment of the Health Care Claim Payment/Advice (835).

IBC claims processed on the Highmark platform use the standard 'Balance Forward Processing' methodology as defined in the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.

Provider Payments from Member Health Care Accounts

IBC members under certain health care programs have the option to have their member liability paid directly to the provider from their health care spending account. The member health care spending accounts include Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), or Flexible Spending Account (FSA). Additional information regarding this new option and the specific programs impacted was sent to providers and facilities. Information is also available from your Provider Relations representative.

IBC will create a separate batch or payment Health Care Claim Payment/Advice (835) transaction (ST to SE Segment) to document the payment from the member's saving/spending account. This separate or second Health Care Claim Payment/Advice (835) reporting methodology is termed a "COB reporting model" meaning the member spending account Health Care Claim Payment/Advice (835) will have the code value attributes of a secondary claim payment. This is a Health Care Claim Payment/Advice (835) reporting model or methodology, designed to utilize existing automated account posting software functionality and is NOT considered to be the same as a true Payer to Payer COB process for claim adjudication. IBC will continue to create a Health Care Claim Payment/Advice (835) transaction to document IBC's payment. If the member has a saving/spending account, has selected the payment to provider option and has funds available in the account, IBC will create another Health Care Claim Payment/Advice (835) transaction to document how the remaining liabilities were addressed by the payment from the member's account. The additional Health Care Claim Payment/Advice (835) transaction, containing members' health care account payments, will have the same structure as the Health Care Claim Payment/Advice (835) transactions IBC currently produces. The health care account Health Care Claim Payment/Advice (835) transactions (ST to SE Segments) will be included in the Trading partner's transmission file (ISA to IEA Segments) currently produced for IBC. Trading partners will be able to

distinguish the health care account Health Care Claim Payment/Advice (835) by the following features:

- Loop 1000A, N102 – The Payer Name will be 'IBC Health Care Account.'
- Loop 2100, CLP02 – The Claim Status Code for all claims contained in the 835 transaction will equal '2 – Processed as secondary.'
- Loop 2100 or Loop 2110, CAS Segment – The Claim Adjustment Group and Reason Code will be OA23 for all dollars that equal the difference between the provider's charge and the Patient Responsibility dollars being considered for reimbursement under the account.

Example: Health Care Claim Payment/Advice (835) Segments Documenting Payment from IBC and Payment from the Member's Account

The example below illustrates the 'COB reporting model' and Health Care Claim Payment/Advice (835) segments documenting claim payment from IBC under the patient's health care coverage plan and reimbursement from the patient's health care account. For purposes of ERA reporting only, Highmark's payment will be treated as 'primary' and payment from the member's health care account as 'secondary'.

In this example, the provider's charge is $200. The Highmark allowance for the procedure is $180, leaving a contractual obligation of $20. Highmark applies $130 of that amount to the patient's deductible and pays the remaining $50 to the provider. This is spelled out in the "primary" example below, on the left.

The right side of the example below displays an accounting of the way the member liabilities were handled through the member's saving/spending account, as it would appear on the Health Care Claim Payment/Advice (835) transaction. The entire patient deductible of $130 is being reimbursed by the member's health care account. The $70 difference ($20 Contractual Obligation plus $50 paid by Highmark) between the $200 charge and the $130 payment from the member's account was assigned a Claim Adjustment Group and Reason code of OA23 – "Other Adjustment/Payment adjusted due to the impact of prior payer(s) adjudication, including payments and/or adjustments.

See the example below:

Highmark Payment (Primary)	Health Care Account Payment (Secondary)
N1^PR^INDEPENDENCE BLUE CROSS~ CLP^ABC123^1^200^50^130^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^50~ DTM^150^20090301~ DTM^151^20090304~ CAS^CO^45^20~ CAS^PR^1^130~	N1^PR^AMERIHEALTH INC HEALTH CARE ACCOUNT~ CLP^ABC123^2^200^130^^12^0123456789~ NM1^QC^1^DOE^JOHN^^^^MI^33344555510~ SVC^HC>99245^200^130~ DTM^150^20090301~ DTM^151^20090304~ CAS^OA^23^70~

7.6 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on IBC Platform

IBC started moving to a new claims processing platform at Highmark in the fourth quarter of 2013. During the platform transition, trading partners will receive the 005010X221A1 Health Care Claim Payment Advice (835) transaction from both the current IBC platform and the Highmark platform, depending on where the claim is adjudicated.

