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March 2008

Dear Software developer,

A revised, updated copy of the *BCBSM EDI U277 Companion Document* is now online at:  
[http://www.bcbsm.com/pdf/physicians\\_resources\\_edi\\_277.pdf](http://www.bcbsm.com/pdf/physicians_resources_edi_277.pdf)

The table below summarizes the changes made.

Section	Description of Change	Page(s)
Table of Contents	Replaced Table of Contents.	TOC
<b>ANSI ASC X12.317 Health Care Payer Unsolicited 277 Claim Status - Clarifications</b>		
General Overview	Revised 2 <sup>nd</sup> paragraph. Revised 1 <sup>st</sup> , 2 <sup>nd</sup> and 3 <sup>rd</sup> bullets.	3
Maximums/Limitations	Revised 1 <sup>st</sup> , 2 <sup>nd</sup> and 3 <sup>rd</sup> bullets.	3
Telecommunication Options	Revised	3
<b>Health Care Payer Unsolicited Claim Status 277 Transaction Set Data Clarifications</b>		
Loop 2100, Segment NM108 & NM109	Revised Instruction.	5
Loop 2200, Segment STC01-1, STC01-2 & STC01-3	Loop – added 2220. Revised Instruction.	5
Loop 2200, Segment STC12	Added.	5

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

Sincerely,

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**Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document  
American National Standards Institute (ANSI) ASC X12 Version 4010 Health Care Payer  
Unsolicited Claim Status**

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## **Introduction**

This document is the property of Blue Cross Blue Shield of Michigan and is for use solely in your capacity as a Trading Partner of health care transactions with BCBSM.

This document is a companion to the ANSI ASC X12.317 Unsolicited 277 transaction set Implementation Guide. Though BCBSM advised trading partners to follow the Version 3070 implementation guide, we will return the 4010 standard of the transaction. Specific payer instructions contained in this document are for clarification purposes only and should be used in conjunction with the applicable Implementation Guide published by the Washington Publishing Company. Implementation Guides can be purchased from the Washington Publishing Company Web site at [www.wpc-edi.com](http://www.wpc-edi.com).

This document is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the BCBSM Web site: [www.bcbsm.com](http://www.bcbsm.com).

Appropriate steps must be taken before receiving production Unsolicited 277 transactions, such as completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please call the EDI Help Desk at 800-542-0945.

## **ANSI ASC X12.317 Health Care Payer Unsolicited 277 Claim Status – Clarifications**

### **General Overview**

The ANSI ASC X12 Unsolicited 277 transaction was selected by BCBSM EDI as the format to return the notification of claim statuses for claims that did not reach the processing system; specifically, claims that have front end reject edited. Claims that receive an Unsolicited 277 reject edit must be corrected and resubmitted.

This transaction set is used to return reject edit information for claims submitted in the 837 format for professional, institutional, vision, hearing and dental. The information in the Unsolicited 277 transactions is also available in report form. Trading partners can choose to receive the report format, the X12 transaction or both.

- Errors for transactions containing claims that do not conform to the Implementation Guide will be returned in either a TA1 (Interchange Acknowledgement) or 997 (Functional Acknowledgement) instead of the 277.
- Claim responses will be returned to the submitter of the original claims for the following payers: BCBSM, BCN, FEP, Medicare, Medicare Advantage/Medicare Plus Blue, Medicaid, PPOM (professional claims only) and Commercial (professional claims only).
- Provider identifiers in the Unsolicited 277 (U277) transaction and U277 edit report will either be an NPI or the Legacy Provider Identifier PIN, but not both.

### **Maximums/Limitations**

- Status responses will be returned at the claim and service levels, with the exception of commercial responses which will only be returned at the claim level.
- Responses are returned for EDI front-end rejects and subsequent rejects for Commercial, Medicare Advantage and the BCBSM Local professional claims processing systems. BCBSM Facility Local Systems rejects continue to be returned in the Control Log Report Format.
- Most EDI Clearinghouse payers will perform additional editing, at their discretion, upon receipt of files. Trading partners should contact those payers on specific formats and dates of availability (e.g., WPS prepass edit report (professional), DMERC pre-pass edit report and NGS GENRESPONSE report).
- When a service is rejected on a claim, all services within the claim should also be resubmitted.
- A maximum of three edit rejects will be returned per claim/service at this time.

### **Telecommunication Options**

**EDI DataLink** - EDI DataLink transmits and receives electronic claims and data files to and from BCBSM using Secure File Transfer Protocol (SFTP).

### **Character Set Requirement**

The following character set guidelines will be followed to avoid file rejections

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

**Medical Code Set Front End Edit Rejections**

Blue Cross Blue Shield of Michigan will validate whether HIPAA-compliant medical code sets are being submitted in the 837 Professional, Institutional and Dental Claim, 278 Referral and 276 Claim Status Inquiry transactions.

