



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

September 2009

Subject: Changes for the 834 transactions

Dear software developer,

A revised updated copy of the *BCBSM EDI Professional 834 Companion Document* is now online at: bcbsm.com/group/pdf/834_comp.pdf

The table below summarizes the changes to the 834 transactions.

Section	Description of Change	Page(s)
Appendix A - CDHP Product Identifiers		
Appendix A - CDHP Product Identifiers	Revised	11

If you have any questions regarding this information, please call the Electronic Data Interchange department, at 800-542-0945.

Sincerely,

Handwritten signature of Wanda Brideau in cursive.

Wanda Brideau
Manager, e-Business Interchange Group

Handwritten signature of John Bialowicz in cursive.

John Bialowicz
Manager, ETP Contracting and Relations
e-Business Interchange Group

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan HIPAA EDI Companion Document
American National Standards Institute (ANSI) ASC X12N 834 (004010X095A1) Benefit Enrollment and Maintenance

Published February 2004



Table of Contents

Table of Contents.....	1
Introduction	2
ANSI ASC X12N Benefit Enrollment and Maintenance 834 (004010X095A1) – Reporting Instruction Clarifications.....	3
General Overview.....	3
834 Architecture	3
Linking a Dependent to a Subscriber within the Transaction.....	3
Terminations.....	3
Updates Versus Full File Audits	4
Coverage Levels and Dependents.....	4
Consumer Driven Health Plans for the Blue Healthcare Bank (CDHP for BHB).....	5
Maximums/Limitations	5
Character set Requirement.....	5
Accepted EDI Transmission Methods	5
Enrollment 834 Interchange Envelope and Functional Group Structure	7
Data Requirements for the 834 Transaction Set	8
Appendix A – CDHP Product Identifiers	11

Introduction

This document is the property of Blue Cross Blue Shield of Michigan (BCBSM) and is for use solely in your capacity as a Trading Partner of health care transactions with BCBSM, Blue Care Network (BCN) and National Account Services Corporation (NASCO). NASCO is referred to in this document as BCBSM National.

This document provides information related to specific elements within the addenda version of the ANSI ASC X12N 834 transaction, but does not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.¹

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N 834 transaction set Addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by the Washington Publishing Company. Implementation Guides can be downloaded from the Washington Publishing Company web site at www.wpc-edi.com. Copyright (c) 2000, Data Interchange Standards Association on behalf of ASC X12.Format (c) 2000, Washington Publishing Company. All Rights Reserved.

All instructions were written as known at the time of publication and are subject to change based on mutually agreed-upon conditions between BCBSM/BCN, BCBSM National and their customers. Changes will be communicated in future letters and on the BCBSM web site: www.bcbsm.com.

Appropriate steps must be taken before submitting production Addenda ANSI ASC X12N transactions, such as testing, approval to submit EDI data by the appropriate BCBSM/BCN membership and technical units and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please contact your membership agent.

¹Standards for Electronic Transactions, *Federal Register*, Vol. 65, No. 160, August 17, 2000 pg. 50368

ANSI ASC X12N Benefit Enrollment and Maintenance 834 (004010X095A1) – Reporting Instruction

Clarifications

General Overview

The Health Insurance Portability and Accountability Act (HIPAA) require that all health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The Addenda version of the ANSI ASC X12 834 transaction set was selected as the HIPAA-mandated format for electronic enrollment and disenrollment in a Health Plan. The major difference between the 834 and the other HIPAA mandated transaction sets is the flexibility to contractually arrange for submission of select data fields within the format.

834 Architecture

BCBSM follows the addenda version of the ANSI X12 834 transaction Implementation Guide and this companion document provides specific clarifications for formatting of data within the transactions to enable updating of our membership systems.

Linking a Dependent to a Subscriber within the Transaction

Subscribers and dependents are sent as separate occurrences within the electronic file. While the initial enrollment for the subscriber must be sent before sending the initial enrollment for a dependent, the enrollment of the dependent may occur in the same transmission or sent separately in a later transmission. Maintaining the existing enrollment of a subscriber and dependents can occur in any sequence when sending an incremental file (BGN08=2).