837 institutional and professional claim transactions submitted to IBC via the Highmark Gateway may be processed on either IBC's current platform or the new Highmark platform. If an 837 claim transaction is processed at IBC, it will generate an 835 transaction from the IBC platform. If an 837 claim transaction is processed at Highmark, it will generate an 835 remittance transaction from the Highmark platform.

Once the transition to the Highmark platform is complete, trading partners will receive only the 835 remittance transaction generated on the Highmark platform.

This section describes business rules specific to the 835 remittance transaction generated on the current IBC platform. See Section 7.5 for business rules specific to the 835 remittance transaction generated on the Highmark platform.

7.7 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. 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.

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 X12 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) IG. 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 "005010X231A1," Note that this will not match the IG identifier that was in the GS08 of the envelope of the original submitted transaction. The GS08 value from the originally submitted transaction resides in the AK103 of the Implementation Acknowledgment For Health Care Insurance (999) guide.

When you were issued your DataStream Trading Partner ID, 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 on record for your DataStream Trading Partner ID, 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.

```
ISA^00^          ^00^          ^33^54771          ^ZZ^XXXXXXX
^060926^1429^{^00501^035738627^0^P^>
GS^FA^XXXXX^999999^20060926^142948^1^X^005010
ST^999^0001
IK1^HC^655
IK2^837^PA03
IK3^GS^114^^8
IK4^2^^7^TRADING PARTNER PROFILE
IK5^R
AK9^R^1^1^0
SE^8^0001
GE^1^1
IEA^1^035738627
```

8. Acknowledgments and Reports

8.1 Report Inventory

TA1 Segment	Interchange Acknowledgment
999 Transaction	Implementation Acknowledgment for Health Care Insurance
277CA Acknowledgment	Claim Acknowledgment to the Electronic Claim[1]
U277 Acknowledgment	Unsolicited Claim Acknowledgment Transaction, generated by IBC (pre-migration)

[1] Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted

Outgoing Interchange Acknowledgment TA1 Segment

The Highmark Gateway returns a TA1 Interchange Acknowledgment segment in batch mode when the entire interchange (ISA-IEA) must be rejected.

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 999 Implementation Guide. Each Highmark Gateway TA1 will have an Interchange Control Envelope (ISA-IEA).

Outgoing Implementation Acknowledgment for Health Care Insurance (999)

The Highmark Gateway returns an Implementation Acknowledgment for Health Care Insurance (999) for each Functional Group (GS-GE) envelope that is 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 Sections 7.7 and 10.6: 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999) of this Companion Guide.

Outgoing Claim Acknowledgment (277CA Transaction)

The 277CA Claim Acknowledgment Transaction is used to return a reply of “accepted” or “not accepted” for claims or encounters processed by IBC 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 Acknowledgment (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 Acknowledgment (277CA) in Section 7.4 of this Companion Guide.

Outgoing Unsolicited 277 Claim Acknowledgment (U277 Transaction)

The Unsolicited Claim Acknowledgment Transaction (U277) is used to return a reply of “accepted” or “not accepted” for claims or encounters processed by IBC submitted via the electronic claim[1] transaction in batch mode. Acceptance at this level is based on the electronic claim[1] IGs and front-end edits, and will apply to individual claims within an electronic claim[1] transaction. For those claims not accepted by IBC for processing, U277 transaction will detail additional actions required of the submitter in order to correct and resubmit those claims. For details on this transaction, please refer to Section 7.3 of this Companion Guide and the independent IBC U277 Trading Partner Specification Guide.

[1]Electronic claim includes both ASC X12/005010X222A1 Health Care Claim: Professional (837) and ASC X12/005010X223A2 Health Care Claim: Institutional (837) unless otherwise noted.

Receiving an Unsolicited Health Care Claim Acknowledgment (U277) versus a Health Care Claim Acknowledgment (277CA)

Non-migrated IBC claims will continue to be adjudicated on the IBC platform and will return the U277 transaction. Migrated claims will be adjudicated on the Highmark platform and will return the 277CA transaction.

Once the migration to the Highmark platform is complete, all claims will be adjudicated on the Highmark platform and only the 277CA transaction will be returned.

9. Trading Partner Agreements

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.

Trading Partners

An EDI trading partner is defined as any entity (provider, billing service, software vendor, employer group, or financial institution) utilizing the Highmark Gateway to transmit or receive electronic data to or from IBC.

Payers have Trading Partner Agreements that accompany the standard IGs to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the Trading Partner Agreement is with an entity or a part of a larger Agreement, between each party to the Agreement.

