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Technical Staff



May 2010

Spring 2010 Systems Enhancements

Blue Cross and Blue Shield of Illinois (BCBSIL) has made a number of enhancements to the Shared Claims Process (SCP) as a part of our semi-annual update. The Spring 2010 System Enhancements became effective April 19, 2010.

Click [here](#) to access entire article.

FAQs for Spring 2010 Systems Enhancements

Click [here](#) to access entire article.

FTP Electronic Attachments

Electronic transmission of attachments is now available to accounts that utilize FTP connectivity to download and upload files. This enhancement will allow accounts to electronically download attachments, such as EOBs, Medical records and any other attachments, that would normally be sent in an overnight package.

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New Security Protocol

An e-mail notification was sent on Nov. 5, 2009, regarding the new user ID (XGM) security process. As of Dec. 1, 2009, end users' and their managers' signatures are now required on mainframe user ID security requests.

Click [here](#) to access entire article.

New Marketing Support Staff Member

Please welcome Breanne McBride, our newest Marketing Support staff member who joined the team in February.

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Spring 2010 Systems Enhancements

Blue Cross and Blue Shield of Illinois (BCBSIL) has made a number of enhancements to the Shared Claims Process (SCP) as a part of our semi-annual update. The Spring 2010 System Enhancements were effective April 19, 2010. Please find a detailed description of each enhancement below.

Procedure Code Date

BCBSIL will implement an enhancement to the Local and BlueCard process to allow hospitals to include the appropriate Principle Procedure Code and/or Procedure Date performed prior to the admission date on the same bill as the inpatient services. To support this change, the procedure code date will be added to the ETR3 and 837 record layouts. The procedure code date will be added to the LDUES reports and LCSL on June 14, 2010.

The following will be allowed for Institutional inpatient and outpatient claims:

- Date associated with each occurrence of the diagnostic and pre-admission claim level procedures, the Principle Procedure Code, and the Principle Procedure Date and/or Procedure Date can be up to three calendar days prior to the 'Admission Date' (for example, the 'Admission Date' is 1/02/09 and the date associated with the 'Procedure Code' can be no earlier than 12/30/08).
- 'Date of Service' can be up to three calendar days prior to the 'Statement Covers from Date', including spanning a calendar year.
- In the claims adjudication process, if the Principle Procedure Code is present but there is no Procedure Code Date, the First Date of Service on the claim will be populated on the ETR3 and HIPAA 837 record layout.

ETR3 Record Layout:

ETR3 Field Name	Length	Position
ETR3-CLM-PROCEDURE-DT(1)	7	1196
ETR3-CLM-PROCEDURE-DT(2)	7	1203
ETR3-CLM-PROCEDURE-DT(3)	7	1210

HIPAA 837 Record Layout:

	Loop	Segment	Data Element	Qualifier
Procedure Code Date 1	2300	HI	HI01-3 and HI01-4	D8
Procedure Code Date 2	2300	HI	HI01-3 and HI01-4	D8
Procedure Code Date 3	2300	HI	HI01-3 and HI01-4	D8

Example:

On Sept. 19, 2008, a patient presents in a facility for an outpatient procedure, either through the outpatient surgery center or the emergency department. The hospital treats that patient and the procedure is dated 9/19/2008. Upon evaluation on 9/20/08, it is determined that the patient needs to be admitted as an inpatient related to the outpatient services. The patient is in the facility for two more days and discharged on 9/22/08. All of these services would be deemed as inpatient and included on a single claim.

With respect to the above example, from an inpatient claim perspective, the SF fields on the claim would appear as follows:

Admission Date	9-20-08
Statement Covers From	9-20-08
Statement Covers To	9-22-08
Principle Procedure OR Procedure	9-19-08

Obsolete DF Message Codes

BCBSIL is modifying its current edit to prevent accounts from using obsolete DF Message Codes. To ensure the obsolete DF Message codes are not used, an edit will be added to both HPA and ALIM. If an obsolete code is used, the account will receive error code UE017 (claim) and/or UE018 (line) 'Invalid claim level DF message code' or 'Invalid line level DF message code'. The same edits will be performed for ALIM line (L2) and finalization (L3) calls.

Please note the logic added with Fall 2009 System Enhancements to reject a claim if obsolete DF message codes are used will be replaced. Reject Reason Code RC064 will no longer be in use.

