

Volume

1

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Labor Shared Claims Processing

**Electronic
Implementation
Manual**

LABOR SHARED CLAIMS PROCESSING

Electronic Implementation Manual

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Introduction

The Labor Shared Claims Process was developed as a means to allow self-administered Labor Funds to access the extensive Blue Cross and Blue Shield of Illinois (BCBSIL) PPO network. The BCBSIL network is the largest in Illinois, with more than 29,000 contracting physicians and specialists and over 200 contracting hospitals.

As the largest health insurer in Illinois, BCBSIL is able to contract for savings or negotiate lower costs with physicians and hospitals. In exchange for a steady volume of patients, network doctors and hospitals agree to provide their services at a discounted fee.

About Labor Shared Claims Processing

Labor Shared Claims Processing has been designed to allow Funds to retain control of benefit determination, membership data and claim processing methods. The goal of Labor Shared Claims Processing is to meet these requirements in the most durable, flexible and cost-effective manner possible.

The Fund and BCBSIL maintains contact with members and providers respectively. The Fund continues to correspond with members, answer claim inquiries, maintain eligibility, make payments to the members, issue Explanation of Benefits (EOB) information, retain accumulator information and collect Coordination of Benefit (COB) information.

BCBSIL will communicate with PPO providers. This arrangement allows BCBSIL to enforce established contracts with providers to receive discounts. BCBSIL will pay its providers as well as answer all their claim status inquiries.

Note: The Fund may not seek to establish independent discount arrangements with BCBSIL hospitals and ancillary providers. This includes PPO and non-PPO hospitals, as well as ancillary providers that have a discount contract with BCBSIL.

Exchange of Claim Data

All medical claims should be received by BCBSIL since most providers will electronically submit their claims directly to BCBSIL. Claims data will be sent to the Fund via the Transmission File. Once the Fund has adjudicated the claims, they will be returned to BCBSIL via the Disposition File. Details of this process will be reviewed throughout this manual. The flowchart (figure 1.1) and implementation responsibility matrix (figure 1.2) on the following pages summarize the primary flow and responsibilities of both parties.

Member Contact

The Fund is responsible for making payments and sending EOBs to its members (figure 1.1). They also communicate with members for updates to their eligibility records as well as requests for additional information.

Provider Contact

BCBSIL makes **all** payments to its contracting physicians and **all** hospitals. As with the relationship of the Funds with its members, BCBSIL handles parallel functions for its providers, including claim status inquiry and new account notifications.

Labor Shared Claims Processing Flowchart

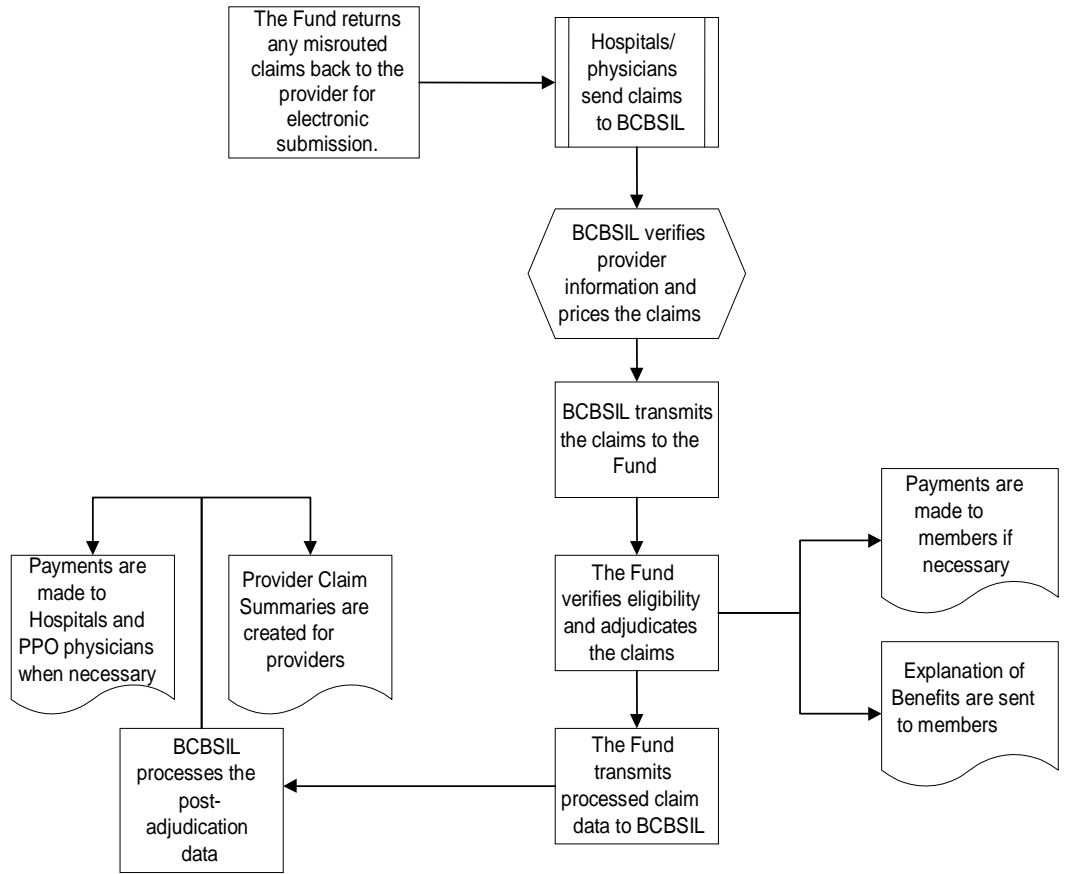


Figure 1.1

Exchange of Claim Data Roles and Responsibilities	
Technical Tasks - Software	
BCBSIL	Labor Fund

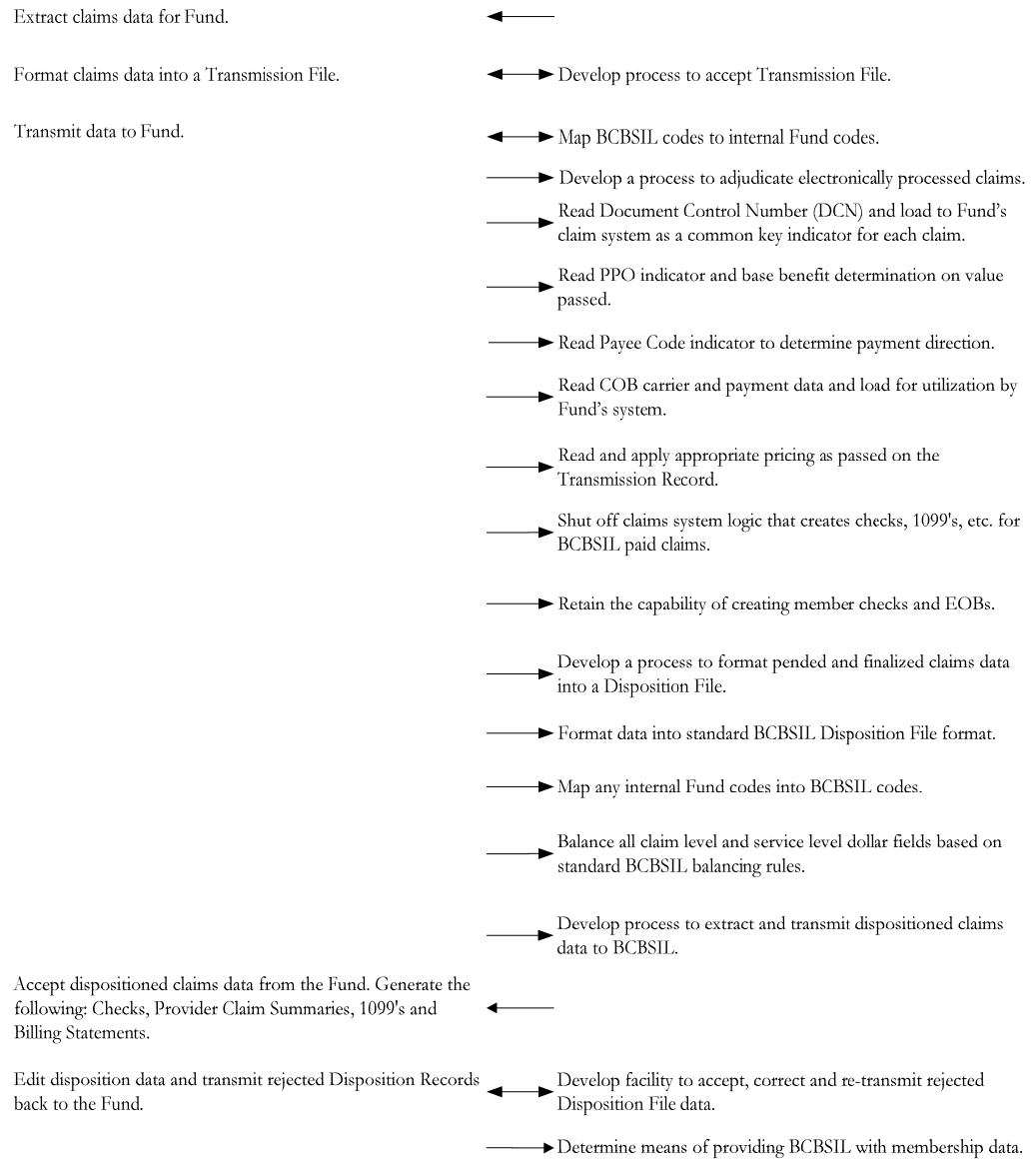
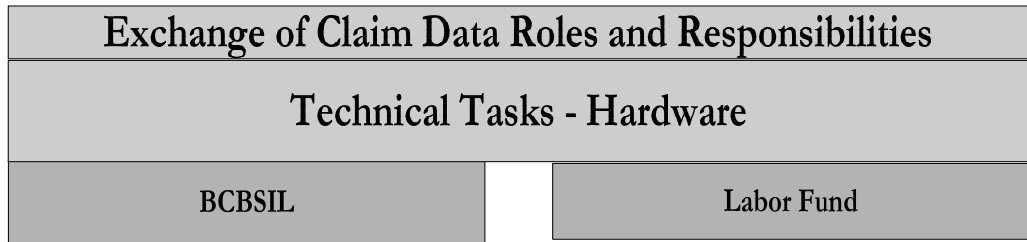
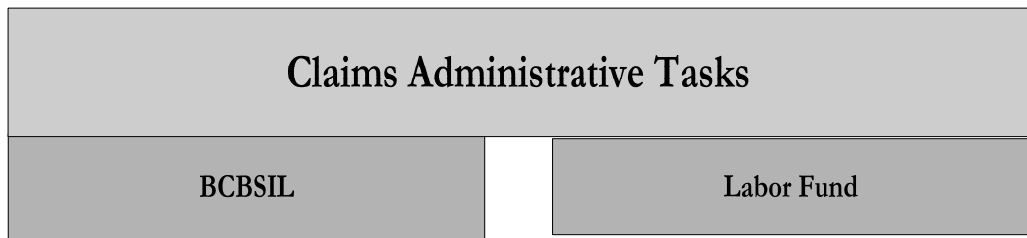