For example, a Trading Partner Agreement might specify the roles and responsibilities of each party to the Agreement in conducting standard electronic transactions.

10. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that IBC has something additional, over and above the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with IBC.

In addition to the row for each segment, one or more additional rows are used to describe IBC's usage for composite and simple data elements and for any other information. Notes and comments will be placed at the deepest level of detail. For example, a note about a code value will 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 suggested use of the rows for the detailed description of the transaction set companion guides:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row indicates a new segment for notes and comments. It is shaded at 10%.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row limits the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by IBC.
			Plan Network Identification	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.

The following table lists the IGs for which specific transaction instructions apply and which are included in Section 10 of this Companion Guide:

Unique ID	Name
005010X222A1	Health Care Claim: Professional
005010X223A2	Health Care Claim: Institutional
005010X214	Health Care Claim Acknowledgment
005010221A1	Health Care Claim Payment/Advice
005010X231A1	Implementation Acknowledgment for Health Care Insurance

IBC through the Highmark Gateway supports all listed transactions in batch mode.

10.1 005010X222A1 Health Care Claim: Professional (837P)

Refer to Section 7.1 for IBC business rules and limitations for this specific transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's assigned DataStream Trading Partner ID. The submitted value must not include leading zeros.
	GS03	Application Receiver's Code	54704 95056	**54704** IBC CMM IBC Traditional IBC PPO IBC PC65 MAPPO **95056** Keystone POS Keystone HMO Keystone Medicare Keystone First (Family Planning claims only)
1000A	NM1	Payer Identification		
	NM109	Submitter Identifier		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		IBC will use contact information on internal files for initial contact.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER01	Contact Function Code	BL	Technical Department
	PER02	Name Communication Number		Payer Contact Name
	PER03	Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
1000B	NM1	Receiver Name		
	NM103	Receiver Name		IBC
	NM109	Receiver Primary Identifier	54704	Identifies IBC 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 IBC 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 IBC.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners therefore U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	N3	Billing Provider Address		The provider's address on IBC internal files will be used for mailing of a check or other documents related to the claim.
	N301	Address Information		The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID 2010AB), if necessary.
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on IBC internal files will be used for mailing of a check or other documents related to the claim.

005010X222A1 Health Care Claim: Professional				
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.
2010AA	REF	Billing Provider Tax Identification Number		
2010AA	REF01	Identification Code Qualifier	0B	Family Planning claims only
2100AA	PER	Billing Provider Contact Information		IBC uses contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on IBC internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E. F, G, H, S, T, U	If value other than “P” (Primary) is populated, then the following Loops/Segments are required: • 2320 or 2430/CAS: With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • 2320/AMT: With AMT01 = ‘D’ and AMT02 Payer Paid Amount • 2320 or 2430/AMT: With AMT01 = ‘AEF’ and AMT02 Payer Paid Amount • 2330A/NM1: With Other Subscriber information
	SBR09	Claim Filing Indicator Code	BL MC	IBC Products Family Planning Claims
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For IBC claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which IBC does not process.

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.
2010BA	REF	Subscriber Secondary Identification		IBC does not need secondary identification to identify the Subscriber.
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For IBC claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which IBC does not process.
2010CA	NM1	Patient Name		
	NM102	Entity Type Code Qualifier	1	For IBC claims, the Subscriber must be a Person, code value "1". The Subscriber can only be a non-person for Worker's Compensation claims, which IBC does not process.
2010BB	NM1	Payer Name		
	NM103	Payer Name		IBC and Family Planning
	NM109	Payer Identifier	54704 95056	**54704** IBC CMM IBC Traditional IBC PPO IBC PC65 MAPPO **95056** Keystone POS Keystone HMO Keystone Medicare Keystone First (Family Planning claims only)

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2010BB	REF	Payer Secondary Identification		IBC does not need secondary identification to identify the payer.
2010BB	REF01	Identification Code Qualifier	G2	IBC
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
2300	CLM	Claim Information		
2300	CLM101	Claim Submitter's Identifier		Do not enter values more than 20 characters.
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and IBC Claim Number in REF02) • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)
2300	REF	Payer Claim Control Number		
2300	REF01	Reference Identification Qualifier	F8	If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and IBC Claim Number in REF02)

