Introducing Secure Transport

Premera Blue Cross has begun to transition all electronic submitters from our older Bulletin Board System (BBS) DOS-based technology, to a new secure Web-based connectivity called Secure Transport (ST). ST is a product of Tumbleweed Communications Corporation that allows transfer of files via a secure internet connection. It utilizes standard security protocols of FTPS and HTTPS, and integrates SSL and Digital Certificate (X.509). It replaces older, less flexible technology, and because it is internet-based, is easily available and integrates well with other applications. It is a field proven, complete solution that allows reliable real-time delivery of large or small files.

As you transition to ST, you will retain your current Premera Blue Cross assigned electronic submitter identification (ID) number. However, your access to Secure Transport will be through a OneHealthPort User ID number, which you may already have. However, if you do not have OneHealthPort access, please register for a user ID at www.onehealthport.com. EDI is currently contacting targeted groups of Trading Partners to begin this transition. For more information about ST, please contact EDI at 1-800-435-2715.

HIPAA Contingency Information

Our current assessed level of HIPAA compliance is now more than 90 percent. We will continue dual-stream, nonstandard and standard electronic claim transactions in support of our HIPAA contingency efforts, while determining the need to alter our current contingency plan. We also continue to monitor guidance from the Center for Medicare and Medicaid Services (CMS) about industry readiness.

Our standard is to provide you with advance notice 30 days before the date that we will no longer support nonstandard electronic claims transactions. Please contact your applicable practice management system vendor or clearinghouse to obtain their HIPAA contingency plans for migrating to the standard transaction format.

Thank you for working with us as we move forward with adoption of and adherence to HIPAA regulations. If you have questions and do not have Web access, please contact an EDI representative for assistance at 1-800-435-2715.
For Physicians and Providers

National Provider Identifier

The federal Department of Health and Human Services issued final regulations early last year on the National Provider Identifier (NPI) numbers, which affect health-care providers, payers (i.e., health plans) and health-care clearinghouses. As part of HIPAA’s Administration Simplification provision, the NPI is a federal mandate requiring the adoption of a standard, unique identifier number for each covered health-care provider. Covered health-care providers are those that transmit health-care information in an electronic form in connection with HIPAA standard transactions.

Beginning May 23, 2005, FOX Systems, Inc., under contract to the Centers for Medicare and Medicaid Services (CMS), will be responsible for issuing NPIs to individual and organizational covered health-care providers. Upon receiving an NPI application from a covered health-care provider, the National Provider and Plan Enumeration System (the “enumerator”) will assign and record the NPI at a national level.

Although covered health-care providers may start applying for an NPI on May 23, 2005, providers are not required to obtain and use their assigned NPI in HIPAA standard transactions until May 23, 2007. Health plans and health-care clearinghouses must be able to use the provider’s NPI to identify the provider on HIPAA standard transactions by the May 23, 2007 date.

Please note the following information:

- Beginning May 23, 2005, we will accept NPIs in HIPAA standard electronic transactions. This includes the ANSI X12 837 claim transactions and all ANSI X12 non-claim transactions (e.g. 270 Eligibility Inquiry, 276 Claim Status Request, 278 Health Care Services Review Request).

- If you plan to use your NPI when sending electronic claim and non-claim transactions, the TIN remains a required element in the Billing Provider and Pay to Provider ‘REF’ Segments of the ANSI X12 837 claims transactions, and applicable Segments within the non-claim ANSI X12 transactions. We strongly recommend that you verify payer(s) requirements for use of the NPI prior to May 23, 2007, before sending it within your electronic transactions.

- The NPI will eventually replace all proprietary (payer-issued) provider identifiers, including Medicare ID numbers (UPINs). The NPI will not replace your tax identification number (TIN) or DEA number.

- If you submit print to mail claims, please do not include your NPI. Paper claims are not subject to the NPI mandate at this time.

NPI Questions and Answers

What do I need to do?

You do not need to do anything at this time. However, we recommend that you contact your systems vendors to learn how they are addressing NPI so you will be ready by the May 23, 2007 compliance date.

Will all payers accept my NPI as of May 23, 2005?

It depends. NPI implementation may vary among payers since the compliance date does not occur until May 23, 2007.

Can your clearinghouse pass on my NPI to other payers to save time?

If you choose to send your NPI as of May 23, 2005 (prior to the compliance date), our clearinghouse will forward the NPI on your claims to the payer(s). Please note: Claims submitted with an NPI beginning May 23, 2005 must also contain the provider’s TIN.