To allow linkage between the subscriber and dependents, a subscriber number is reported as the identifier to link all members associated with a subscriber.

Terminations

Terminations are identified by the following rules:

- If the termination date is passed for a subscriber, then all coverage for that subscriber and all associated dependents will be terminated effective that date.
- If the termination date is passed for a dependent, then all coverage for that dependent will be terminated effective that date. The coverage for the subscriber and other dependents will not be affected.
- If the termination date is passed at the insurance coverage level for any member, then coverage for that specific insurance product for that member will be terminated effective that date. Coverage for other insurance products for that member will not be affected nor will coverage for other members linked to the same subscriber.
- Terminating all covered insurance products for a dependent at the insurance coverage level is the equivalent of terminating that dependent at the member level.
- Terminating all insurance products for a subscriber at the insurance coverage level will terminate coverage for the subscriber and dependents. Dependents cannot have more coverage than the subscriber.
- In the case of a transfer from one coverage to another, it is necessary to terminate the old coverage and then add the new coverage. An add to a new coverage must never be assumed to result in the automatic termination of the prior coverage.

Updates Versus Full File Audits

The 834 transaction set can be used to provide either updates to the membership database or full file audits against the membership database.

An update is either an add, terminate or change request. This transaction only contains information about the changed members.

A full file audit lists all current members. This facilitates keeping the sponsor's and payer's systems synchronized. It is not intended to contain a history of all previous enrollments.

Full files can be used, but are not recommended for Blue Care Network (when sending a file, the dependent records should follow the subscriber records).

Submitters are encouraged to send terminations on full and change files.

BGN08 is used to indicate whether the transaction is a full file audit (4) or an update (2). When sending a full file audit, Loop 2000, INS03 must be 030. INS04 must be XN and Loop 2300, HD01 must be 030.

Coverage Levels and Dependents

The contract between the payer and the submitter must identify the member reporting requirements for the 834 transaction set. Reporting of the coverage level code (e.g., individual, family.) is reported at the employee level. Changes for the employee may need to be submitted with the addition or termination of a dependent or coverage level.

- The identification number of the submitter is their Federal Taxpayer's Identification.
- The Maintenance Type Code identifies the action to be taken for this member. Valid code values are:
 - 001 – Change
 - 021 – Addition
 - 024 – Cancellation or Termination
 - 025 – Reinstatement
 - 030 – Audit or Compare

The codes reported in Loop 2300 HD01 segment should correspond accordingly to the code report in Loop 2000, INS03.

- Group numbers are reported in the 2000 REF Segment (1L identifier code) and/or Loop 2300 REF Segment (1L identifier code). The student status is only required when describing a non-spouse dependent whose age requires a qualifying condition for enrollment. The Plan contract needs to define the age requirements for students.
- The date of death does not replace use of the termination date. Report termination dates.
- Birth sequence number is required for family members with the same birth date.
- Medicare A and B benefits begin or end dates are reported in the 2320 COB loop. For BCN, MEDA, MEDB and /or MEDPRIMARY should be entered in the associated 2320 N102 Segments. For BCBSM PPO and Traditional, PART A and PART B should be entered in the associated 2320 N102 segments.
- Corrected insured information must be submitted in addition to the original information, when applicable.

- Disability information should only be sent when enrolling a disabled member or when disability information about an existing member is added or changed. This information should be reported in INS10.

Consumer Driven Health Plans for the Blue Healthcare Bank (CDHP for BHB)

Refer to the Data Requirements section for details to report information related to Health Savings Account (HSA), Health Reimbursement Account (HRA) and Flexible Spending Account (FSA) benefits.

Maximums/Limitations

- BCBSM/BCN accepts transmissions containing more than 10,000 INS segments per transaction.
- When possible, lines of business should be submitted in separate submissions (i.e., all PPO together, all HMO together or all POS together).