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2300	NTE	Claim Note		For fastest processing of anesthesia claims where the surgery procedure code reported in the Anesthesia Related Procedure HI segment is a Not Otherwise Classified code, report a complete description of the surgical services in this NTE segment. If CLM05-3 contains '7' or '8', prior claim information is required in the following Segments are required in Loop 2300: • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)
2300	HI	Health Care Diagnosis Code		ICD-10-CM Diagnosis Codes will not be accepted at this time. Further information addressing IBC implementation of the ICD-10 mandate will be issued in the future.
2310A	NM1	Referring Provider		With the implementation of the Ancillary Claim Filing mandate, the referring provider is required on Specialty Pharmacy and Independent Laboratory claims.
2310B	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one IBC 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 IBC.
2310B	REF	Rendering Provider Secondary Identification		
	REF01	Identification Code Qualifier	G2	IBC Family Planning Claims

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
2310C	REF	Service Facility Secondary Identification		
2310C	REF01	Identification Code Qualifier	G2	IBC
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2320	CAS	Claims Level Adjustment		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2320	AMT	COB Payer Paid Amount		If SBR01 is a value other than "P" (Primary), this segment is required.
2320	AMT	Remaining Patient Liability		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the line level, this data is not required.
2330B	NM1	Other Payer Name		If SBR01 is a value other than "P" (Primary), this segment is required.
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2330B	N4	Other Payer City, State, ZIP Code		This segment is required. If the paired N3 is sent, this segment must contain the corresponding city, state, and ZIP information. If the paired N3 is not sent, and the submitter does not know the Other Payer's city, state, and ZIP, send the Billing Provider address information as the default.
2400	SV1	Service Line		
	SV101-1	Product/Service ID Qualifier		Qualifier value HC, HCPCS, is the only value IBC will accept in this element.
2400	DTP	Last Seen Date		This date is not needed for the payer's adjudication process; therefore, the date is not required.
2400	AMT	Sales Tax Amount		This amount is not needed for the payer's adjudication process; therefore, the amount is not required.
2400	PS1	Purchase Service Information		This information is not needed for the payer's adjudication process; therefore, it is not required.
2410	LIN	Drug Identification		• NDC codes are required when specified in the provider's agreement with IBC. • IBC encourages submission of NDC information on all drug claims under a medical benefit to enable the most precise reimbursement and enhanced data analysis.
2420A	REF	Rendering Provider Secondary Identification		
2420A	REF01	Identification Code Qualifier	G2	IBC
	REF02	Identification Code Qualifier		Enter the appropriate Provider Identification Number.

005010X222A1 Health Care Claim: Professional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2420A	PRV	Rendering Provider Specialty Information		When the Rendering Provider's National Provider Identifier (NPI) is associated with more than one IBC 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 IBC.
2420C	N3	Service Facility Location Address		When the 2420C Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.
2430	CAS	Claims Level Adjustment		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.
2430	COB Payer Paid Amount	Remaining Patient Liability		If SBR01 is a value other than "P" (Primary), this segment is required. *Note:* If reported at the claim level, this data is not required.

10.2 005010X223A2 Health Care Claim: Institutional (837I)

Refer to Section 7.2 for IBC business rules and limitations for this specific transaction.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code	54704 95056	**54704** IBC CMM IBC Traditional IBC PPO IBC PC65 FEP BlueCard **95056** Keystone POS Keystone HMO Keystone Medicare Keystone First (Family Planning claims only)
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier		Sender's DataStream Trading Partner ID. The submitted value must not include leading zeros.
1000A	PER	Submitter EDI Contact Information		IBC uses contact information on internal files for initial contact.
1000B	NM1	Receiver Name		
	NM103	Receiver Name		IBC or Keystone Health Plan East
	NM109	Receiver Primary Identifier	54704 95056	**54704** IBC CMM IBC Traditional IBC PPO IBC PC65 FEP BlueCard **95056** Keystone POS Keystone HMO Keystone Medicare Keystone First (Family Planning claims only)