Figure 1.2



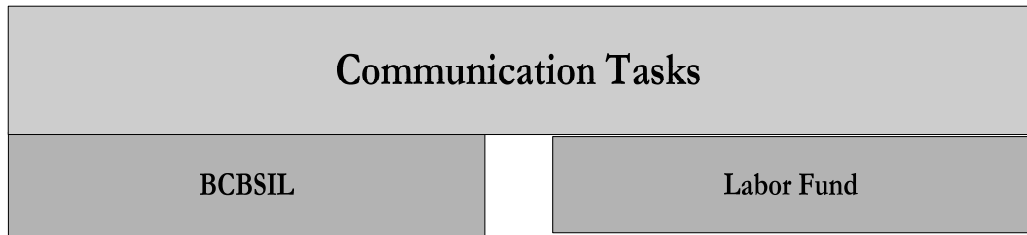
Assist Fund in evaluation of internal hardware requirements. ← → Evaluate internal hardware requirements.



Determine procedures for claims with service dates prior to the effective date. ←

Determine procedures for providing the Fund access to additional claims information. ←

→ Establish procedures for routing paper claims received by the Fund back to the provider.



Generate ID cards and forward to members or other designated party. ←

Create and distribute provider bulletin called *BlueReview*. ←

Review content of member communications materials developed by the Fund. ← →

→ Create and distribute member communications materials.

Figure 1.2

Open Communication

The key to fully understanding the process and the responsibilities of both the Fund and BCBSIL is to keep communication lines open. Extensively testing the claims transmission and disposition process will reveal areas that need to be addressed by the Implementation Team (see “Chapter 10 – Implementing the Process” for a list of team members). Once in production, it is still crucial to continue communicating questions or concerns to ensure quality claims processing is maintained.

Overview of Manual Contents

This manual has been designed to provide the most convenient access to pertinent information by specific Fund personnel. Technical information required by systems programming personnel is contained in certain chapters, while claims administrative information is provided in other chapters. Please note the following:

1. Technical personnel should review the following chapters that discuss technical and systems requirements for the Fund:
 - Pre-Adjudication Transmission File – Chapter 2
 - Claim Adjudication – Chapter 3
 - Disposition File – Chapter 4
 - Post-Adjudication Process – Chapter 5
 - Adjustments – Chapter 6
 - Support Files and Electronic Reports – Chapter 8
 - Implementing the Process – Chapter 10
 - Systems Availability – Chapter 11

2. Claims administrative personnel should review the following chapters:

- Customer Service – Chapter 7
- Support Files and Electronic Reports – Chapter 8
- Other Administrative Procedures – Chapter 9
- Implementing the Process – Chapter 10

Pre-Adjudication

The purpose of the Transmission File is to supply the Fund with the necessary data to adjudicate claims. The data elements on the file should include all information needed for the Fund to adjudicate the majority of claims.

The Transmission File also helps to standardize the claims adjudication process so that BCBSIL is always the first party to begin processing. This assures that BCBSIL applies the necessary pre-adjudication edits prior to receiving the claims.

This chapter focuses on the following topics:

- [Claims Routing](#)
- [Pre-Adjudication](#)
- [Record Layout of the Transmission File](#)
- [Downloading Claim Files](#)

Claims Routing

All claims should be sent directly to BCBSIL if the member shows the provider his/her ID card. However, because not all members do so, some claims are inevitably routed to the Fund office. Funds should return these claims to providers with a letter instructing them to file directly with BCBSIL. This approach may correct future filing errors if the providers have not updated their patients' files. Refer to ***Sample Provider Cover Letter (Appendix A)*** for an example of a letter instructing providers to

file with BCBSIL. If a significant number of claims continue to be filed to the Fund, BCBSIL can assist the Fund in creating a communication piece to send to the members that encourages them to show their BCBSIL ID card at the time services are rendered.

Pre-Adjudication

When BCBSIL receives claims, pre-adjudication edits are applied. These include the following steps:

- Verification of provider data
- Validation of Procedure and Diagnosis Codes
- Application of bundling/unbundling logic
- Pricing
- Establishment of payment direction
- Minimal duplicate checking

An understanding of these steps will provide the Fund with background information about the key fields on the Transmission File Record.

Verification of Provider Data

BCBSIL will verify the provider number (a unique number assigned to each provider by BCBSIL for internal use) and assure that the appropriate address is included on the claim transmitted to the Fund. This address will match the provider's billing address stored on the BCBSIL provider file database.

Note: This address is not necessarily the office where the provider practices. Providers may submit claims using a billing service or an address, such as a clinic, other than where the member received services.

Based on data contained on the BCBSIL provider file database, the PPO Indicator field (Etr3-Pro-PPO-Ind; position 100) on the Transmission Record will be set in the following manner:

1. A value of "Y" will be passed for all PPO network providers in Illinois and Northwest Indiana.

2. A value of “**N**” will be passed for all non-PPO and non-solicited providers in Illinois. See ***Solicited & Non-Solicited Providers (Appendix B)*** for a list of non-solicited providers.
3. A value of “**O**” will be passed for providers outside of the Illinois PPO network service area.

Note: Please refer to “Chapter 3 – Claims Adjudication” for guidelines on how the Fund should utilize the PPO Indicator.

Validation of Procedure and Diagnosis Codes

Edits are performed on the claim to ensure that only valid national codes (i.e., CPT, ICD-9, HCPC, Revenue, etc.) are applied to the claim before sending it to the Fund.

Note: Funds utilizing national coding structures on their internal processing systems will occasionally experience problems with matching specific codes on incoming claims when annual updates to the coding structure occur. If the Fund utilizes these codes, they should stay current with any annual updates to prevent such editing problems.

Application of Bundling/Unbundling Logic

BCBSIL has internal logic to identify situations in which providers inappropriately “unbundle” surgical procedures and report them on claims under multiple Procedure Codes. Prior to transmitting such claims to the Fund, BCBSIL will apply this bundling logic. Typically the lines will be left unbundled, just as the provider submitted them, but appropriate pricing will be applied as if it had been bundled, often zero pricing some lines.

Pricing

BCBSIL will price claims according to the provider’s PPO status and the type of service performed. The following is a description of pricing procedures:

1. **PPO network providers:** These are providers who have a signed contract with BCBS. Their pricing procedures are as follows:
 - For *institutional* claims, the Fund will receive a “Discount Percentage” (Etr3-Svc-Discount-Percent; position 1846) to apply to each line of service.
 - For *professional* claims, the Schedule of Maximum Allowances (SMA) will be applied to each service line.

Any amount over the SMA will be indicated as an ineligible amount (Etr3-Svc-Ba-Inelig-Amt; position 1884) on the transmission file, with an Ineligible Reason Code of "SMA" (Etr3-Svc-Basic-Inelg-Rsn; position 1983). The SMA amount passed is based on a percent of billed charges. The percentage amount depends on the provider's zip code, offering Funds a reasonable market price in the area where services are rendered.

Note: Throughout this manual whenever a service level position number is stated, it is referring to the first line of service for illustration purposes.