Character set Requirement

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field. All Transactions must be submitted in upper-case characters.

A...Z	0...9	!	“	&	,	()	+
'	-	.	/	;	?	=	@	Space

Accepted EDI Transmission Methods

EDDI - EDI Data Link

- A) SFTP - Secure FTP over the Internet (SSH - port 22)
 BCBS supports PKZIP, Compress, and Gzip

- B) FTP - File Transfer Protocol
 - FRAME RELAY
 Data is transferred using GETS and PUTS
 - LEASED LINE
 Data is transferred using GETS and PUTS
 - INTERNET
 GET - BCBSM pulls files from the customer’s site.
 Data must be encrypted using PGP or GNU PG software
 PGP = Pretty Good Privacy
 GNU PG = GNU Privacy Guard
 - VPN – INTERNET (Virtual Private Network)
 Data is transferred using GETS and PUTS

C) E-MAIL

INTERNET

Encrypted Data sent via E-mail

Data must be an encrypted attachment using
PGP software or GNU PG software

D) HTTP

Data sent over the Internet using HTTP

HTTP = Hyper Text Transport Protocol

BCBSM pulls files from the customer's site

Data must be encrypted using PGP or GNU PG software

E) HTTPS

INTERNET

Data sent over the Internet using Secure HTTP

BCBSM pulls files from the customer's site

HTTPS must use 128 bite encryption methods

Enrollment 834 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS) and Functional Group Structure (GS) guidelines for HIPAA that are located in the HIPAA implementation guides in Appendices A and B. Specific BCBSM data values are listed below.

Element Name	Element	Instruction	Imp Gde Pg#
Authorization Information Qualifier	ISA01	Report 00.	B.3
Authorization Information	ISA02	Report spaces.	B.3
Security Information Qualifier	ISA03	Report 00.	B.4
Security Information	ISA04	Report spaces.	B.4
Interchange ID Qualifier	ISA05	Report ZZ.	B.4
Interchange Sender ID	ISA06	Report the Federal Tax ID of the Submitter.	B.4
Interchange ID Qualifier	ISA07	Report ZZ.	B.4
Interchange Receiver ID	ISA08	Report 382069753.	B.5
Interchange Date	ISA09	Report the date that the interchange was created in YYMMDD format.	B.5
Interchange Time	ISA10	Report the time that the interchange was created in HHMM format.	B.5
Interchange Control Standards Identifier	ISA11	Report U.	B.5
Interchange Control Version Number	ISA12	Report 00401.	B.5
Interchange Control Number	ISA13	Report the Sender-defined control number.	B.5
Acknowledgement Requested	ISA14	Report 0 or 1.	B.6
Usage Indicator	ISA15	Report P when submitting production data, T when submitting test data.	B.6
Component Element Separator	ISA16		B.6
Number of Included Functional Groups	IEA01	Report the number of functional groups submitted in the interchange.	B.7
Interchange Control Number	IEA02	Report the same Control # provided in ISA13.	B.7
Functional Identifier Code	GS01	Report BE.	B.8
Application Sender's Code	GS02	Report the Federal Tax ID of the Submitter.	B.8
Application Receiver's Code	GS03	Report 382069753.	B.8
Date	GS04	Report the date that the interchange was created in CCYYMMDD format.	B.8
Time	GS05	Report the time that the interchange was created in HHMM format.	B.8
Group Control Number	GS06	Report the Sender-defined control number.	B.9
Responsible Agency Code	GS07	Report an X.	B.9
Version/Release/Identifier Code	GS08	Report 004010X095A1.	B.9
Number of Transaction Sets Included	GE01	Report the number of transaction sets included in the functional group.	B.10
Group Control Number	GE02	Report the same Sender-defined value provided in GS06.	B.10