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2000A	PRV	Billing Provider Specialty Information		When the Billing Provider's National Provider Identifier (NPI) is associated with more than one IBC 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 IBC.
2000A	CUR	Foreign Currency Information		Do not submit. All electronic transactions will be with U.S. trading partners, therefore, U.S. currency will be assumed for all amounts.
2010AA	NM1	Billing Provider Name		
2010AA	NM108	Identification Code Qualifier		When the organization is not a health care provider (is an "atypical" provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" provider must submit their TIN in the REF segment and their assigned IBC Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).
2010AA	NM109	Identification code		When the organization is not a health care provider (is an "atypical" provider) and, thus, not eligible to receive an NPI, the NM108 and NM109 fields will be omitted. The "atypical" provider must submit their TIN in the REF segment and their assigned IBC Corporate ID in loop 2010BB/REF (Billing Provider Secondary Identification segment).
2010AA	N3	Billing Provider Address		The provider's address on IBC 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**
2010AA	N4	Billing Provider City, State, ZIP Code		The provider's address on IBC 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		IBC will use contact information on internal files for initial contact.
2010AB	NM1	Pay-To Address Name		The provider's address on IBC internal files will be used for mailing of a check or other documents related to the claim.
2000B	SBR	Subscriber Information		
	SBR01	Payer Responsibility Sequence Number Code		If value other than “P” (Primary) is populated, then the following Loops/Segments are required: • 2300/HI: If IBC secondary to Medicare, appropriate Value Codes if applicable • 2300/CAS: With appropriate Claim Adjustment Group and Claim Adjustment Reason codes along with amounts • 2300/AMT: With AMT01 = ‘D’ and AMT02 Payer Paid Amount • 2330A/NM1: With Other Subscriber information
2000B	SBR09		BL MC	**BL** for IBC Products **MC** for Family Planning claims only
2010BA	NM1	Subscriber Name		
	NM102	Entity Type Code Qualifier	1	For IBC claims, the Subscriber must be a Person, code value “1”. The Subscriber can only be a non-person for Worker’s Compensation claims, which IBC does not process.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM104	Subscriber First Name		Subscriber's first name is required when NM102 = 1 and the person has a first name. If the subscriber has a Single Legal Name, NM102 must = 1 and Single Legal Name must be populated in NM103 and NM104 must not be populated.
	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. When the Subscriber is not the patient, the patient's ID (from the ID card) will be submitted in this 2010BA/NM109 field segment. The remainder of the patient's information (name, birth date, etc.) will continue to be submitted in the 2010CA loop.
2010BA	REF	Subscriber Secondary Identification		IBC does not need secondary identification to identify the Subscriber.
2010BB	NM1	Payer Name		
	NM103	Payer Name		IBC (based on values submitted in GS03)

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Payer Identifier	54704 95056	**54704** IBC CMM IBC Traditional IBC PPO IBC PC65 FEP BlueCard **95056** Keystone POS Keystone HMO Keystone Medicare Keystone First (Family Planning claims only)
2010BB	REF	Payer Secondary Identification		Although not required, based on IBC's business, IBC recommends this segment be included. IBC requires submission with only the below data elements for this segment.
	REF01		G2	For all IBC Products except Family Planning
	REF02			Enter the IBC assigned Provider Identification Number
2300	CLM	Claim Information		
	CLM05-1	Facility Type Code	84	IBC considers Free Standing Birthing Center to be Outpatient when applying data edits.
	CLM05-3	Claim Frequency Type Code		If CLM05-3 contains '5', '7', or '8', prior claim information is required in the following Segments are required in Loop 2300: • REF – Payer Claim Control Number (REF01 = 'F8' and IBC Claim Number in REF02) • REF – Medical Records Number (REF01 = 'EA' and Medical Record Number in REF02) • NTE – Billing Note (NTE01 = 'ADD' and detailed description regarding the adjustment in NTE02)

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
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		
	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	REF	Payer Claim Control Number		IBC requires the Payer Claim Control Number segment when Loop 2300/CLM05-3 is ‘5’, ‘7’, or ‘8’.
	REF02	Payer Claim Control Number		IBC Claim Number associated with the Late Charge, Replacement or Void noted by Loop 2300/CLM05-3
2300	REF	Medical Record Number		IBC requires the Medical Record Number segment when Loop 2300/CLM05-3 is ‘5’, ‘7’, or ‘8’.
	REF01	Reference Identification Qualifier	EA	
2300	NTE	Billing Note		
	NTE02	Original Reference Number		Enter a detail description regarding the adjustment request.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
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 IBC 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 IBC 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 IBC 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 IBC 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 IBC 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 IBC implementation of the ICD-10 mandate will be issued in the future.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	HI01-1	Code List Qualifier Code		Until further notification from IBC, 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.
2300	HI	Value Information		When IBC is secondary to Medicare, Value Code information is required as necessary:
	HI01-01		BE	
	HI01-02		09, 11, 08, 10, 06, 80, 81, 82, 83	• 09 (Coinsurance Amount in 1st calendar year) • 11 (Coinsurance Amount in 2nd calendar year) • 08 (Lifetime Reserve Amount in 1st year) • 10 (Lifetime Reserve Amount in 2nd year) • 06 (Medicare Blood Deductible) • 80 (Covered Days) • 81 (Non-covered Days) • 82 (Coinsurance Days) • 83 (Lifetime Reserve Days) *Note:* **For Medicare Part A:** Coinsurance amounts use Value Codes 9-11 (CAS segments are not required). **For Medicare Part A:** Deductible (previously identified by Value Codes A1, B1, C1) are to be reported in the CAS (Claim Adjustment Group Code “PR” = Patient Responsibility) segment.