2. **Non-PPO network providers:** These are providers who are not in the BCBSIL PPO network; however, they may have another contractual arrangement with BCBSIL offering some type of discount amount. Their pricing procedures are as follows:

- For *institutional non-network* claims, the Fund will receive the "Discount Percentage" (Etr3-Svc-Discount-Percent; position 1846), if applicable, to apply to each line of service.
- For *professional non-network* claims, the pricing procedure is similar to that of professional network claims. The difference is that, since non-contracting providers do not have a PPO contract with BCBSIL, they may balance bill members for dollar amounts over the SMA. Funds also have the option of overriding the pricing schedule and opting for an alternative (i.e., Usual and Customary, HIAA, etc.).

Note: Per the Network Administration Agreement, Funds may **not** use billed charges as one of the alternative pricing options.

3. **Non-contracting providers:** These are providers who are not in the BCBS PPO network and they have no contractual agreements with BCBSIL. Their pricing procedures are as follows:

- For *institutional and professional non-contracting* claims, the pricing procedure is similar to that of the professional network claims. The difference is that,

since non-contracting providers do not have a PPO contract with BCBSIL, they may balance bill members for dollar amounts over the SMA.

Note: Please refer to "Chapter 3 – Claims Adjudication" for guidelines on how the Fund should apply the pricing when processing the claim.

Establishment of Payment Direction

The Transmission File will indicate the party that should receive the payment on the claim using a Payment Payee Code (Etr3-Key-Payment-Payee-Cd; position 66). The appropriate values for the Payment Payee Code are as follows:

1. A value of "0" indicates that payment should be sent to the **provider** by BCBSIL. The Payment Payee Code will be set with this value in the following instances:

- Professional services for which the PPO Indicator (Etr3-Pro-PPO-Ind; position 100) is "Y," and the member has not issued payment up-front to the provider.
- Professional services for which the PPO Indicator is "N," yet the provider has an alternate contract with BCBSIL (i.e. ambulatory services).
- Professional services for which the PPO Indicator is "Y" and the member has paid a portion of the total charge to the provider. This is known as a "split payment" claim. In this situation, the Patient Paid Amount field (Etr3-Pat-Paid-Amt; position 405) will have a dollar amount on the Transmission Record. The Fund is to refund the member any monies owed to them and return a Disposition Record for the remaining amount owed to the provider.

Note: Split payments are made only on professional claims, not institutional claims.

- All institutional services with a PPO Indicator of "Y" or "N."

Note: In instances in which the Payment Payee Code is set to "0", the Fund is required to return a Disposition Record to BCBSIL so that payment can be made to the provider.

2. A value of "1" indicates that the Fund should make payment to the **member**. The Payment Payee Code (Etr3-

Key-Payment-Payee-Cd; position 66) will be set with this value in the following instances:

- Professional services for which the PPO Indicator is “N” or “O” and the provider is not contracted with BCBSIL, or all non-solicited providers who don’t have an alternate contract with BCBSIL. See ***Solicited & Non-Solicited Providers (Appendix B)*** for a list of non-solicited providers.
- All institutional services for which the PPO Indicator is “O.”

Note: In instances in which the Payment Payee Code is set to “1”, the Fund should not return a Disposition Record to BCBSIL and should issue payment directly to the member.

Minimal Duplicate Checking

Logic will be applied to determine if a claim has been previously submitted based on BCBSIL’s internal records. This logic varies for exact match duplicate claims versus partial match duplicate claims.

1. **Exact match duplicates:** BCBSIL will deny duplicate claims, open or finalized, if the duplicate criteria matches exactly and if the duplicate claims were transmitted by the provider less than 30 days apart from one another. If, however, the duplicate claims were transmitted more than 30 days apart from one another, they will both be forwarded to the Fund.
2. **Partial match duplicates:** Should any of the duplicate checking criteria differ, BCBSIL will transmit the claim to the Fund. An Ineligible Reason Code (Etr3-Svc-Basic-Inelig-Rsn; position 1983) value of “SDU” (suspected duplicate) or “SAJ” (suspected adjustment) will appear on the line of service of the claim where the information differs. If a duplicate claim submission has not yet been finalized by the Fund, the subsequent claim will **not** be flagged with these indicators.

Note: It is the Fund’s responsibility to read these flags and make the final determination as to whether or not a claim is a duplicate based on historical information maintained on the Fund’s internal claims adjudication system.

Record Layout of the Transmission File

The Transmission File Record Layout was designed to include all information needed to adjudicate claims. If the Fund determines that additional information is required to process claims, it should be addressed with the Implementation Team.

Note: It is crucial that the Fund understands each of the file elements. If the elements are reviewed and understood in the initial stages, concerns can be addressed early in the implementation, which will ease the claims testing process.

Refer to *Transmission File (Appendix C)* for the file layout, data dictionary and field population examples.

Downloading Claim Files

In order for the Fund to obtain the Transmission File, or any other electronic file, it must download it from an electronic bulletin board called EMC-Net. For a detailed set of instructions as well as file prefix names and definitions, please refer to the *EMC-Net User's Guide for Labor Funds* which can be found on the Labor Web site at www.bcbsil.com/labor.

Claims Adjudication

Once the Transmission File Records have been received and uploaded into the Fund's internal adjudication system, the Fund is responsible for all claims adjudication processes. This includes the following steps:

- [Batch Input of Transmission File Data](#)
- [Eligibility and Benefit Verification](#)
- [Application of Pricing Data](#)
- [Duplicate Checking](#)
- [Deductibles, Coinsurance and Benefit Maximums](#)
- [Coordination of Benefits](#)
- [Explanation of Benefits](#)
- [Payment to Members](#)

Batch Input of Transmission File Data

The Fund must develop a process to upload claims data received on the Transmission File into its internal adjudication system. In certain instances, the Fund may need to develop programming that maps specific code values received on the Transmission File to internal codes that are specific to the Fund's internal system.

Eligibility and Benefit Verification

The Fund retains responsibility for verifying eligibility and member history. The Fund will ultimately determine whether the member is eligible for claims submitted on the Transmission File. The Fund also retains responsibility for determining which specific services are covered under its program.

Application of Pricing Data

As indicated in the previous chapter, BCBSIL will pass an Eligible Amount (Etr3-Svc-Ba-Elig-Amt; position 1873) for each service line on the Transmission File Record. BCBSIL will price claims according to the provider's PPO status and the type of service performed. The following guidelines should be utilized when applying BCBSIL pricing:

1. PPO network providers

- For *institutional* claims, on each line of service, a "Discount Percentage" will be indicated (Etr3-Svc-Discount-Percent; position 1846). This percentage represents the BCBSIL savings percentage applicable to that claim. The percentage indicated in this field should be applied to reduce the "Eligible Amount" for that line of service. It should be noted that the Eligible Amount field in the Disposition File Record (Edf2-Svc-Eligible-Amt; position 604) should not reflect payment reductions caused by interim discounting. The actual amount that is deducted from the Eligible Amount field in the Transmission File Record (Etr3-Svc-Ba-Elig-Amt; position 1873) should be saved for reporting on the Disposition File Record as the "Interim Discount Amount" (Etr3-Svc-Interim-Discnt-Amt; position 615). Please note the following:
 - If the Eligible Amount changes in the adjudication process (e.g., the member has reached a benefit maximum), the Fund will need to recalculate, or recalibrate, the Discount Amount based on the new Eligible Amount. See ***Recalibration Worksheet Steps (Appendix D)*** for an explanation and examples.

Note: For PPO claims, the Fund may not alter or change any of the pricing data indicated by BCBSIL and should apply it as indicated on the Transmission Record.

- For *professional* claims, when a service exceeds the Schedule of Maximum Allowances (SMA), the dollar amount in excess of the SMA will be indicated as an Ineligible Amount (Etr3-Svc-Ba-Inelig-Amt; position 1884) and the Ineligible Reason Code field (Etr3-Svc-Basic-Inelig-Rsn; position 1983) will indicate a value of "SMA." Payment for PPO services must be based on the SMA amount.

Note: Refer to the section regarding EOBs later in this chapter for important information regarding BCBSIL hold harmless logic for ineligible dollar amounts in excess of SMA.

2. Non-PPO network providers

- For *institutional non-network* claims, the application of this pricing is handled the same way as pricing for the PPO network providers, if there is a discount sent on the claim.
- For *professional non-network* provider claims the pricing application is handled the same way as the PPO network provider claims. The difference is that it is not mandatory that Funds use the SMA pricing sent on the claim. They may override that pricing and opt for an alternative one. As mentioned in the previous chapter, Funds may **not** use billed charges as one of the alternative pricing options.

3. Non-contracting providers

- Pricing application for *institutional and professional non-contracting* claims for non-contracting providers is handled the same way as professional claim pricing for PPO network claims. As mentioned in the previous chapter, the difference is that these providers hold no contract with BCBSIL; therefore, members may be held responsible for any amount over SMA.

Duplicate Checking

The Fund has ultimate responsibility for checking claims history to determine if a claim should be denied as a duplicate of a previously submitted claim. However, as mentioned in Chapter 2, BCBSIL will send Ineligible Reason Codes "SDU" or "SAJ" on suspected duplicate lines of service for finalized claims. Funds should look for these codes and use them as a tool to check for duplicate claims.