**The following types of codes will be validated:**

- ICD-9-CM (Volume 1 & 2) – diagnosis codes
- ICD-9-CM (Volume 3) – procedure codes
- HCPCS (Level 1 – CPT-4) – procedure codes
- HCPCS (Level 2) – procedure codes
- Modifiers (CPT)
- Modifiers (HCPCS)
- Revenue Codes
- CDT-4 - dental procedure codes

When a claim fails medical code set validation, the entire claim will not be accepted for processing. Transactions that fail medical code set validation will receive front-end reject edits, which can be viewed in either the Unsolicited 277 transaction or the Unsolicited 277 report. Claims that reject edit must be corrected and retransmitted.

**Unsolicited 277 Envelope and Functional Group Structure**

Transaction Set	Element	Instruction	Pg #
Health Care Claim Status Response 277	ISA05 – Interchange ID Qualifier	ZZ will be returned from EDI.	B.4
Health Care Claim Status Response 277	ISA06 – Interchange Sender ID	382069753 will be returned from EDI.	B.4
Health Care Claim Status Response 277	ISA07 – Interchange ID Qualifier	ZZ will be returned from EDI.	B.4
Health Care Claim Status Response 277	ISA08 – Interchange Receiver ID	For Institutional and Dental claims, the Federal Tax ID number of the submitter of the claim being edited will be returned. For Professional claims, the EDI-assigned Billing Location Code of the submitter of the claim being edited will be returned.	B.5
Health Care Claim Status Response 277	ISA12 – Version Number	Although the IG shows ‘00307’, EDI will return ‘00401’.	B.5
Health Care Claim Status Response 277	GS02 – Application Sender’s Code	382069753 will be returned.	B.8
Health Care Claim Status Response 277	GS08 – Version Number	Although the IG shows ‘003070X070’, EDI will return ‘004010’.	B.9

## Health Care Payer Unsolicited Claim Status 277 Transaction Set Data Clarifications

Loop	Segment/Element	Instruction	Industry/Element Name	Pg #
2100	NM108 & NM109	Qualifier PI will be returned in NM108 and one of the following Payer ID's will be returned in NM109, based on what was reported as the destination payer ID on the claim: 00710 – BCBSM, BCN & FEP Professional, Dental, Vision & Hearing, Medicare Advantage/Medicare Plus Blue 00210 – BCBSM, BCN & FEP Institutional, Medicare Advantage/Medicare Plus Blue D0111 – Medicaid Professional/Institutional 00953 – Medicare Part B, Professional 00452 – Medicare Part A, Institutional 17003 – Medicare, DMERC THIN – EDI or Commercial Payer ID from original claim. The EDI commercial Payer Table listing can be downloaded from the BCBSM website at: <a href="http://www.bcbsm.com">www.bcbsm.com</a>	Payer ID	33
2200 and 2220	STC01-1, STC01-2 & STC01-3	Health Care Claim Status Category Codes (Code Source 507) are used to organize the Health Care Claim Status Codes (Code Source 508) into logical groupings. The Claim Status Code identifies the status of an entire claim. Commercial claim reject responses (with the exception of PPOM/Cofinity) will only be provided at the claim level and will always have a claim status code of 122 (Missing/Invalid data prevents payer from processing claim). Refer to STC12 for a description of the error.	Health Care Claim Status Category Code and Health Care Claim Status Code	70 & 99
2200	STC12	Commercial claim reject responses (with the exception of PPOM/Cofinity) – Description of the error that caused the claim to not be accepted for processing.	Free-Form Message Text	102

### General EDI Terminology

**ANSI X12.317 Unsolicited 277 v3070** – HIPAA standardized ANSI X12 transaction format for claims status inquiry request and response data. Trading partners should follow the 3070 IG. However, BCBSM EDI will return the v4010 standard of the transaction.

**Data Segment** – Corresponds to a *record* in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

**Data Element** – Corresponds to a *field* in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are:

- Nn** Numeric (with an assumed number of decimal positions)
- R** Decimal Real Number (including decimal or negative sign)
- ID** Identifier
- AN** Alphanumeric string

**DT** Date

**TM** Time

**Delimiter** – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

**EDI** – An acronym for Electronic Data Interchange.

**Electronic Data Interchange** – the application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.

**Implementation guides** – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: [www.wpc-edi.com](http://www.wpc-edi.com).

**Interface** – The point at which two systems connect to pass data.

**Loops** – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

**Routing** – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

**Trading partners** – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

**Translation Software** – Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

**X12 Transaction Set** – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.

**X12N** – An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. A special health care task group within this subcommittee is responsible for the development of health care insurance transactions.