276/277 Health Care Claim Status Request and Response Transactions

Disclaimer

This AmeriHealth (hereinafter referred to as AH) Companion Guide to EDI Transactions (the "Companion Guide") provides Health Plan's trading partners with guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12N Implementation Guides require transmitters and receivers to make certain determinations/elections *(e.g.,* whether, or to what extent, situational data elements apply), this Companion Guide documents those determinations, elections, assumptions, or data issues that are permitted to be specific to Health Plan's business processes when implementing the HIPAA ASC X12N 4010 Implementation Guides.

This Companion Guide does not replace the HIPAA ASC X12N Implementation Guides, nor does it attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of Health Plan that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This document provides information on Health Plan specific codes and situations that are within the parameters of the HIPAA Administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

This Companion Guide provides supplemental information to the Trading Partner Agreement that exists between Health Plan and its trading partners. Trading partners should refer to the Trading Partner Agreement for guidelines pertaining to Health Plan's legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on Health Plan's business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this Companion Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency between the terms of this Companion Guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement will govern.

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Overview of Document

This guide is to be used as a supplement to the 276/277 Claim Status Request and response Implementation Guide, version 4010A1, issued February 2003. These transactions should be used to obtain claim status from AmeriHealth, hereinafter referred to as AH.

The purpose of this document is to outline AH processes for handling the 276/277 Health Care Claim Status Request and response transactions (hereinafter referred to as the 276/277), and to delineate specific data requirements where that option is available within the 4010A1 Implementation Guide. A provider, recipient of health care products or services, or their authorized agent can request the status of a health care claim or encounter from a health care payer via this transaction set.

This document will be part of any *Trading Partner Agreement* between a health plan and an electronic trading partner, such as an intermediary, a hospital, a physician group, etc. TOP

National Provider Identifier (NPI)

AmeriHealth will require the submission of National Provider Identification Number (NPI) for all electronic transactions submitted May 23rd 2007 or thereafter.

If you have obtained your NPI(s) and submitted them to us, you may begin to report them **in addition to your current provider identification numbers**.

General Instructions

The information provided in the transaction will reflect that status of the claim at the point in time the request is made. The status of the claims may change. The transaction will not automatically notify a provider about a change in the claims status. Status information will only be provided upon request.

The intent of this transaction is not to provide information explaining how the claim was adjudicated or why certain amounts were or were not paid. Answers to those types of questions will be contained within the Remittance Advice (835) transaction.

The 276 transaction can be received from the trading partner at the line level, but AH will only be responding at the claim level on the 277 transaction. AH does not have the functionality to process a line level response. The 276 request is a solicited request that is made by the Trading Partner. The 277-response transaction will only be returned when a solicited 276 is received.

The following STC data elements will be returned on the 277 transaction depending if the claim was paid or rejected:

- **STC 05 – Claim Payment Amount**: This element will be used to reflect the claim paid amount. When a claim is not paid or the adjudication period is not complete this amount will be 0.
- **STC 06 – Adjudication or Payment Date**: This element will be used to reflect the date the claim was paid or rejected. If the claim has not completed the adjudication cycle this field will not be populated.
- **STC 07 – Payment Method Code**: This element will be used to reflect the type of method that will be used to pay the adjudicated claim. This element will not be used for claims that are in process, have not completed the adjudication process, or have rejected.
- **STC 08 – Check Issue or EFT Date:** This element will be used to reflect the date that the check was produced or the date the EFT funds were released. This element will only be used for claims that have completed and adjudication and payment cycles.
- **STC 09 – Check Number**: This element is REQUIRED by HIPAA for all PAID and **finalized** claims, when the entire claim has been paid using a single check or EFT. This element will not be used for claims that are in process, have not completed the adjudication process, or have rejected. Claim Search Criteria TOP

Submitting a 276-status request to AH for a claim that has already been submitted to the payer is the first step in the claim status request/response process. In order for AH to locate a claim status, the following information from the original claim must be populated accurately on the 276 request:

Element Name & Qualifier	Loop ID	Segment Element
Provider ID Number SV	2100C	NM108
National Provider ID XX	2100C	NM108
Federal Tax ID FI	2100C	NM108
Subscriber ID/SSN MI	2100D/2100E	NM108
Claim Service Date 232	2200D/2200E	DTP01
Patient Last Name QC	2100D/2100E	NM103
Patient First Name QC	2100D/2100E	NM104
Patient Date of Birth D8	2100D/2100E	DMG01

Requests that fail to match any of the search criteria listed above will result in the generation of a 277 Response with the following default values:

- STC01-1 : HIPAA Claim Category Code = A4 = Acknowledgement not found
- STC01-2: HIPAA Claim Status Code = 35 = Claim/Encounter not found. TOP

Out of Area Requests

In some instances, AH is required to electronically send the 276 transactions through Blue Exchange to the Home Plan for the most accurate 277-response. The "Home Plan" is defined as the Plan the member is subscribed to.

Blue Exchange is the Blue Cross and Blue Shield Association's Inter-Plan system that will handle the transaction processing. Blue Exchange will provide Plan-to-Plan communications to ensure timely processing of the 276 request and 277 response.