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 IBC 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 IBC.
2310E	N3	Service Facility Location Address		When the 2310E Service Facility Location Name loop is sent, this N3 Location Address segment must be the physical location where the service was rendered. Post Office Box, Lockbox, or similar delivery points that cannot be the service location will not be accepted in this segment.
2310E	N4	Service Facility Location City/State/ZIP		
	N403	ZIP Code		The full 9 digits of the ZIP+4 Code are required. The last four digits cannot be all zeros.
2310F	NM1	Referring Provider Name		Referring Provider Name loop and segment limited to one per claim.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2320	CAS	Other Subscriber Information		IBC requires this information either at this 2320/CAS (claim level) or the 2430/CAS (service line) when the Loop 2000B/SBR01 is other than 'P'. *Note:* **For Medicare Part A:** Deductible (previously identified by Value Codes A1, B1, and C1) should be reported as follows in the 2320 loop: • CAS01 = "PR" (Patient Responsibility) • CAS02 = 1 (Deductible) **For Medicare Part A:** Coinsurance amounts (previously identified by Value Codes A2, B2, C2) use Value codes 09-11 (CAS Segment is not required). **For Medicare Part B:** Coinsurance amounts should be submitted at the 2430 loop. • CAS01 = "PR" (Patient Responsibility) • CAS02 = 2 (Coinsurance)
	CAS01	Claim Adjustment Group Code	CO CR OA PI PR	**CO** (Contractual Obligations) **CR** (Corrections and Reversals) **OA** (Other Adjustments) **PI** (Payer Initiated Reductions) **PR** (Patient Responsibility)
	CAS02	Claim Adjustment Reason Code		Enter Adjustment Reason Code at the claim level.

005010X223A2 Health Care Claim: Institutional				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	NM109	Other Payer Primary Identifier		Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop. Use a unique number that identifies the other payer in the submitter's system. If the submitter's system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique for each other payer within this transaction.
2410	LIN	Drug Identification		IBC requires submission of Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Populate LIN01 with 'N4' and LIN02 with the National Drug Code (NDC).
2410	CPT	Pricing Information		IBC requires the submission of Loop ID 2410 and the provision of a price specific to the NDC provided in LIN03 that is different from the price reported in SV102.
	CPT04	Quantity		Enter National Drug Unit Count
	CPT05-1	Unit or Basis for Measurement	F2 GR ME ML UN	**F2** for International Unit **GR** for Gram **ME** for Milligram **ML** for Milliliter **UN** for Unit
2410	REF	Reference Identification		IBC requires the submission of Loop ID 2410 if dispensing of the drug has been done with an assigned Rx number.
	REF01	Reference Identification Qualifier	XZ	
	REF02	Reference Identification		Prescription Number

10.3 005010X214 Health Care Claim Acknowledgment (277CA) – Generated on Highmark Platform

Refer to Section 7.4 for IBC business rules and limitations for this specific transaction.

IBC started moving claims processing to the Highmark platform in the fourth quarter of 2013.

During the migration period, some claims will be processed on the IBC current platform. For those claims, IBC will return a U277 transaction. Other claims will be processed on the Highmark platform and will return a 277CA transaction with the attributes described below.

Once the transition to the Highmark platform is complete, trading partners will receive only the 277CA transaction.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code		This matches the ID in the GS03 of the claim transaction.
	GS03	Application Receiver's Code		This is the DataStream Trading Partner ID for the entity receiving this transaction.
2100A	NM1	Information Source Name		
	NM109	Information Source Identifier		This matches the payer ID in the GS03 of the claim transaction.
2100B	NM1	Information Receiver Name		
	NM109	Information Receiver Identifier		This is the DataStream Trading Partner ID for the entity that submitted the original 837 transaction.
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.
	STC01-1	Health Care Claim Status Category Code	A1	Default value for this status level.
	STC01-2	Health Care Claim Status Code	19	Default value for this status level.