Where do I send the NPI on my electronic claim?

ANSI 837 4010 Addenda claims format: the NPI is designated in the various Provider Identifier NM1 Segments (e.g., Billing Provider, Referring Provider, Rendering Provider, etc.)

NSF T0301 claim format: There is currently no designation for the NPI within this format, at this time.

What happens on the NPI compliance date of May 23, 2007?

Providers need to have their NPI by the compliance date to include in each standard HIPAA transaction. Premera Blue Cross must also be able to receive NPIs, and use them to identify the submitting providers on those transactions in both our health plan and clearinghouse operations by this date. Please note the Premera Blue Cross and affiliate company NPI requirements listed below*.

We will keep you informed as new information becomes available. Our staff will also include NPI information at upcoming provider workshops. Meanwhile, if you need more information about the NPI mandate, Medicare timelines, and/or the enumeration process, visit the CMS Web site at http://www.cms.hhs.gov/hipaa/hipaa2, or call our EDI Clearinghouse department at 1-800-435-2715.
*NPI requirements for Premera Blue Cross health plan and affiliate company claim and non-claim HIPAA transactions.

On or after May 23, 2005:

If you choose to use your NPI when sending Premera (or one of our affiliate companies) electronic claim and non-claim transactions, we will continue to require your Tax ID Number (TIN) until May 23, 2007. Health plan transactions received without a TIN will be rejected as incomplete.

- You may submit the NPI as follows:
  - ANSI 837 4010 Addenda claims format: send the NPI in the various Provider Identifier NM1 Segments (e.g., Billing Provider, Referring Provider, Rendering Provider, etc.)
  - NSF T0301 claim format: There is currently no designation for the NPI within this format. Analysis is currently being conducted. Information regarding NPI placement within this format will be provided at a later date.

- You must submit the TIN as follows:
  - ANSI 837 4010 Addenda claims format: send the TIN in the various Provider “Secondary” Identifier REF Segments (e.g., Billing Provider, Referring Provider, Rendering Provider, etc.)
  - NSF T0301 claim format: Since there is not currently a designation for the NPI within this format, continue to send your TIN as you do today.

- Until notified otherwise, continue submitting your three- or four-digit identifier with all Premera hospital claims as per our billing guidelines.
- Premera does not plan on returning the NPI on electronic transactions until further notice, but no later than the compliance date of May 23, 2007.

**Washington Labor and Industries (L&I) Update**

Premera Blue Cross is now sending claims to L&I in the ANSI X12 837P 4010A1 format. Only error free L&I claims that Premera receives in a compliant format are forwarded in the 837P format. Claims received in a non-compliant format will continue to be forwarded in the L&I proprietary format.

L&I has not yet set a deadline for discontinuing the proprietary format. Two other payers, Washington DSHS and Noridian Medicare, will now only accept 837P formatted claims from Premera and we expect other payers to make the change soon.

You may notice new errors on your L&I Explanation of Services (EOB) as a result of this change. Several specific data elements/fields need special attention on your part:

1. L&I specifications require that each claim contain an EMPLOYMENT RELATED indicator. Claims without this information may be delayed or rejected by L&I in their processing. Premera has added a WARNING message for claims missing this information. These claims will be forwarded to L&I but will be rejected at a future date that is determined by L&I.
2. Premera will edit for the EMPLOYMENT RELATED indicator in the following elements/fields:
   a. ANSI 837P Claims – Loop 2300, CLM11-1 (Related Causes Information) must be the value “EM”
   b. NSF T0301 – Record/Field EA0.04 (Employment Related Indicator) must be the value “Y”

3. L&I specifications require that the L&I Claim Number be present in two different data elements/fields – the Group Number and the Subscriber Number. The claim number should be placed in the following elements/fields:
   a. ANSI 837P Claims – Loop 2000B, SBR03 (Reference Identification (Group Number)) and Loop 2010BA, NM109 (Identification Code (Subscriber Primary Identifier (Subscriber Number)).
   b. NSF T0301 Claims – Record/Field DA0.10, Sequence 01 (Group Number) and DA0.18, Sequence 01 (Insured Subscriber Number).

Your claims will not reject if you do not submit the claim number in the Group Number. If the Group Number element/field is blank, we will forward the Subscriber Number in the Group Number element/field as well as in the Subscriber Number element/field.