Deductibles, Coinsurance and Benefit Maximums

The Fund is responsible for calculating deductibles, coinsurance amounts and any benefit maximums that may be applicable. BCBSIL will not maintain any of this member history. As the appropriate coinsurance percentage is based on the PPO status of the provider as of the date of service, the Fund's adjudication system should be programmed to read the PPO Indicator field (Etr3-Pro-PPO-Ind; position 100) on the incoming Transmission File Record (refer to the Data Dictionary in *Transmission File (Appendix C)* for a list of PPO Indicator values) and base payment according to the following guidelines:

PPO Indicator	Payment Level
Y (yes)	PPO
N (no)	Non-PPO
O (outside network area)	Either level, based on Fund's internal policy

Note: The Fund's system should be programmed based on this indicator, not on any internal PPO Status Indicator that may be loaded on the Fund's internal provider file database, regardless of the source of data.

Coordination of Benefits

If the member has coverage with another group insurance carrier, the Fund is responsible for coordinating benefit coverage.

If information is received on an individual claim regarding other insurance carrier names and/or payments, that data will be included on the Transmission Record in the following fields:

- Etr3-Pro-Dup-Cov-Ind; position 230
- Etr3-Clm-COB-Carr-Name; position 538
- Etr3-Clm-COB-Carr-Street1; position 578
- Etr3-Clm-COB-Carr-City; position 608
- Etr3-Clm-COB-Carr-State; position 626
- Etr3-Clm-COB-Carr-Zip; position 628
- Etr3-Clm-OI-Paid-Amt; position 962

The Fund's system should be programmed to read these fields and utilize this data on the incoming record.

The adjudication of COB claims is a potential point of confusion in Labor Shared Claims Processing. Please note the following rules to be applied in COB situations:

- **Professional claims:** Regardless of whether or not another carrier has made payment on a claim, the BCBSIL Schedule of Maximum Allowances (SMA) applies on all PPO network professional claims.
- **Institutional claims:** If the Fund is paying secondary to another carrier on a claim, the Fund is not entitled to the BCBSIL facility discount. The savings incurred, as a result of the other carrier making payment, should be reflected on the Disposition File in field Edf2-Svc-OI-Savings-Amt (position 648). In addition, the discount percentage sent on the Transmission File (Etr3-Svc-Discount-Percent; position 1846) from BCBSIL should not be applied to the claim.

If the Fund is paying primary benefits on a claim for which it is the secondary carrier, the Fund should apply the provider discount to the eligible dollars on the claim. This typically occurs when the entire payment made by the other carrier has been applied to the member's deductible. The claim should be adjudicated per the normal procedures, with the

Edf2-Svc-OI-Savings-Amt field (position 648) on the Disposition File remaining blank.

For COB claim balancing examples, please see ***Coordination of Benefits (COB) Balancing Examples (Appendix E)***.

If the member has other group coverage for which BCBSIL is the carrier, the other insurance payment information can be coordinated internally by the BCBSIL Full Service Unit (FSU) without having the member resubmit paperwork after benefits are applied under the first contract. Instead of the member resubmitting a claim form to BCBSIL to coordinate coverage under the second contract, the FSU will work with the appropriate departments to process the claim under both contracts upon the initial submission of the claim.

Explanation of Benefits

The Fund retains responsibility for creating and issuing an Explanation of Benefits (EOB) statement to the member for each claim regardless of payment direction (provider or member). In most cases, an existing format of the Fund EOB can continue to be used. During the Implementation process, BCBSIL should be provided with a copy to verify acceptability. Since the communication is coming from the Fund, BCBSIL letterhead cannot be used.

In the development of EOB messages, the Fund should take into consideration the appropriate application of BCBSIL hold harmless logic for professional services. Based on BCBSIL provider contracts, PPO network professional providers are contractually obligated to hold the member harmless for any dollar amounts disapproved as over the SMA. Non-PPO professional providers are not under the same obligation and may bill the member for these amounts. These dollars should be explained appropriately to the member on the EOB issued by the Fund. Whether the member may be held harmless for payment over the SMA is based on the following logic:

- If the PPO Indicator (Etr3-Pro-PPO-Ind; position 100) value is equal to "Y" the member is held harmless for any amounts in excess of the SMA.

- If the PPO Indicator value is equal to “N” or “O” the member is responsible for any amounts in excess of the SMA.

PPO Indicator	Hold Harmless
Y	Yes
N	No
O	No

On institutional claims, the discount amount should be noted on the EOB since the member will be held harmless for these charges.

Note: Members may receive an EOB from the Fund before the providers receive payment for their services. Professional providers are paid weekly by BCBSIL on a predetermined day of the week (see Chapter 5 on Post Adjudication for further details). Due to this cyclical payment method, providers may issue another bill to the member during the same time that the member receives an EOB from the Fund. To avoid confusion, the Fund should consider including language in the message on the EOB such as, “Payment to the provider has been authorized by BCBSIL.”

Payment to Members

The Fund will make payments to the member when applicable as indicated below. Refer to the Payment Payee Code (Etr3-Key-Payment-Payee-Cd; position 66) on the Transmission File Record to determine the appropriate payment direction.

- A Payment Payee Code value of “O” indicates that payment is to be issued to the *provider* by BCBSIL.

Note: In cases of a split payment claim, the Patient Paid Amount field will have a dollar amount populated on the Transmission Record. The Fund is to refund the member any monies owed to him/her and return a Disposition Record for the remaining amount owed to the provider. Split payments are made only on professional claims, not institutional claims.

- A Payment Payee Code value of “1” indicates payment is to be issued to the *member* by the Fund (i.e., an up-front payment in full by the member to the provider, non-PPO network providers, etc.).

Disposition File

As outlined in the previous chapter, the Fund adjudicates the claims and is responsible for collecting and maintaining members' histories as well as making payments to members. BCBSIL must complete the adjudication cycle by making payments to PPO physicians and hospitals. For BCBSIL to perform this function it must receive confirmation of how the Fund adjudicated a claim based on the aforementioned factors. The Disposition File is the tool used to receive this information. Refer to the ***Disposition File (Appendix F)*** for the file layout, data dictionary and field population examples.

The following is a list of scenarios for which Funds should send a Disposition File:

- [Pended Claims](#)
- [837 HIPAA Request Response](#)
- [Finalized Claims](#)

Pended Claims

A Disposition File Record is required from the Fund for any claim that was transmitted with a Payment Payee Code (Etr3-Key-Payment-Payee-Cd; position 66) value of "0" which must be delayed at the Fund office. BCBSIL must receive notification that a claim has been delayed in order to respond appropriately to any provider inquiries regarding claim status.

There are four occurrences for Pend Code Reasons allowing for five characters per occurrence. Pend Code Reasons should be populated in field Edf2-RFI-Letter-Cd (position 95 – 114) on the Disposition File.

HIPAA Pend Codes

In order to respond to HIPAA 276 (claim status) requests with a 277 (claim status) response, BCBSIL must receive a HIPAA Pend Code. Funds will need to pass this code in the first RFI Letter Code field, or position 95 on the Disposition File Layout.

While these codes may be specific enough for providers, they may not be as specific as the codes that Funds would like to use. For this reason, Funds may transmit BCBSIL pre-established codes or its own internal codes in addition to the HIPAA Pend Code. These additional codes may be sent in the second, third and/or fourth position (position 100-114) of the RFI Letter Code field.

Note: If the Fund chooses to use its internal codes, the specific codes and their explanations must be forwarded to the Fund's designated Marketing Support representative.

Should a claim contain a code other than a HIPAA Pend Code in the first field, the claim will reject with Reject Reason Code RC009 – RFI Letter Code invalid (Edf2-Reject-Rsn-Cd; position 116). Please see the *Code Reference Manual*, which can be located on the Labor Web site at www.bcbsil.com/labor, for a full list of Reject Reason Codes.

Note: A complete list of HIPAA Pend Codes is available for review at www.wpc-edi.com/codes/Codes.asp.

837 HIPAA Request Response

An Informational Disposition Record is required from the Fund if a claim is transmitted with an 835 Indicator of "Y" (Etr3-Pro-835-Ind; position 229), an Origin Code (Etr3-Clm-Origin-Cd; position 673) value of "H" and a Payee Code (Etr3-Key-Payment-Payee-Cd; position 66) value of "1" or "Fund to Pay" claims. These are claims for which a provider sent an 837 HIPAA electronic claims transaction for filing purposes. BCBSIL must provide an 835 HIPAA electronic remittance advice explaining the amount of the payment being issued to the member.

When transmitting an Informational Disposition Record, Funds should make sure that they return a Record Type (Edf2-Record-Type; position 94) of "3." It should be noted that Funds are not allowed to deny claims that require an Informational Disposition File as "handle direct." There may, however, be legitimate reasons that a claim must be denied. For these claims, Funds should place the appropriate Ineligible Reason Code in field Edf2-Non-Pymt-Rsn-Cd (position 578). Here are examples of claims which may be denied and corresponding codes:

- Claims for non-members may be denied with Ineligible Reason Code 006.
- Benefits not covered through Blue Cross and Blue Shield of Illinois (e.g., vision, dental or prescription drug coverage) may be denied with Ineligible Reason Code H31.