Obsolete DF Message Codes

CODE	DEFINITION
0070	Claim cannot be processed until other insurance/Medicare processes the claim.
0159	Our records indicate that this dependent is not an eligible dependent as defined.
0421	Previously paid. Payment for this claim/service may have been provided in a previous payment.
0516	Send physician service report with Medicare EOB for this charge.
0570	Coordination of Benefits - claim closed - file with other insurance.
0804	Concurrent medical care for different physicians.
1060	Handle outside of ITS. Host Plan does not need to send a paper claim unless requested. Home Plan will make payment from SF record.
1061	Third party liability-handle outside of ITS. Host Plan does not need to send a paper claim unless requested. Home Plan will make payment on SF record.
1064	For claims for which the subscriber is not held harmless, subscriber cannot be held harmless for provider discounts. Subscriber may be balanced billed.
1078	Product not eligible for BlueCard Program Delivery.
1080	Another insurance carrier handles these services. Please handle directly with the Home Plan.

1081	Subscriber has not responded to other coverage inquiry.
1088	The application of cost sharing invalidates the discount on this claim. Claim will be handled direct by the Home Plan. Do not send paper claim.
1099	Benefit adjusted. Plan procedures not followed.
1184	These charges are not covered. Custodial care is excluded under the patient's benefit plan or policy (This message code is duplicates of 1165).
*0749	This provider is not eligible to bill for these services.
*0762	Invalid CPT code (service referred to Par Plan for correction).
*1055	This provider is not eligible.
*1057	This service is ineligible in the reported place of service.

*Note – In HPA only, DF Message Codes 0749, 0762, 1055 and 1057 will prompt an invalid system prompt “IUC002 HIGHLIGHTED FIELD(S) ARE IN ERROR” in lieu of UE017(claim) or UE018 (line).

For a complete listing of DF Message Codes and HPA Batch Edit Error Codes, please contact your Marketing Support representative.

New Provider Type and Specialty Type Codes

A new Provider Type and Specialty Code will be passed on the ETR3 or HIPAA 837 layout at the claim or line level.

Provider Type Code: Provider Specialty Code:

Cardio Pulmonary Diagnostic Testing - PD Cardio Pulmonary Diagnostic Testing - 591

ETR3 Record Layout:

Field	Field Location	ETR3 Field Name	Length	Position
Provider Type	Claim level	ETR3-PRO-TYPE	2	101
	Line level	ETR3-SVC-PRO-TYPE	2	1915
Specialty Code	Claim level	ETR3-CLM-PRO-SPECIALTY-CD	3	1138
	Line level	ETR3-SVC-PRO-SPECIALT-CD	3	1989

HIPAA 837 Record Layout:

Field	HIPAA Layout	Field Location	Loop	Segment	Data Element	Position
Provider Type	Professional	Claim level	2300	K3	K301	11-12
		Line level	2400	K3	K301	1-2
	Institutional	Claim level	2300	K3	K301	11-12
		Line level	2400	PWK	PWK06	1-2
Specialty Code	Professional	Claim level	2300	K3	K301	13-15
		Line level	2400	K3	K301	3-5
	Institutional	Claim level	2300	K3	K301	13-5
		Line level	2400	PWK	PWK06	3-5

For a complete listing of Provider Types and Specialty Codes, please contact your Marketing Support representative.

New BlueCard Adjustment Reason Codes - Claim Appeal

Two new BlueCard adjustment reason codes, 234 and 288, will be added with the Spring 2010 System Enhancements. If an account needs to adjust a claim due to a member appeal, a request will be sent by the account to the FSU using the transmittal process. The FSU would transmit the adjustment using one of the new adjustment reason codes.

VOID	VOID - REISSUE	HIPAA ANSI	NOMENCLATURE
234	288	B19	Member Appeal

ETR3 Record Layout:

Field	Field Location	ETR3 Field Name	Length	Position
Adjustment Reason Code	Claim level	ETR3-CLM-FSS-ADJUST-RSN-CD	11	951

HIPAA 837 Record Layout:

Field	HIPAA Layout	Field Location	Loop	Segment	Data Element	Qualifier	Adjustment Value	Position**
HIPAA	Professional	Claim level	2300	REF	REF01	9C		
Adjustment					REF02		B19*	
Reason Code	Institutional	Claim level	2300	REF	REF01	9C		
					REF02		B19*	
Proprietary	Professional	Claim Level	2300	REF	REF01	F8		
Adjustment					REF02		234 or 288	18-20
Reason Code	Institutional	Claim Level	2300	REF	REF02	F8		
							234 or 288	18-20

B19* = Proprietary value 234 and 288 will convert to HIPAA value B19.

Position** = The original claim document number is passed in position 1-17. The proprietary adjustment reason code value is passed in position 18-20.

For a complete listing of Adjustment Reasons Codes, please contact your Marketing Support representative.