Any information you send in the Group Number element/field will be forwarded exactly as you send it. We cannot, under HIPAA rules, substitute data for existing data in an element/field. Claims with information other than the L&I Claim Number may be delayed or rejected by L&I in their processing.
Department of Social and Health Services Reminder

Effective as of March 1, 2005 Department of Social and Health Services (DSHS) only accepts claims from Premera Blue Cross that have been submitted in a HIPAA compliant format.

Standard HIPAA compliant electronic formats include ANSI X12 837 4010A1 and NSFH T0301. Submitters not sending claims in one of those formats must bill DSHS via paper claims until the transition to a compliant format is complete.

If you’re not currently sending claims to the Premera Clearinghouse in a compliant format, we encourage you to contact your software vendor immediately to make this change. Please contact an EDI representative at 1-800-435-2715 if you have questions regarding this requirement.

Noridian Updates

Medicare Reports

Premera Blue Cross currently mails these reports. However, they will soon be available online via our Bulletin Board System. Once this option is available, we will include notification of the online report availability in the report mailing, and details about the hard copy mailing cut-off timeline.

Medicare Reminder

Effective April 15, 2005, Noridian Medicare only accepts claims from Premera Blue Cross that have been submitted in a HIPAA compliant format. Premera Blue Cross no longer forwards Noridian claims received in a non-compliant format.

Electronic Billing Helpful Hints

Editor’s Note: This section of the EMC Hotline is dedicated to troubleshooting electronic claim issues and preventing claims rejections. Please watch for new important billing information in each issue of the EMC Hotline.

DSHS and Labor and Industries (L&I) Referring Provider Information

Effective February 14, 2005, claims that did not contain required information were rejected. Please include referring information in the claims to prevent claim rejections from occurring. We’ve listed the requirements below:

ANSI X12 4010A1 837P submitters –

Claim Level Referring Provider – Loop 2310A (when used) must contain a REF Segment where REFO1 must contain the appropriate qualifier.

DSHS use qualifier: ‘1D’

L&I use qualifier ‘X5’

Loop 2310A REFO2 must contain the DSHS or L&I provider number of the referring provider.

DSHS - must be a seven position number

L&I - may be seven positions or less

Line Item Referring Provider – Loop 2420F (when used) must contain a REF Segment where REFO1 must contain the appropriate qualifier.

DSHS use qualifier: ‘1D’

L&I use qualifier ‘X5’

Loop 2420F REFO2 must contain the DSHS or L&I provider number of the referring provider.

DSHS this must be a seven position number.

L&I – may be seven positions or less

NSF_T0301 submitters –

Option 1 - Place the DSHS or L&I provider number of the referring provider in EA0.20. Qualify the number by placing the appropriate qualifier in EA0.55.1

‘1D’ for DSHS

‘X5’ for L&I

Note: The referring provider name fields EA0.24 and EA0.25 must be filled when EA0.20 is used.

Option 2 - Place the DSHS or L&I provider number of the referring provider in EA0.21. It is not necessary for you to include the qualifier.

Premera is able to determine if it is a DSHS number or an L&I number in EA0.21. It is not necessary for you to include the qualifier.

Seven digit numeric value for DSHS

Seven position value or less for L&I

The DSHS qualifier ‘1D’ or L&I qualifier ‘X5’ is forwarded to DSHS or L&I respectively.

Note: The referring provider name fields EA0.24 and EA0.25 must be filled when EA0.21 is used.

Option 3 - Place the DSHS and L&I provider number of the referring provider in FB1.13. It is not necessary for you to include the qualifier.
NSF_T0301 submitters (continued)

Premera is able to determine if it is a DSHS number or an L&I number in EA0.21 and if the field contains:
- Seven digit numeric value for DSHS or
- Seven position value or less for L&I

The DSHS qualifier ‘1D’ or L&I qualifier ‘X5’ is forwarded to DSHS or L&I respectively.

L&I. Note: The referring provider name fields FB1.10 and FB1.11 must be filled when FB1.13 is used.
Option 1 is the preferred solution but option 2 or 3 will allow you to submit compliant information.

All Claim Types
Carrier code 9999, Printed as Hardcopy claim batches cannot contain multiple payers. Multiple payer claims in one batch causes the payer to receive invalid claim information. Separate batches are required for each billed payer.

Referring Provider Information Edits
New edits for claims containing referring provider information have recently been implemented for NSF T0301 submitters. Similar edits were already in place for ANSI X12 4010A1 837P submitters. The new edits verify that if the referring provider’s name or number is used in the claim, that all required referring provider fields are populated.