Data Requirements for the 834 Transaction Set

Loop	Segment/Element	Instruction	Industry/Element Name
Header	BGN08	The BGN08 action code identifies whether the file should be used to update a membership database or to verify that the payer's and submitter's systems are synchronized.	Action Code
Header	REF01 & REF02	Required for all 834 transactions. Report 38 in REF01 and one of the following master policy codes in REF02, as applicable: BCN HMO: Report HMO. BCBSM Local: Report PPO or POS. BCBSM National: Report HLT. Note: If you have split files (containing more than 1 line of business), supply a group number.	Master Policy Number
Header	DTP01	BCBSM Local and National: The following dates are required: 007 – Effective 303 – Maintenance Effective	Date/Time Qualifier
1000A	N101 & N102	Report P5 in N101 and the constant name of the submitter in N102.	Plan Sponsor Name
1000B	N104	Report 382069753.	Insurer Tax ID
1000C	N103 & N104	Report 94 in N103 and the BCBSM agent code in N104 when applicable.	Qualifier and TPA or Broker Identification Code
2000	DTP01	BCBSM and BCN HMO: Only the following qualifiers will be recognized: 336 – Employment begin 356 – Eligibility begin 340 – COBRA begin 357 – Eligibility end 341 – COBRA end	Employment Begin and COBRA End Date
2000	INS04	When enrolling a surviving spouse, report 11 in INS04 and S in INS05.	Maintenance Reason Code
2000	REF01 & REF02	Report 0F in REF01 and the contract number (e.g., SSN) of the subscriber in REF02.	Subscriber Number
2000	REF01 & REF02	For proper adjudication of your enrollment files, we strongly encourage you to report the group number. BCN HMO: Report 1L in REF01 and the insured's group number in REF02. BCBSM Local: Report 1L in REF01 and the insured's group number followed by the group-suffix in REF02 (e.g. xxxxx-xxx). Include dash. BCBSM National: The group number is reported in HD04 of Loop 2300.	Group or Policy Number
2000	REF01 & REF02	BCN HMO: Report 17 in REF01 and the insured's Class I.D. in REF02.	Client Reporting Category
2000	REF01 & REF02	BCN HMO: Report DX in REF01 and the insured's Sub-Group I.D. in REF02.	Department/Agency Number
2000	REF01 & REF02	Report qualifier F6 and the member's health insurance claim (HIC) number when the member has Medicare coverage.	Medicare HIC Number
2100A	NM108 & NM109	BCBSM National: The member's social security number may be required. When reported, must be the Social Security Number (SSN) of the insured identified in NM103-NM107 of this segment.	Insured Identifier
2100A	PER Segment	Only home and work phone numbers will be recognized.	Member Communication Number
2100A	DMG03	For proper updating, limit usage to codes M and F.	Member Gender Code
2100A	DMG04	Only values of I and M will be recognized for BCBSM Local and BCN enrollment.	Marital Status Code