Blue Distinction® Centers SF Message Codes

BCBSIL will implement new SF Message Code fields to accommodate claim level informational SF message codes for Blue Distinction Centers (BDC). The BDC SF Message Codes may be passed in the existing SF Message Code fields or the new BDC SF Message Code fields; however, the new BDC Message Code fields will only pass BDC SF Message Codes.

BDC SF Message Codes	
1018	Bariatric
1019	Cardiac Care
1020	Complex and Rare Cancers
1028	Acute Leukemia *
1029	Breast Cancer *

1030	Spine Surgery *
1031	Pediatrics *
1032	Knee and Hip Replacement *
1033	Kidney Transplant *
1034	Colon Cancer *
1035	Prostate Cancer*
1036	Additional Program (undefined) *
1037	Transplants - Alternate Model *

* Future Blue Distinction Centers that may be transmitted on future claims.

ETR3 Layout:

Field	Field Location	ETR3 Field Name	Length	Position
SF Message Code	Claim Level	CLM-SF-MSG-CD (1)	4	907
		CLM-SF-MSG-CD (2)	4	911
		CLM-SF-MSG-CD (3)	4	915
		CLM-SF-MSG-CD (4)	4	919
		CLM-SF-MSG-CD (5)	4	923
BDC Informational	Claim level	CLM-BDC-SF-MSG (1)	4	1176
SF Message Code		CLM-BDC-SF-MSG (2)	4	1180
		CLM-BDC-SF-MSG (3)	4	1184
		CLM-BDC-SF-MSG (4)	4	1188
		CLM-BDC-SF-MSG (5)	4	1192

HIPAA 837 Record Layout:

Field	HIPAA Layout	Field Location	Loop	Segment	Data Element	Position
SF message (1)	Institutional	Claim level	2300	K3	K301	49-52
SF message (2)			2300	K3	K301	53-56
SF message (3)			2300	K3	K301	57-60
SF message (4)			2300	K3	K301	61-64
SF message (5)			2300	K3	K301	65-68
BDC SF Message (1)	Institutional	Claim level	2300	K3(2)	K301	29-32
BDC SF Message (2)			2300	K3(2)	K301	33-36
BDC SF Message (3)			2300	K3(2)	K301	37-40
BDC SF Message (4)			2300	K3(2)	K301	41-44
BDC SF Message (5)			2300	K3(2)	K301	45-48

For a complete listing of SF Message Codes, please contact your Marketing Support representative.

Online Transmittal Enhancements (TRMN)

Enhancements have been implemented to improve the Online Transmittal process. Enhancements implemented in February included:

- On the Main Menu and Response Inquiry Detail screen, the 'Fund Request Number' field will be changed to read 'Fund Claim Number.'
- On the Online Initiate Transmittal Request screen (option 1 from the main menu), Request Codes 05 (R05 – Refund Requests for \$500.00 or less), 10 (Need Itemized Bill), and 12 (Need EOB) will only be allowed for Local Claims. If Request codes 5, 10, 12 are used on a BlueCard claim, the operator will receive an error message stating that the Request code is invalid for BlueCard claims. The remaining Request codes will be valid for both Local and BlueCard claims. Other enhancements to this screen include Auto-populating the Claim location and Group Number based on the DCN/SCCF entered.
- On the Online Initiate Response Detail screen (option 5 from the main menu), the full operator's ID number or the Labor Accounts XGM number will display in the 'Requestor ID' field.
- On the Online Same-Day Open Transmittal Request Detail screen (option 7 from the main menu), the 'Claim Type' is no longer required when modifying or deleting a Transmittal created the same day.

Enhancements effective June 14, 2010 include:

- On the Online Initiate Response Detail screen (option 1 from the main menu); the cursor will now default to the DCN/SCCF field for operator convenience.
- On the Response Inquiry screen (option 4 from the main menu), Response descriptions will be displayed from "Most Current" to "Oldest" based on the Response Date and allow the "Fund Claim Number" field to be a searchable option. Displaying the response descriptions from most current to oldest will allow the Labor Accounts and the Labor Full Service Units to view the recent Response instead of having to navigate through the Response Inquiry screen to view recent responses. Allowing the Fund Claim Number to be a searchable option (with the corresponding Group number) will allow the account the ability to review a specific response without having to navigate in search of a fund claim numbers response.

For questions regarding the Online Transmittal process, or if you are interested in utilizing the Online Transmittal process, please contact your Full Service Unit Representative.

New Ineligible Reason Codes

Several new ineligible reason codes have been added with the Spring 2010 System Enhancements. A complete listing can be found on the SCP Web site at www.bcbsil.com/labor.