When EA0.20 or EA0.21 contains the referring provider number, the referring provider name fields – EA0.24 and EA0.25 must be populated.

When the referring provider name fields EA0.24 and EA0.25 are filled, the referring provider number must be included in EA0.20 or EA0.21. When FB1.13 contains the referring provider number, the referring provider name fields FB1.10 and FB1.11 must be populated.

When the referring provider name fields FB1.10 and FB1.11 are filled, the referring provider number must be included in FB1.13.

ICD-9 Diagnosis Codes
Claim level rejections frequently occur due to the billing of invalid diagnosis codes. Please include the correct ICD-9 diagnosis codes and the 4th and 5th digit whenever applicable.

Billing Provider Credentials
If you include provider credentials on your electronic claims, please ensure you do not place them in the last name field. Correct placement will help to avoid claims processing delays.

Updated NSF_T0301 Manual Available
The NSF T0301 specification manual has been updated and is available on the Premera Blue Cross Web site at www.premera.com.

BlueCard® Out of Area Claims Can Be Sent Electronically
Patients participating in the BlueCard® program can be identified by a suitcase symbol on the top right of the patient’s Blue Cross and/or Blue Shield identification card.
This is a reminder that if you treat an out-of-area patient who is a member of another Blue Cross and/or Blue Shield Plan, you can submit your claims electronically with your Premera Blue Cross claims. Make sure to include the complete ID number with the Alpha Plan Prefix and group number from the front of the Blue Cross and/or Blue Shield identification card when you submit your electronic claims.

Premera Blue Cross Clearinghouse Services
Only professional ANSI X12 837 and NSF T0301 claims submitters will be offered Premera clearinghouse services. Note, if you are a clearinghouse submitting electronic professional claims to the Premera clearinghouse, you are only allowed to submit Premera products.
Bulletin Board System (BBS) Reports

Downloading the Electronic Claims Transaction Report from the Premera Bulletin Board System (BBS) will help you avoid lost claims, eligibility errors and missing rejected claim information. Verifying these reports against your office reports ensures accurate receipt of your claims. Please remember the following key points:

• Reports are only available in an online format from the BBS
• Picking up your reports regularly ensures notification that we have received your claims and whether there were any rejections
• Rejected claims will not be processed; they must be corrected and re-billed.

ANSI X12 Submitters:
The following additional reports are placed on the BBS for retrieval:

• ANSI Transaction reports are available for downloading from the BBS under the ”menu” option
  <A> ANSI X12N Transaction Downloads.
  The following menu selections are available:
  <1> Medicare Part-A ANSI X12 Transaction Download
  <2> Non-Medicare ANSI X12 Transaction Download
  <3> Non-Medicare ANSI Error Report Download

  Note: The 837 error report only lists actual, rejected claims instead of the entire ST-SE segment.

997 (Functional Acknowledgement)

• The 997 is found under menu selection <2> Non-Medicare ANSI X12 Transaction Download
• It is the responsibility of each provider office to download their 997 after every claims transmission
• The 997 is normally available within one hour of claims transmission
• If any portion of your file does not pass HIPAA validation or contains other errors, all or part of the file may be rejected and reported on the 997
• Contact your software vendor for assistance in interpreting this report.

837 TRANSACTION ERROR REPORT

Note: To correctly balance files transmitted to our Clearinghouse you will need to reference both the Electronic Claim transaction report (ECC16000) and the 837 Transaction error report to reflect a full accounting of the claims transmitted to Premera. For assistance, please contact an EDI Representative.

This report is found under menu selection <3> Non-Medicare ANSI Error Report Download.
• The ‘837 Transaction Error Report’ was developed to report claims that reject in the HIPAA validation process. This report provides detailed information regarding the HIPAA validation errors. This report is created only when HIPAA validation errors are detected – your 997 will show rejections. Claims rejected at this level do not appear on any other BBS report and must be corrected and re-transmitted.
• The ‘837 Transaction Error Report’ is provided online for retrieval from the Premera Blue Cross Bulletin Board System in a PDF format.
• The report file name is ‘837ERnnn.PDF’, (Example: 837ER001.PDF). The three positions following 837ER denotes the generation of the report. At this time only a non-compressed version of the report is available.
• In order to view and print this report you will need Adobe Reader. If your computer does not have Adobe Reader, you can download it at no cost from: http://www.adobe.com/products/acrobat/readstep2.html
General Information

BBS System Availability

BBS is available seven days a week, virtually every hour of the day, except for Monday - Friday 3:00 p.m. to 4:00 p.m. (PST). Please note:

- Files received by 3:00 p.m. Monday through Friday are processed in that day’s cycle with the reports available the following morning.
- Files received after 3:00 p.m. are processed the next working day with the reports available the following morning (2nd day after receipt).
- Online reports are available after 6:00 a.m. each day.