Note: Typically claims in the Labor Shared Claims Process are transmitted with a DCN location of an "X" or a "C." The exception is if an out-of-state provider sends a claim which requires an 835 transaction. These claims will be transmitted to Funds with a DCN location of an "H." These claims will also have different PPO Indicators (See Etr3-Pro-PPO-Ind; position 100 in the ETR3 Data Dictionary located in Appendix C for a list of values).

Finalized Claims

Finally, a Disposition File is required for all finalized claims which includes paid, denied or adjusted claims (see Chapter 5 for details regarding finalized claims). All dollar fields on the Disposition File should balance based on standard BCBSIL balancing rules. These rules are as follows:

Service Level Balancing

Total Charge - Assumed Ineligible Amount** = Eligible Amount

Eligible Amount - Discount - Deductible - Coinsurance - OI Savings - Medicare Savings - Worker's Compensation Savings = Payable Amount

** This is an assumed amount since the Eligible Amount is what is passed on the Disposition File.

Claim Level Balancing

The sum of the Payable Amounts for each service line must equal the Total Payment Amount of the claim.

Note: *For Institutional claims, the discount amount must equal zero if the Other Insurance savings, Medicare savings or Worker's Compensation savings are greater than zero.*

Note: Claims that do not balance or do not meet other editing criteria internal to the BCBSIL post-adjudication process will be rejected and re-transmitted back to the Fund for correction. This editing and rejection process is described in further detail in the following chapter, "Post-Adjudication Processing."

Post-Adjudication Processing

Once the Fund has transmitted the Disposition File to BCBSIL, the following edits and processing steps are applied:

- [Disposition File Format](#)
- [Claim Rejection](#)
- [Payment to Providers](#)
- [Issuance of Provider Claim Summaries](#)
- [Future Reporting and Billing](#)

Disposition File Format

The Disposition File must be in the specified record layout. See *Disposition File (Appendix F)* for a copy of the layout. In addition, the total number of claim records stated in the trailer record must equal the number of claims on the file. If the file is not in the correct format or the number of records does not balance to the count in the trailer record, the entire file will be rejected for correction and re-transmission by the Fund. Funds will be notified that a file was accepted or rejected by reading one or both of the following messages:

1. **.RTN files** – An .RTN file is a “return receipt” sent via EMCnet which gives the date, time and name of the file

sent, whether or not the file was successfully received by BCBSIL and the number of records in the file.

2. **E-mail notification** – Funds may elect to receive the above mentioned .RTN message via e-mail. Details regarding the set up of this option may be further discussed with the Implementation Team.

Claim Rejection

Upon receipt of a Disposition File Record from a Labor Fund, certain data validation and balancing edits are applied to the record. Should the record fail any of these edits, the Disposition File Record will be rejected and sent back to the Fund for correction. It will be sent in a separate file called the “Reject File.” This file is transmitted to the Fund on a daily basis even if BCBSIL did not reject any claims. (In this case, the Fund will receive an empty file.) The Reject File will be in the Disposition File format. The rejected record will be sent to the Fund on the first business day after the incorrect Disposition File Record was processed by BCBSIL. These edits/Reject Reason Codes can be found in the *Code Reference Manual* located on the Labor Web site at www.bcbsil.com/labor.

Note: Historically, the reject rate has been extremely low. This low rate is attainable if BCBSIL and the Fund work together to fully understand Labor Shared Claims Processing and thoroughly test claim transmissions prior to moving to production. Once the process is moved into production, BCBSIL will continue to monitor the reject rate. The Reject Reason Codes will be evaluated and reviewed with the Fund so that the potential discrepancies in the process can be addressed in the initial stages.

The Fund is responsible for reviewing the individual rejected Disposition File Records, making the appropriate corrections and re-transmitting the impacted records back to BCBSIL in a subsequent Disposition File.

Payment to Providers

1. **Professional:** Payments are issued to professional providers by BCBSIL based on the payment amounts authorized by the Fund on the Disposition File Record. Professional providers typically receive reimbursement on a

pre-determined date each week for all BCBSIL claims that have been processed. Given this fact, the check will be issued on the next date that a particular provider's weekly payment is scheduled (Monday through Friday). About 20 percent of providers are paid on each day.

2. **Institutional:** Hospitals often are reimbursed on Fridays. The payment will equal the payable amount (Edf2-Svc-Payable-Amt; position 681) authorized by the Fund plus the discount amount (Edf2-Svc-Interim-Discnt-Amt; position 615).

Note: If the Fund has access to the BCBSIL inquiry function IMNU, it can confirm payment by verifying the check number field. See the *Mainframe Reference Manual* on the Labor Web site at www.bcbsil.com/labor for details concerning IMNU and other Mainframe inquiry functions available to Funds. To obtain access to IMNU or any other mainframe functions, please talk to one of the members of the Implementation Team.

Issuance of Provider Claim Summaries

When issuing payments to the providers, BCBSIL will also issue Provider Claim Summaries (PCS), the provider's version of the member's Explanation of Benefits. These summaries will be in the same format as all other BCBSIL claims that have been processed and will be received electronically by providers the day after a claim has been finalized.

Future Reporting and Billing

Finalized claims are then reported to the BCBSIL financial database for future reporting purposes such as the generation of monthly billing reports (see "Chapter 8 – Support Files and Electronic Reports" for details) to the Labor Fund and annual 1099 reporting for provider payments.

Adjustments

Adjustments to previously processed claims may occasionally be required through the Labor Shared Claims Process due to a variety of circumstances. This chapter will focus on the following topics:

- [Identification of Adjustments](#)
- [Adjustment Types](#)

Identification of Adjustments

For all adjustment scenarios, with the exception of R06's, a Transmission File Record representing an adjustment to the original entry claim will be created and transmitted to the Fund. For all adjustments, Funds are required to send a Disposition File. The following sections list fields in both the Transmission and Disposition File which identify adjustments.

Transmission File

The Fund will recognize that a record is an adjustment through the population of the following fields:

- **Etr3-Key-Claim-Adj-Suffix (position 61):** Indicates the number of adjustments on the claim. The two-digit adjustment suffix will be greater than zero (01, 02, 03, etc.).
- **Etr3-Clm-FSS-Adjust-Rsn-Cd (position 468):** This code will indicate the reason a claim is being adjusted.

This field will contain one of the following values: R01 – R05, R07 and A07 – A23 (please refer to the *Code Reference Manual* located on the Labor Web site at www.bcbsil.com/labor for all Adjustment Reason Code definitions).

- **Etr3-Clm-FSS-Ind (position 530)**: A value of “Y” will be passed in this field for credit adjustments unless it is an R05 and then a value of “N” will be passed.
- **Etr3-Clm-Upfront-Credit-Amt (position 702)**: For R05 up-front credits, this field will contain the amount of the Fund’s up-front credit (under \$50). This field will use no punctuation or symbols, only numeric values (i.e., \$147.50 will be 14750).
- **Etr3-Clm-Transmitted-Dt (position 855)**: The date the adjustment was sent in the Transmission File to the Fund. The format of this field will be YYDDD.
- **Etr3-Clm-Prior-Paid-Amt (position 929)**: The amount previously paid out on the claim as of the last claim update.
- **Etr3-Clm-FSS-Returned-Amt (position 951)**: For credit adjustment situations, with the exception of R05s, this field will contain the amount of money returned by the provider.
- **Etr3-Clm-Discount-Amt (position 973)**: The discount amount applied to the original entry claim.
- **Etr3-Clm-Tot-No-Of-Svcs (position 995)**: Indicates the number of lines of service on a claim.
- **Etr3-Svc-CPT-Modifier (1) (position 1781)**: This field is populated with “99” for R03 late charges.

Disposition File

The following is a list of fields Funds may populate (depending on the adjustment type); in addition to the dollar fields Funds should use to make sure that the claim balances, on the Disposition File for adjustments:

- **Edf2-Key-Claim-Adj-Suffix (position 28):** Indicates the number of adjustments on the claim. The two-digit adjustment suffix will be greater than zero (01, 02, 03, etc.).
- **Edf2-Complete-Pend-Dt (position 155):** The date the Disposition Record was sent back to BCBSIL.
- **Edf2-Adj-Rsn-Cd (position 160):** This field is used for R06 adjustments only. It should be populated with "R06."
- **Edf2-Clm-Prov-Payment-Amt (position 506):** The amount to be paid to the provider for services rendered. This field is required when payment is made to the provider.
- **Edf2-Clm-RFCR-Amt (position 539):** Amount returned by the provider on FSS adjustments.

Adjustment Types

There are two main categories of adjustments:

- [Non-credit adjustments](#)
- [Credit adjustments](#)

"Non-credit" adjustments involve claim reprocessing situations that are unrelated to returned monies. "Credit" adjustments are created when BCBSIL either receives money back from a provider or issues an up-front credit. An adjustment must be processed to the original claim for the Fund to receive a credit on its billing. The following sections provide details regarding both adjustment types.

Non-Credit Adjustments

To initiate a non-credit adjustment, with the exception of an R06 adjustment which the Fund initiates from their office, the Fund must make a request via the transmittal process to the BCBSIL Full Service Unit (FSU). See "Chapter 8 – Support Files and Electronic Reports" as well as *Transmittal Options (Appendix H)* for detailed instructions regarding each option. An adjustment

claim record will be created and transmitted to the Fund within (3) business days of BCBSIL receiving the request.