ALIM – DME Field Expansion

The DME remaining amount field in the ALIM copybook will be expanded from 6 bytes to 10 bytes. The DME day month unit will move down 4 bytes because of the expansion. If an account is interested in testing this change, please contact your Marketing Representative.

Reject Reason Code Changes

Effective with the Spring 2010 System Enhancements, BCBSIL will be modifying the following Reject Reason Code.

RC017 - Currently, the RC017 Reject Reason Code is defined as 'Ineligible Reason Code invalid.' The definition will now read 'Ineligible Reason Code invalid or missing.'

Effective June 14, 2010, BCBSIL will be adding the following Reject Reason Codes:

RC064 – This code will no longer be in use.

RC065 - Account reduced eligible amount and did not return multiple Ineligible Reason codes. SMA and another ineligible reason code are required (HIPAA Professional).

Example: If the DF eligible amount is reduced and the disposition record ineligible reason code is equal to a pend record ineligible reason code SMA. Additional ineligible reason codes must be sent or claim should reject RC065

RC066 - Account reduced eligible amount without returning ineligible reason code on facility claims. (HIPAA Institutional)

Example: If DF eligible amount is reduced and disposition record non-payment reason code is equal to blank or space(s) on facility claims.

RC067 - Account returned SMA or 503 Ineligible Reason Code on a facility claim. These should only be used on Professional claims (HIPAA Institutional).

Example: If non-payment reason code is equal to SMA or 503 on a facility claim.

For a complete listing of Reject Reason Codes, refer to the [SCP Web site](#).

HIPAA Enhancements

Effective with the Spring 2010 System Enhancements, BCBSIL will begin passing two additional HIPAA ICD-9 Procedure Codes when available.

HIPAA Layout	Field Location		Loop	Segment	Data Element/Qualifier	Data Element
Institutional	Claim level	Procedure Code 1	2300	HI	HI01-1 = BR	HI01-2 = CODE
		Procedure Code 2 <i>New</i>	2300	HI	HI01-1 = BR	HI01-2 = CODE
		Procedure Code 3 <i>New</i>	2300	HI	HI01-1 = BR	HI01-2 = CODE

Soft Edits Enhancement

Claims are passed through a series of matching data criteria in the Soft Edits process. The edits validate the claim data against the data BCBSIL receives from account membership files.

Effective in February, the matching data criteria began validating claims against active and inactive membership excluding date of service with the search. If an active membership match is found, the membership information provided by accounts will be utilized to apply accurate membership data within the BCBSIL internal system. This data will be passed to accounts in the existing membership fields found along with a Membership Record Indicator of "1." If a positive match is not found or a match is found on an inactive member a Membership Record Indicator of "0" will be applied to the claim and no membership data will be changed.

Code	Definition
0	No membership or inactive membership found/ claim was not processed through the Soft Edits process*
1	Full membership found
2	Multiple memberships found

* Accounts not yet using the Soft Edits process will receive a value of "0" on all claims.

For questions, please contact your Marketing Support representative.

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Frequently Asked Questions for Spring 2010 Systems Enhancements

Q: In reference to the Procedure Code Date, would charges from a preadmission service be included with inpatient services and charges?

A: No. The inpatient claims will only have the charges for the inpatient services (rev codes) and charges. Therefore, the claim 'from date' would not change. This enhancement is to allow the principle procedure codes (ICD9 codes) to have a date prior to the admission. This information may be useful to groups in determining benefits, or matching up the outpatient/preadmission services/charges. This will also assist in letting groups know what was done to require an inpatient admission.

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Electronic attachments will be transmitted in a Tagged Image File, TIF, file format. Attachments for both Illinois and BlueCard claims will be available on daily basis in Illinois production mailbox.

This enhancement will substantially reduce both paper handling costs and improve cycle time. If you are currently using FTP connectivity for transmission of data and are interested receiving electronic attachments, or if you would like to convert to FTP please contact your Marketing Support representative.

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New Marketing Support Staff Member

Please welcome Breanne McBride, our newest Marketing Support staff member who joined the team in February. Bre graduated from Western Illinois University with a BS in Family and Consumer Science. She began her career at HCSC in 2006, assisting the OTC department in Jacksonville, IL with the Oklahoma merger. In 2008, she transferred to the Chicago FSU, as a BlueCard Specialist and Customer Advocate Technician. Bre brings a wealth of BlueCard and Labor/Municipal experience to the staff.



Residing in the Chicago Suburbs with her two daughters, Bre is currently working on her MBA, specializing in Healthcare Services, during her spare time.

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