Northstar Administrators Name Change

Effective April 1, 2005 Northstar Administrators changed its name to Lifewise Administrators—another member of the Premera Blue Cross family of companies. Please contact an EDI representative at 1-800-435-2715 if you have questions.

TriCare Claims for WebMD Reminder

Prior to sending TriCare claims for WebMD to the Premera Blue Cross Clearinghouse, enrollment with WPS/TriCare/Triwest is required. You can link directly to the WPS/TriCare Triwest enrollment form at the following link: http://www.wpsic.com/edi/pdf/triwest_clm_agmt.pdf

Please follow the WPS/TriCare Triwest instructions for enrollment. If you have questions about this enrollment, you may contact a WPS/TriCare representative at 1-800-782-2680, extension 35855.

WebMD Updates

With WebMD’s ability to accept ANSI 837 4010A1 files, some payers are unable to accept more than four diagnosis codes. Rejections may occur and a paper re-bill of the claim will need to be sent to the payer rejecting your claim, until they are able to accept the ANSI format.

You do not need to submit WebMD batched claims separately any longer. You can include all payers in one batch as long as the valid payer identification number is used.

WebMD Payer Listing

We encourage you to obtain the most recent payer listing directly from WebMD Envoy on a monthly basis by either accessing their Web site or calling their fax-on-demand service. To download the Medical Participating Payer list, go to www.envoy.com or www.webmdenvoy.com.

The Web site has been updated, use the following steps:

How to Contact EDI

❖ Fax numbers: 
  Mountlake Terrace office: 425-918-4234
  Spokane office: 509-252-7794
❖ Questions or problems: E-mail the EDI department at EDI@premera.com.
❖ Premera health plan information: Use our Web site at www.premera.com
❖ Connection issues:
  If you have questions regarding your connection to Premera, call the Network Coordinators, Cindy Carmichael or Ken Beasley at 425-918-4040.

  If you have questions or wish to obtain information about any of the articles in this newsletter, please call one of the EDI representatives listed below.

Phone hours: 8 a.m. – 4:30 p.m. (PST), M – F

Toll-free 1-800-435-2715
Select Option 1 for Seattle office
Select Option 2 for Spokane office
Select Option 3 for Bend office

Mountlake Terrace office
Direct Lines

Lynnette Boulch 425-918-4218
Teresa Busch 425-918-4644
Lenea Dyer 425-918-3505
Linda Heitman 425-918-4751
Norma Seymour 425-918-4077
Rowena Solomon 425-918-4983
Dana Thomas 425-918-5129

Spokane office:
Toll-free 1-800-572-5256
Joan Ruyle 509-252-7471
Larry Stansbury 509-252-7986
Shari Johnson 509-252-7488

Bend office:
Alex Dufault 541-318-2133
Kirsten Tastula 541-318-2216

Continued on page 8
Please post or circulate this newsletter in your office

WebMD Payer Listing
Continued from page 7

to access the Medical Participating Payer list:
  • Select Claim Payers
  • Payer name – leave blank
  • Payer type – select ALL
  • Par type – select Par
  • Line of business – Medical
  • Search
To obtain a copy via fax, simply call 1-800-760-2804 and request document #31. WebMD will fax it to your office immediately. You may also obtain a copy from our office by contacting any of our EDI representatives. For any further questions, call the WebMD Payer List Help Line at 1-800-933-6869 or their Help Desk at 1-800-845-6592.

Please Help Us with Office Updates
Any time you have a change in your software vendor, billing service, billing staff, or office addresses, please contact an EDI representative to update your office information.

Holiday Closures
Premera will be closed on:
  July 4, 2005 – Independence Day
  September 5, 2005 – Labor Day

EMC Hotline
(Electronic Media Claims) comes out quarterly to provide important information relating to electronic claims processing for the office billing staff, billing services and software vendors from Premera Blue Cross. We strongly recommend you keep this newsletter for future reference.

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The Premera Blue Cross EDI team is dedicated to providing excellent service, and we appreciate your continuing efforts to submit error-free claims.