The following Adjustment Reason Codes identify non-credit adjustment claims. For a full list of definitions for these codes, please refer to ***Adjustments (Appendix G)*** or the *Code Reference Manual* which can be found on the Labor Web site at www.bcbsil.com/labor.

- **R01:** All dollars on the original claim were denied. The Fund requests the claim to be re-opened to re-adjudicate the charges on the original claim. Please note that the R01 adjustment is similar to an original entry claim. It should be adjudicated as usual, with the Fund paying or denying benefits.
 - **R02:** This code applies only to institutional claims with a discount. All eligible dollars on the original claim were applied to the deductible. BCBSIL paid the discount amount applied on the original claim to the provider. The Fund requests the claim to be re-opened to re-adjudicate the disposition on the original claim. Please note that the R02 adjustment is similar to an original entry claim. It should be adjudicated as usual, with the Fund paying or denying benefits.
 - **R03:** The original claim was paid. However, the Fund requests the claim to be re-opened to pay additional charges. The Prior Paid Amount field (Etr3-Clm-Prior-Paid-Amt; position 929) on R03 adjustment records will contain the previous amount paid out by the Fund on the original claim. *Please note that the R03 adjustment may not be used if the Fund intends to deny total or partial benefits previously paid on the original claim.*
- A late charge adjustment is a subset of an additional pay adjustment. The adjusted late charge claim contains the original service lines plus the late charges. The late charges are added to the original claim by adding additional charges on separate lines of service with the corresponding Revenue Codes. However, in rare situations in which the original claim contains the maximum 39 lines of service, the hospital late charges will be lumped with the corresponding Revenue Codes.

These additional lines of service will be identified with CPT Modifier "99" so that the processor may compare the prior claim's total charge to the adjusted claim's total charge. Please note that the original lines of service are not denied.

- Also, the R03 Adjustment Reason Code can be used to do a statistical adjustment. The payment will remain the same as the original entry. A statistical adjustment is used to reconsider the dollars applied to the Ineligible, Deductible, Coinsurance or Savings fields.

The following adjudication guidelines apply to R03 adjustments.

- **Adjusted Total Payable Amount** (*Edf2-Clm-Prov-Payment-Amt; position 506*) – **Prior Paid Amount** (*Etr3-Clm-Prior-Paid-Amt; position 929*) = **Draft Amount** (*Edf2-Clm-Current-Draft-Amt; position 528*)

Note: R01, R02 and R03 adjustments will be transmitted to the Fund with the same information as the original entry. The only fields that will differ from the original entry are the Adjustment Suffix, the Adjustment Reason Code, the Prior Paid (for R03 adjustments), the Total Number of Services (for late charges) and the CPT Modifier (for late charges).

- **R04:** The original claim was paid. However, special situations require the claim to be processed further. R04 adjustments are very infrequent. When they are necessary, the adjustments are handled on a claim-by-claim basis.
- **R06 (Fund initiated adjustment):** All dollars on the original claim were either denied or partially paid. The Fund would like to initiate the adjustment from its office without using a transmittal form. The Fund wants to re-open the claim and re-adjudicate the charges on the original claim.

An R06 adjustment could look similar to an R01, R02 or R03 adjustment.

- In both cases, the Fund is re-opening a claim and re-adjudicating the charges on it.

- As with an R01, Funds should pass the dollar amounts showing the new payable amount.

There are, however, differences between an R06 and an R01, R02 or R03.

- First, the Fund - not BCBSIL - initiates the adjustment.
- Second, to initiate an R06 adjustment, Funds must be able to send back an Adjustment Reason Code of "R06" in field Edf2-Adj-Rsn-Cd (position 160). This field should be populated only for R06 adjustments.
- Lastly, Funds will have to send back an Adjustment Suffix in field Edf2-Key-Claim-Adj-Suffix (position 28) populated with a sequential number greater than zero to show that an original entry claim is being adjusted. This field is always populated "00" for original entry claims. Anything greater than zero indicates how many times the claim has been adjusted (e.g., "01" means this is the first adjustment to the original claim).

An R06 cannot be used for claims where a credit or refund is being given. Also, it is important that Funds retain BCBSIL pricing in their systems for all claims; otherwise, when the claim is re-opened as an R06, it will not have the correct pricing information.

Note: For all adjustments that the Fund initiates, with the exception of R06s, a transmittal form must be completed and sent to the BCBSIL Labor Full Service Unit (FSU). See "Chapter 9 – Other Administrative Procedures" as well as ***Transmittal Options (Appendix H)*** for more information.

Credit Adjustments

The following Adjustment Reason Codes identify credit adjustment claims. For a full list of definitions for these codes, please refer to ***Adjustments (Appendix G)*** or the *Code Reference Manual* found at www.bcbsil.com/labor.

- **R05 and R07; A07 – A17; A19 – A30:** These Adjustment Reason Codes are used for up-front credits, or when the provider has returned partial or full claim payment to BCBSIL.

- **A18:** This type of adjustment applies when all eligible dollars on the original claim were applied to the deductible, with BCBSIL paying the discount amount to the provider. The money returned by the provider is the full or partial discount amount of the discount amount that was paid by BCBSIL. The adjustment is sent to the Fund to give credit for the Access Fee paid on the discount applied on the original claim. Please note, for full refunds the Fund should either take all dollars and make them ineligible or report all eligible dollars in a savings field. For partial refunds, the Fund needs to maintain the original disposition. The “Informational Notes” field (Etr3-Clm-Informational-Notes; position 744) will identify whether the adjustment is a partial or full credit.

Note: A18 adjustments will be transmitted to the Fund with the same information as the original entry. The only fields that will differ from the original entry are the Adjustment Suffix and the Adjustment Reason Code.

- **R05:** The original claim was paid. The Fund requests, through the transmittal process, that the claim be adjusted for a credit amount of \$50 or less. The Prior Paid field (position 929) on R05 adjustment records will contain the previous amount paid out by the Fund on the original claim.

Note: If the credit amount is greater than \$50, the claim will reject with Reject Reason Code RC049 – refund request amount exceeded.

The following adjudication guideline applies to R05 adjustments.

- **Adjusted Total Payable Amount** (*Edf2-Clm-Prov-Payment-Amt; position 506*) = **Prior Paid Amount** (*Etr3-Clm-Prior-Paid-Amt; position 929*) – **Credit Amount** (*Edf2-Clm-RFCR-Amt; position 539*)

Note: R05 adjustments will be transmitted to the Fund with the same information as the original entry. The only fields that will differ from the original entry are the Adjustment Suffix, the Adjustment Reason Code, the Prior Paid and the Fund Claim Number (which contains the up-front credit amount, not the Fund claim number).

- **R07:** The original claim was paid. However, payment was made to the wrong provider. This adjustment allows Funds to receive an up-front credit for the refund amount without having to wait for the provider to return the money. Funds should keep in mind the following when processing an R07:
 - All eligible dollars must equal zero. If the eligible dollars are greater than zero, the claim will reject with Reject Reason Code RC052 – payable dollars cannot be greater than zero for an R07 adjustment.
 - The adjusted claim must always be for the same provider because BCBSIL cannot change the provider name on the adjustment.

Depending on the type of claim scenario and the type of credit involved, a particular adjudication process is required to properly balance the adjustment. Following are some general adjudication guidelines to be followed when processing credit adjustments. For more specific guidelines, as well as balancing examples for credit adjustment processing, please refer to ***Adjustments (Appendix G)***.

- If there is a discount percent transmitted it must be applied unless other insurance, Medicare or Worker's Compensation savings are involved. This is the same guideline that applies to original entry claims adjudication.
- Full credit adjustments:
 - **Draft Amount** (*Edf2-Clm-Current-Draft-Amt; position 528*) + **Total Payable Amount** (*Edf2-Clm-Prov-Payment-Amt; position 506*) = **zero**
- Partial credit adjustments:
 - **Draft Amount** (*Edf2-Clm-Current-Draft-Amt; position 528*) = **zero**
 - **Prior Paid Amount** (*Etr3-Clm-Prior-Paid-Amt; position 929*) – **Credit Amount** (*Edf2-Clm-RFCR-Amt; position 539*) = **Total Payable Amount** (*Edf2-Clm-Prov-Payment-Amt; position 506*)

For most credit adjustment scenarios, the adjustment will not be initiated unless the money in question has actually been returned to BCBSIL by the provider. The Fund may initiate an adjustment by requesting a refund. In instances when the Fund identifies an overpayment, a transmittal form should be submitted to the BCBSIL FSU to initiate the request for refund from the provider. Once the provider has returned the money to BCBSIL, the credit adjustment process described above will be initiated.

Note: The current Claim Payable Amounts must balance to the claim (Edf2-Clm-Prov-Payment-Amt; position 506) and service (Edf2-Svc-Payable-Amt; position 681) level. Below are examples of Reject Reason Codes a Fund may receive if a service line or the entire claim is out of balance:

- RC036 – Provider Payment Amount and Sub Payment Amount do not equal Current Draft Amount
- RC037 – Total claim paid amount not equal to the sum of all service paid amounts.