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	STC01-3	Entity Identifier Code	PR	Default value for this status level.
	STC03	Action Code	WQ	This element is set to WQ to represent Transaction Level acceptance. Claim specific rejections and acceptance will be reported in Loop 2200D.
	STC04	Total Submitted Charges		In most instances this is 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. See Section 7.4 about the exception process.
2200C		Provider of Service Information Trace Identifier		The 2200C loop is 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.
	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		
	DTP02	Date Time Period Format Qualifier	RD8	RD8 will always be used.
	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.
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		

005010X214 Health Care Claim Acknowledgment				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	DTP02	Date Time Period Format Qualifier	RD8	RD8 is used
	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.

10.4 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on Highmark Platform

Refer to Section 7.5 for IBC business rules and limitations for this specific transaction.

During the IBC transition to the Highmark platform, you will receive 835 remittance transactions generated from both the current IBC platform and the Highmark platform.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54704	This should be a hardcoded value for IBC business.
	GS03	Application Receiver's Code		This will always be the DataStream Trading Partner ID for the entity receiving this transaction.
	BPR	Financial Information		
	BPR01	Transaction Handling Code	H	**RT Estimation and Adjudication use:** This value will always be used since no actual payment is being made.
	BPR04	Payment Method Code	NON	**RT Estimation and Adjudication use:** This value will always be used since no actual payment is being made or money moved.
	REF	Receiver Identification		

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	REF02	Receiver Identification		This will be the DataStream Trading Partner ID assigned by Highmark's EDI Operations for transmission of Health Care Claim Payment/Advice (835) transactions
1000A	REF	Additional Payer Identification		
	REF01	Reference Identification Qualifier	NF	This value will always be used.
	REF02	Additional Payer Identification	54704	IBC
1000B	REF	Additional Payee Identification		
	REF01	Additional Payee Identification Qualifier	TJ	
	REF02	Additional Payee Identifier		Additional Payee Number
2000	LX	Header Number		A number assigned for the purpose of identifying a sorted group of claims.
	LX01	Assigned Number	1	All claims except IBC Identified Overpayment reversal and correction claims where refund offset is delayed.
	LX01	Assigned Number	2	IBC Identified Overpayment reversal and correction claims where refund offset is delayed. Refer to Section 7.5 of this document for further information.
2100	CAS	Claim Adjustment		
	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.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	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	Crossover Carrier Name		This segment will only be used to report a 'Blue on Blue' Coordination of Benefits coverage situation. In this situation, IBC indicates the claim has been processed by IBC and is being transferred to a second IBC coverage.
2100	NM1	Corrected Priority Payer Name		
	NM108	Identification Code Qualifier	PI	IBC uses this value
	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		
	REF01	Reference Identification Qualifier	CE	
	REF02	Other Claim Related Identifier		**Professional claims:** This value is used to provide the payer's Class of Contract Code and code description. **Institutional claims:** This value is used to provide the Reimbursement Method Code.
2110	SVC	Service Payment Information		

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	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		
	PLB01	Reference Identification		When the provider is a covered health care provider under HIPAA, the National Provider Identifier (NPI) assigned to the provider is required.
	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. Refer to Section 7.5 for more information.
	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. Refer to Section 7.5 of this document for more information on interest related to deferred refunds.
	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. Refer to Section 7.5 for more information.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	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 X12/005010X221A1 Health Care Claim Payment/Advice (835), Section 1.10.2.12 Balance Forward Processing.
	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 IBC Claim Number for the claim associated to this refund recovery. For IBC identified overpayments, the claim number will be followed by the word “DEFER” (example: 06123456789DEFER) when the reversal and correction claims are shown on the current Health Care Claim Payment/Advice (835), but the refund amount will not be deducted until after the appeal period. Refer to Section 7.5 for more information on Claim Overpayment Refunds.

10.5 005010X221A1 Health Care Claim Payment/Advice (835) – Generated on the IBC Platform

Refer to Section 7.6 for IBC business rules and limitations for this specific transaction.

During the IBC transition to the Highmark platform, you will receive 835 remittance transactions generated from both the current IBC platform and the Highmark platform. This section describes the transaction generated on the IBC platform.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS	Functional Group Header		
	GS02	Application Sender's Code	54704	This should be a hardcoded value for IBC business.