Loop	Segment/Element	Instruction	Industry/Element Name
2100A	HLH01	Health related code may be required for specific submitters. N – None T – Tobacco use	Health Information
2200	DSB Segment	Required for BCBSM enrollment when member is disabled and Medicare coverage is secondary to their BCBSM coverage.	Disability Information
2300	HD Segment	For proper adjudication of your enrollment files, we strongly encourage you to report at least one HD loop.	Health Coverage
2300	HD03	Report one of the following lines of business: BCN HMO: Report HMO. BCBSM Local: Report PPO for Traditional or Preferred Provider Organization (PPO) coverage or POS for Point of Service (POS) health coverage. BCBSM National: Report HLT or appropriate Insurance Line Code. BCBSM Local and National: Report HLT for each CDHP product.	Insurance Line Code
2300	HD04	For proper adjudication of your enrollment files, we strongly encourage you to report the information if requested. BCN HMO: Do not report as this data is internally generated by BCN. BCBSM Local: Report the 12-character service code. BCBSM National: Report the applicable group, section and package code. BCBSM Local and National: For HSA, HRA or FSA benefits complete this data element as follows: report CDH in positions 1 - 3, space fill position 4, report the product identifier (refer to Appendix A for a list of valid product identifier codes) in positions 5 – 12 (left justified and space filled), report the goal amount (if applicable) in positions 13 – 21 (formatted as 999999.99 or leave blank), and for BCBSM National report the product indicator (will be provided upon enrollment with a CDHP product) in positions 22 - 25. Note: Reporting of HSA, HRA or FSA benefits requires submission of an additional HD segment to provide the CDH related information. Each product selected by the member requires a separate HD Loop. Example: HD*021**HLT*CDH FSA 001000.00*EMP~	Plan Coverage Description
2300	DTP02	BCN HMO: Use only codes 348 (Benefit Begin) and 349 (Benefit End). Do not report the maintenance date in this segment. The maintenance date should only be reported in the Header record.	Benefit Begin and Benefit End Date
2300	REF01 & REF02	BCN HMO: Not used at this level unless necessary for exception reporting. BCBSM Local: Report 1L in REF01 and the insured's group number followed by the group-suffix in REF02 (e.g. xxxxx-xxx). Include dash. BCBSM National: Report 1L in REF01 and the insured's group/section in REF02. BCBSM POS: Report 1L in REF01 and the insured's group number followed by the group-suffix in REF02 (e.g. xxxxx-xxx). Include dash.	Policy or group number
2300	REF01 & REF02	BCBSM National: Report 17 in REF01 and Plan Code in REF02.	Client reporting category
2300	IDC Segment	At this time, BCBSM cannot support this functionality.	Identification Card
2310	NM1 Segment	BCN: This segment is used to report information related to the Primary Care Provider. The NPI of the Primary Care Provider should be reported when available. Otherwise, report the name of the PCP and either their identifier from the hardcopy provider directory or their physician number from www.mibcn.com.	Provider Name

Loop	Segment/Element	Instruction	Industry/Element Name
2320	N102	Report Medicare Part A, Medicare Part B and/or Medicare Part D when applicable. The 2320 loop may need to be reported multiple times to accommodate this information. BCBSM PPO and Traditional: Report Part A, Part B and/or Part D. Each Medicare part will need a DTP to indicate the Benefit Begin or Benefit End dates. BCN: Report MEDA, MEDB and/or MEDPRIMARY as applicable. Medicare Part D not applicable.	Coordination of Benefits

Appendix A – CDHP Product Identifiers

Product Identifier (Account Codes)	Full Product Name (Account Code Name)	Meaning
HSA	HSA	HSA
HRA	HRA	HRA
HRALPDEN	HRA Limited Purpose Dental	HRA Limited Purpose Dental
HRALPVIS	HRA Limited Purpose Vision	HRA Limited Purpose Vision
HRALPDV	HRA Limited Purpose Dental & Vision	HRA Limited Purpose Dental & Vision
FSA	FSA Medical	FSA Health Care Full
FSALPDEN	FSA Medical	FSA Limited Purpose Dental
FSALPVIS	FSA Medical	FSA Limited Purpose Vision
FSALPDV	FSA Medical	FSA Limited Purpose Dental & Vision
FADEPCA	FSA Dependent Care	FSA Dependent Care
FSATRANS	FSA Transportation	FSA Transportation
FSAPARK	FSA Parking	FSA Parking
HRAPDED	HRA Post Deductible	HRA Post Deductible
HRARET	HRA Retiree only	HRA Retiree only
FSAPDED	FSA Medical	FSA Post Deductible
FSASPEN	FSA Medical	FSA Limited Purpose Dental + Post Deductible
FSASPVIS	FSA Medical	FSA Limited Purpose Vision + Post Deductible
FSASPDV	FSA Medical	FSA Limited Purpose Dental & Vision + Post Deductible
HRASPDEN	HRA Special Purpose Dental	HRA Limited Purpose Dental + Post Deductible
HRASPVIS	HRA Special Purpose Vision	HRA Limited Purpose Vision + Post Deductible
HRASPDV	HRA Special Purpose Dental & Vision	HRA Limited Purpose Dental & Vision + Post Deductible