Customer Service

Labor Shared Claims Processing keeps the customer contact constant, whether it is between the member and the Fund or between the provider and BCBSIL. This arrangement helps maintain a level of comfort for the member population.

The three sections in this chapter will illustrate the importance of customer service by focusing on the following relationships:

- [Provider Communication with BCBSIL](#)
- [Provider Communication with the Fund](#)
- [Member Communication with the Fund](#)

Provider Communication with BCBSIL

Labor Shared Claims Processing is transparent to the providers. A Fund claim is treated just as any other BCBSIL claim and is handled per the contracted conditions.

Provider Education

BCBSIL's Provider Affairs department distributes a bulletin, *BlueReview*, which introduces new accounts and provides updates regarding existing groups on a monthly basis. *BlueReview* typically includes the Fund's group number(s) and product type. To view a sample copy of *BlueReview*, please see **BlueReview (Appendix I)**.

Claim Status Inquiry

Providers are directed in *BlueReview* to call BCBSIL's Provider Telecommunication Service Center (PTC). The only way for PTC to accurately update the provider is if the Fund has sent a pended Disposition Record with a Pend Code to BCBSIL or if the claim has been finalized. Therefore, it is imperative that Funds return claims on a timely basis with a valid Pend Code or payment information.

Provider Issues

If a member has presented his/her BCBSIL ID card and the provider is directing the member to file the claim, the Fund's Account Executive should be notified. He/she will contact a Provider Affairs representative who will contact the provider in question. It is the responsibility of BCBSIL to ensure that providers are providing service in accordance with the PPO contract.

Provider Communication with the Fund

There may be occasions when providers will call the Fund office.

- **Eligibility Verification and Benefit Determination:** Since the Fund maintains all eligibility information and they determine member benefits, providers may call the Fund office to verify a member's eligibility status or his/her specific benefits.
- **Out of Network Claims:** Providers may also call the Fund office with questions concerning any claims which are out of network.

Member Communication with the Fund

The Fund will continue to answer members' questions and to educate them about various aspects of the new arrangement with BCBSIL.

Educating Members

During the implementation process, the Implementation Team will review a variety of educational materials (e.g., Web site brochure, PPO Institutional listings, etc.) for members. These materials will help in the education process of how to take

advantage of all the benefits and services that the PPO contract has to offer. BCBSIL can also assist in creating letters and bulletins. See ***Sample Member Communication Letter (Appendix J)*** for a standard introductory letter.

Presenting the BCBSIL ID Card

The BCBSIL ID card is the most important tool for the member. The Fund's communications to its members should stress the importance of showing providers their new BCBSIL ID card so that they can be identified as a BCBSIL member. When visiting a PPO provider, members receive the following benefits:

- Direct claims submission to BCBSIL by the PPO provider
- No balance billing to the member for any amounts in excess of the BCBSIL Schedule of Maximum Allowance (SMA).

Note: These benefits are only possible if the member shows their BCBSIL ID card!

BCBSIL will produce ID cards based on required information received in an electronic membership file from the Fund. Funds may send membership in the BCBSIL standard membership record layout, also referred to as the "BlueStar AEP layout", or the HIPAA 834 Benefit Enrollment and Maintenance layout. Please see ***Membership File Layouts (Appendix K)*** for details.

The ID card will include the following information: claim filing instructions, inquiry telephone numbers and pre-certification requirements (if applicable). The card must contain the standard BCBS logo. The Fund's name and/or logo may be included on the card if the Fund so desires. An ID card mock-up will be created by BCBSIL, which is subject to the Fund's review. ID cards are usually created and distributed to members approximately two weeks prior to the implementation date. Please see ***Sample BCBSIL ID Card (Appendix L)*** for an example of a typical BCBSIL ID card mock-up.

Member Claim Inquiries

The Fund will be the primary source of information for the members. This includes data such as accumulator status, deductible status, claim status, membership status, claim filing procedures, etc.

To receive the most current PPO provider status, Funds should direct their members to log on to www.bcbsil.com. This is an excellent means for members to locate a provider or to check whether their existing provider is in the BCBSIL PPO network. *Note that the Fund will also field claim status questions from BCBSIL's FSU when a claim has not been finalized and additional information is needed.*

Support Files and Electronic Reports

Chapter 8 concentrates on support files as well as financial reports which BCBSIL has created to aid Funds in reconciling their own claims data to BCBSIL claims data. It will also focus on the electronic membership file which Funds will need to send BCBSIL on a regular basis. The following is a list of discussed files and reports:

- [Department of Labor Informational Files](#)
- [BARS Report](#)
- [BlueGateway Report](#)
- [Membership Files](#)

Department of Labor Informational Files

Funds may be required to notify members that a claim has been withdrawn due to insufficient information or has been denied by BCBSIL. To assist Funds in meeting member notification requirements, BCBSIL transmits electronic informational claim files. These files are available to download into the Fund's claims system via EMC-Net. The expectation is that Funds will use this information to generate member letters as they deem necessary based on their interpretation of the Department of Labor regulations. Whether these letters are generated through each Fund's normal claims system or through some other process is the group's decision. Regardless of how it is handled, BCBSIL does not expect a Disposition Record.

The file formats for these informational files are the same as the Transmission Record. However, some fields may not be populated as BCBSIL may not have all of the information (particularly on withdrawn claims). Also, Funds should pay particular attention to the Status/Status Reason Code (Etr3-Clm-Status; position 466) and the Ineligible Reason Code (Etr3-Svc-Basic-Inelg-Rsn; position 1983). Please see the *Code Reference Manual* located on the Labor Web site at www.bcbsil.com/labor for a full list of these codes. These are the codes that will help determine whether a claim was withdrawn or denied and the reason for the action.

BARS Report

The BARS Report is a paid claims detail report, which lists all claims that have been included on the weekly wires for a given month. It includes the following data:

- Group Number
- Claim Process Date
- Access Fee
- Section Number
- Claim Paid Amount
- Member Name
- Member Number
- Discount Amount
- Provider Number
- Claim Number
- Net Paid Amount
- Provider Name

This information is available via an electronic file on a monthly basis. It is usually generated during the first week of the month with the prior month's paid claims data. Please see ***BARS (CLO3) Record Layout & Field Explanations (Appendix M)*** for detailed information concerning the file layout.

BlueGateway Report

BCBSIL also produces a weekly report that is available electronically in either a printable report or a data file. The data file is automatically sent to Funds during production. The printable report is available upon request during the implementation process. Please see ***BlueGateway Layout (Appendix N)*** for the file layout.

Funds should consider what medium would most suit their needs and then discuss these options with the BCBSIL Implementation Team.

Membership Files

The Fund will be requested to provide BCBSIL with membership information on a scheduled basis in either the BCBSIL BlueStar AEP or the HIPAA 834 Benefit Enrollment and Maintenance layout via an electronic transmission. Please see ***Membership File Layouts (Appendix K)*** for specifics regarding the two file layouts. Terms of these requirements will be reviewed in the implementation process. BCBSIL will use this membership data in order to produce ID cards as well as route claims if they are received with partial information.

Note: When BCBSIL receives a membership file from the Fund, it is used only to produce ID cards as well as for routing purposes in the mailroom. The file is not used to make any benefit determinations. Information received on the claim is what BCBSIL will pass to the Fund in the Transmission File. If the member/dependent data on the Transmission File is inaccurate the Fund can correct the data on the Disposition File. This procedure is in line with the rule that the Fund maintains membership.

Note: Labor Shared Claims Processing is not applicable to any person who has selected Medicare as his/her primary coverage. Medicare primary members should not be included on any membership files created by the Fund for use by BCBSIL.

Other Administrative Procedures

Chapter 9 focuses on topics pertaining to claims processing. The following is a list of those topics:

- [Prompt Payment](#)
- [Requests for Additional Information](#)

Prompt Payment Claims

Many states have prompt payment statutes or regulations that require payers to reimburse providers in a timely manner. Insurance commissioners in several states have been aggressively enforcing their respective prompt payment requirements. Since timeframe requirements and penalties for Administrative Services Only (ASO) business differ from state to state, it is important that Funds have the ability to identify prompt payment requirements when they receive a claim. To assist Funds in identifying these claims, BCBSIL sends an SF Message Code (Etr3-Svc-SF-Msg-Cd; position 1895) which identifies specific claims that may have a prompt payment requirement, along with a field (Etr3-Clm-Spc-Days; position 1141) identifying the number of days associated with that requirement. *Please contact your Marketing Support representative to obtain a full list of SF Message Codes.*

Three fields on the Etr3 claims Transmission Record should be considered when identifying specific claims with state prompt payment requirements:

- SF Message Code
- Special Pricing Consideration Days
- Claim Received Date

1. **SF Message Code:** The field name containing this code on the Etr3 record layout is Etr3-Clm-SF-Msg-Cd (position 1895). There is a possibility of receiving up to 5 occurrences of SF Message Codes on one claim.

When a state prompt payment requirement may be applicable, the following code values will be populated in the field noted above:

- P301: Prompt Pay penalty applies to insured and Administrative Services Only (ASO) business
- P302: Prompt Pay penalty applies to insured business only
- P303: Prompt Pay applies to international claims

2. **Special Pricing Consideration Days:** The field name containing the number of days associated with the prompt payment requirement is Etr3-Clm-Spc-Days (position 1141).