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	GS03	Application Receiver's Code		This will always be the DataStream Trading Partner ID for the entity receiving this transaction.
2100	DTM	Coverage Expiration Date		
	DTM01	Date/Time Qualifier	036	Expiration Date: This is the expiration date of the patient's coverage.
	DTM02	Date		Date expressed as CCYYMMDD
1000A	PER	Payer Technical Contact Information		
	PER01	Contact Functional Code	BL	Technical Department
	PER02	Name		Payer Contact Name
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
	PLB	Provider Level Adjustment		
	PLB01	Reference Identification		When the provider is a covered health care provider under HIPAA, the National Provider Indicator (NPI) assigned to the provider must be provided.
2110	SVC	Service Payment Information		
	SVC01-1	Product/Service ID Qualifier	HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
2100	REF	Service Identification		
	REF01	Payee Additional Identification Qualifier	APC	Ambulatory Payment Classification
2110		Service Payment Information		
	REF01	Reference Identification Qualifier	6R	Provider Control Number – new data element for Facility Claims
1000A	PER	Payer Contact Information		

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
	PER01	Contact Function Code	CX	Payers Claim Office
	PER02	Name		Payer Contact Name
	PER03	Communication Number Qualifier	TE	Telephone
	PER04	Communication Number		Payer Contact Communication Number
Header	DTM			
	DTM01	Date/Time Qualifier	405	Production
	DTM02	Date		Date expressed as CCYYMMDD
2100	REF	Rendering Provider Identification		
	REF01	Payee Additional Identification Qualifier	1A	IBC Provider Number
	REF02	Rendering Provider Identifier		Rendering Provider Identifier
1000B	N1	Payee Identification		
	N103	Identification Code Qualifier	XX	National Provider ID
	N104	Payee Identification Code		National Provider ID Number
1000B	REF	Payee Additional Identification		
	REF01	Payee Additional Identification Qualifier	PQ TJ	**PQ:** IBC Provider Number **TJ:** Federal Tax ID
	REF02	Additional Payee Identifier		Additional Payee Number
2100	NM1	Service Provider Name		
	NM108	Payee Additional Identification Qualifier	BD FI XX	**BD:** IBC Provider Number **FI:** Federal Tax ID **XX:** National Provider ID
	NM109	Rendering Provider Identifier		Rendering Provider Identifier

005010X221A1 Health Care Claim Payment/Advice				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2110	REF	Rendering Provider Identification		
	REF01	Payee Additional Identification Qualifier	1A	IBC Provider Number
	REF02	Rendering Provider Identifier		Rendering Provider Identifier

10.6 005010X231A1 Implementation Acknowledgment for Health Care Insurance (999)

Refer to Section 7.6 for IBC business rules and limitations for this transaction.

005010X231A1 Implementation Acknowledgment For Health Care Insurance				
Loop ID	**Reference**	**Name**	**Codes**	**Notes/Comments**
2100	CTX	Segment Context		Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.
2100	CTX	Business Unit Identifier		Highmark has implemented levels 1 through 4 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		Highmark has implemented levels 1 through 4 edits only. This CTX segment will not be used at this time.

Appendices

1. Implementation Checklist

IBC does not have an Implementation Checklist.

2. Business Scenarios

No business scenarios at this time.

3. Transmission Examples

No examples at this time.

4. Frequently Asked Questions

No FAQs at this time.

5. Change Summary

The items listed in the chart below were revised from the September 2013 version to this December 2013 version of the Companion Guide. Please note that there were no changes to transaction-specific information or codes.

Page(s)	Section	Description
8	Scope	Updated migration status, updated naming convention for Highmark, Inc.
10	Working with Highmark Inc. ("Highmark")	Updated naming convention for Highmark, Inc.
14	Trading Partner Registration	Added "Delegate" indicator for Update software vendor category
15, 26-27, 32, 57	Multiple	Updated migration status
29	005010X221A1 Health Care Claim Payment/Advice (835) – Generated on Highmark Platform	Revised overpayment process language
32	005010X221A1 Health Care Claim Payment/Advice (835) – Generated on Highmark Platform	Removed Real-time Health Care Claim Payment/Advice (835) Response
37	005010X222A1 Health Care Claim: Professional (837P)	Removed FEP and BlueCard and added MAPPO in Reference GS03 under 54704
40	005010X222A1 Health Care Claim: Professional (837P)	Removed FEP and BlueCard and added MAPPO from Loop ID 2010BB, Reference NM109 under 54704
43	005010X222A1 Health Care Claim: Professional (837P)	Moved ZIP Code requirement information from Loop ID 2310B to 2310C

59-63	005010X221A1 Health Care Claim Payment/Advice (835) – Generated on Highmark Platform	Removed references to Real-time Health Care Claim Payment/Advice (835), revised overpayment process language