3. **Claim Received Date:** The field name containing the date the claim was originally received by the local BCBS plan is Etr3-Clm-Received-Dt (position 848). It should be used as the starting date to determine if a claim is being paid within the prompt payment requirement.

It is the Fund's responsibility to process all claims within the required number of prompt pay days. Funds should discuss any special internal reporting required to track these claims with their system's vendor or internal information technology staff as appropriate.

Requests for Additional Information

Once the Fund receives claims from BCBSIL, the Fund must determine if any additional information is needed to process the

claims based on information stored at the Fund and data included on the claim records.

Member Information

If additional member information is required to adjudicate a claim, the Fund is responsible for requesting and pursuing it from the member. *It is up to the Fund to decide how to request this information from its member. No requests can be made using BCBSIL letterhead.*

Provider Information

If additional information is needed from providers, BCBSIL will request the information on the Fund's behalf. They would simply create a transmittal form and send it to the FSU.

There are three options for submitting transmittals:

- Fax to image
- Mainframe on-line entry
- Electronic file submission

1. **Fax to image:** Funds may simply fax transmittal forms to (312) 540-4708 (for Chicago FSU accounts) and (217) 442-4809 (for Danville FSU accounts). This number routes the forms to the BCBSIL image system. The form is then routed to the appropriate FSU location and then assigned to an examiner. These forms are available through the FSU. However, should Funds decide to create their own form they should make sure that the letters "NADJ" are typed in the upper left-hand corner in a large font size. See ***Transmittal Options (Appendix H)*** for a sample copy of the transmittal form for both the Chicago and Danville FSU. Also, keep in mind that transmittal forms should not be attached to claims which were received by the Fund and not BCBSIL. These claims should be sent separately under a different fax cover sheet. Lastly, each transmittal should be limited to one member. It may include several claims as long as there is only one group and member number.

Note: Please contact Account Management if you are unsure of your FSU location.

2. **Mainframe on-line entry:** The mainframe on-line entry process provides users with the ability to connect directly to the BCBSIL mainframe. Users have the ability to browse, respond to or perform same-day deletions of transmittal requests on-line. Use of the mainframe on-line process requires that users initiate mainframe connectivity and obtain the appropriate security access. This access may be obtained through a member of the Implementation Team.
3. **Electronic file submission:** The electronic file submission process requires users to establish the ability to send and receive transmission files via EMC-Net, using predefined record layouts. It may be performed daily and consists of requests and responses.
 - The Electronic Transmittal ***Request*** is an electronic file transmitted from Labor Funds to BCBSIL via EMC-Net. These files are created using predefined procedures and record layouts (discussed later in this documentation).
 - The Electronic Transmittal ***Response*** is an electronic file transmitted from BCBSIL to the Labor Funds via EMC-Net, and contains the responses to the electronic transmittal requests previously submitted for processing.

Funds can use either one or both of the automated transmittal methods to send requests to BCBSIL. Listed below are the requirements for each method:

- **Mainframe on-line entry**
 - Develop internal procedures governing use of the on-line application
 - Develop internal procedures governing the processing of responses via the on-line application
 - Develop internal process to audit transmittal activity
 - Develop the capability of initiating a mainframe session
 - Obtain security access by contacting the appropriate Marketing Support representative

- **Electronic file submission**

- Develop a new process to transmit transmittal request files
- Develop a process to receive transmittal response files
- Develop the ability to receive error files
- Develop a process to audit transmittal activity

Details of these procedures should be discussed in the implementation process. Please see ***Transmittal Options (Appendix H)*** for detailed instructions, a file layout and mainframe screen shots.

Implementing the Process

Once a Fund has made the decision to move forward with the Labor Shared Claims Process, an implementation date will be established and an Implementation Team from BCBSIL will assist and guide the Fund through the entire three- to six-month process.

The Implementation Team will consist primarily of three key individuals:

- **Account Executive:** Responsible primarily for financial questions, contractual issues, individual member requests and various production concerns.
- **Marketing Support representative (a.k.a., Implementer):** Main point of contact during the implementation as well as systems related issues during production.
- **Full Service Unit coordinator:** Key contact person for most claims-related questions.

The implementation will progress through the following stages:

- [Initial Evaluation](#)
- [Planning](#)
- [Implementation and Testing](#)
- [Production](#)

Initial Evaluation

The first step in the implementation process involves an initial evaluation, both on BCBSIL and the Fund's part. BCBSIL will meet with the Fund to review its internal capabilities.

Following the initial meeting, both BCBSIL and the Fund should evaluate the information obtained and come to a mutual agreement regarding a target implementation date. This date should be based on a common understanding of the level of effort involved to implement the process.

Planning

Once the initial evaluation has been completed and the target implementation date has been established, further meetings will be held between the Fund and BCBSIL in order to completely define roles and responsibilities for the process. In addition, the BCBSIL Marketing Support representative will develop a ***Labor Shared Claims Processing Implementation Plan (Appendix O)***. This plan will include both testing and other administrative processes associated with the implementation (e.g., ID card issuance, etc.). The target dates for all implementation activities will be reviewed and agreed to by both the Fund and BCBSIL.

Implementation and Testing

The exchange of claims data between BCBSIL and the Fund must be thoroughly tested through the transfer of several cycles of test Transmission, Disposition and Reject Record files both for original entry claims as well as adjustments. Meetings and/or conference calls will be scheduled on a regular basis to review the results of each test file. A test schedule will be utilized as a tracking mechanism to monitor the status of each file through the entire test cycle (Transmission, Disposition and Reject files). Please see ***General Test Cycle Schedule & Scenarios (Appendix P)*** for details concerning the test schedule as well as a list of standard test scenarios.

Concurrent with the testing process, other administrative activities required to implement the process will also take place. The status of these items will continue to be monitored through the use of the implementation timetable, and will be included as

agenda issues for regularly scheduled meetings and/or conference calls so that all parties are fully updated.

The implementation and testing phase is completed when the Fund and BCBSIL are fully satisfied with the test results and mutually agree that the process is ready to move into the production phase.

Production

The meetings and conference calls that are a part of the testing phase will continue through the initial weeks of production until both BCBSIL and the Fund are satisfied that the process is stable and that the claims are flowing through the system smoothly.

In addition, the Implementation Team will monitor the flow of claims for the first several months to identify and quickly correct any initial production problems. Special attention will be paid to the Disposition File rejection process, as this is the area where data problems are typically first identified. Special attention will also be paid to the number of Disposition File Records that are returned by the Fund to BCBSIL and the frequency.

Labor Bytes

After a Fund is in production BCBSIL will periodically make systems-related updates and improvements. To help inform our Funds' technical support staffs and their vendors in advance of upcoming systems changes and other technical news BCBSIL developed *Labor Bytes*. Please see **Labor Bytes (Appendix R)** for a sample copy. This quarterly newsletter is distributed to Funds, their vendors, consultants and TPAs exclusively via email. It may also be found on our Web site, www.bcbsil.com/labor. To be added to the e-mail distribution list, simply alert one of the Implementation Team members.

Systems Support and Availability

Below is systems support and availability information for the following areas:

- [BCBSIL Mainframe](#)
- [EMC-Net](#)
- [BCBSIL Labor Support Help Desk](#)

BCBSIL Mainframe

The BCBSIL mainframe includes HPA, ALIM, LCSSL, IMNU and the Transmittal screens:

- Monday through Friday: 7:00 a.m. – 11:45 p.m., CST
- Saturday: 7:00 a.m. – 3:30 p.m., CST
- Sundays and Holidays: Not available

As a general rule, Funds should contact their Marketing Support representative if they plan to work on Saturday. BCBSIL frequently performs file conversions and production moves on weekends, which may affect mainframe system availability.

Note: A copy of the current year's holiday schedule may be found at www.bcbsil.com/labor.

EMC-Net

Transmission Files:

Transmission files are sent by BCBSIL via EMC-Net Tuesday through Saturday by 6:00 a.m., CST and on Sunday evenings.

Disposition Files:

- Files sent before 10:00 p.m., CST will be processed the next business day.
- Files sent after 10:00 p.m., CST will be processed the second business day.

BCBSIL Labor Support Help Desk

For Labor support issues, call the BCBSIL Help Desk at (877) 242-1369.

Help Desk Support Hours:

- **Full Support** Monday through Friday:
7:00 a.m. – 10:00 p.m., CST
- **Limited Support** Before/after full support hours,
Saturday, Sunday and BCBSIL Holidays

By calling the Help Desk, Funds will be able to speak to support staff trained specifically to handle technical Labor inquiries.

In order to provide Funds with the best possible customer service, please have the following information available when calling the Help Desk:

- Labor Fund name
- Caller name
- Phone number (with area code)
- Group number

Please also have a detailed problem description, as well as the appropriate operating platform. Some examples of problems and their associated operating platforms are as follows:

If you are experiencing problems...	The operating platform is...
downloading or uploading files	EMC-Net
connecting to or working in HPA with ALIM	Mainframe Connectivity Automation