All guidelines and information pertaining to the 276-transaction mentioned previously in this document must be adhered to for out-of-area members. The transferring of the 276-request between AH and the Home Plan will be transparent to the trading partner. TOP

Transmission Size/Type

AH will be supporting Real Time and Batch Mode processing for all incoming 276 transactions. Real Time and Batch Transaction will have file size limitations that are documented below. All incoming 276 transactions will receive a negative or positive acknowledgement via the 997 transaction. Trading Partners will only receive a negative TA1 transaction when the transmitted file is corrupted and/or cannot be processed by AH. TOP

Real Time Transaction

Real time transactions contain one 276 request for status information on no more than 1 claim that was previously submitted to AH. Each envelope that is received from the Trading Partner will contain a single 276 request transaction. A single request is identified as one TRN per ST – SE. Within that request, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, and IEA. If the submitting Trading Partner exceeds the single request per 276 transaction, AH will return a 277 transaction with the following:

- STC01-1: HIPAA Claim Category Code = EO = Response not possible. System Status found
- STC01-2: HIPAA Claim Status Code = 481 = Claim/submission format is invalid

The requesting Trading Partner will send the single request to AH through electronic means that were discussed previously within the Reference Guide and will remain connected while the request is processed and AH returns a 277 transaction. TOP

HIPAA mandates a maximum 60-second turn around response for all 276 real time requests. If the transaction reaches the time out window of 60 seconds, AH will return the following on the 277-response transaction:

- STC01-1: HIPAA Claim Category Code = E1 = Response not possible. System Status found
- STC01-2: HIPAA Claim Status Code = 0 = Cannot provide further status electronically

Health Plans will respond to Real Time transactions within a few seconds to around thirty seconds, and should not exceed one minute. The speed of processing a real time Transaction will depend upon how long it takes to match a claim in the claims processing system using information that is contained in the 276. TOP

Batch Transactions

Batch transactions contain multiple claim status requests for previously submitted claims. A batch transaction can contain multiple requests, but cannot exceed 99 requests (TRN). The TRN segment identifies a request within the transaction (ST – SE). When the batch transaction is received by the AH, if there are more then 99 requests, the EDI system will return a 277 transaction stating the following for each request:

- STC01-1: HIPAA Claim Category Code = E1 = Response not possible. System Status found
- STC01-2: HIPAA Claim Status Code = 0 = Cannot provide further status electronically

TOP

Functional Acknowledgments

AH intends to respond, with some type of acknowledgment, to every batch or real time requests of 276s that are received. This acknowledgment will be sent whether or not the Trading Partner, requests it. The acknowledgment will indicate that the 276 transaction was received and whether the request was accepted for processing or rejected. The TA1 and 997 transactions will be the used as the means of communication to the Trading Partner of their request.

Upon receipt of a Real Time or Batch Claims Status Request (276), if the enveloping is unreadable or does not comply with Implementation Guide or AH standards, we will respond with an appropriate TA1 transaction. The request will not be processed and treated as a full file reject.

Upon receipt of a Real time and Batch Claim Status Request (276), if the Functional Group is unreadable or does not comply with Implementation Guide or AH standards, we will not able to process the request, AH will respond with a 997. The 997 transaction will also report the claim status requests that have been accepted for processing by AH. This action will only occur for Batch file requests. TOP

276/277 Claim Status Request and Response Sample Transactions

276 Request Sample Transactions

The following are two sample transactions of how the 276 transaction will need to be submitted. Specific situational fields within the transaction are required in certain situations for AH processing of the request. The TP can use the fields not depicted in the section at their own digression.

In addition to the fields depicted in the section 3.0 Claim Search Criteria, AH will need to have the TRN and DTP segments populated at either the 2000D for subscriber is the patient requests and at 2000E for dependent requests. If the 276 request transaction does not contain the TRN segments, AH will reject the transaction for compliance issues. TOP

The following is a basic 276 request of a subscriber that is the patient. At the minimum this is how the 276 transaction to AH should be populated:

ST*276*0046!

BHT*0010*13**20030109!

HL*1**20*1!

NM1*PR*2* PAYER NAME ****21*9012345918341!

PER*IC*PROVIDER CONTACT INFO*TE*6145551212!

HL*2*1*21*1!

NM1*41*2******46*111222333!

HL*3*2*19*1!

NM1*1P*2*PROVIDER NAME*****FI*FEDERAL TAX ID!

NM1*1P*2*PROVIDER NAME*****XX*NPI NUMBER!

NM1*1P*2*PROVIDER NAME*****SV*PROVIDER NUMBER!

HL*4*3*22*0!

DMG*D8*19191029*M!

NM1*QC*1*DOE*JOHN****MI*MEMBERID

TRN*1*500!

REF*1K*940922!

REF*BLT*131!

AMT*T3*28.00!

DTP*232*RD8*20020501-20020501!

SE*18*0046!

TOP

The following is a basic 276 request of a subscriber that is not the patient. At the minimum this is how the 276 transaction to AH should be populated:

ST*276*0046!

BHT*0010*13**20030109!

HL*1**20*1!

NM1*PR*2* PAYER NAME ****21*9012345918341!

PER*IC*PROVIDER CONTACT INFO*TE*6145551212!

HL*2*1*21*1!

NM1*41*2******46*111222333!

HL*3*2*19*1!

NM1*1P*2*PROVIDER NAME*****FI*FEDERAL TAX ID!

NM1*1P*2*PROVIDER NAME*****XX*NPI NUMBER!

NM1*1P*2*PROVIDER NAME*****SV*PROVIDER NUMBER!

HL*4*3*22*1!

NM1*IL*1*DOE*JOHN****MI*MEMBERID

TRN*1*500!

HL*5*4*23!

DMG*D8*19171106*F!

NM1*QC*1*DOE*JANE!

TRN*1*500!

AMT*T3*68.69!

DTP*232*RD8*20021016-20021016!

SE*19*0046!

Note: *There are no examples of how a 276 should be submitted for line level requests, because AH will not be returning Line Level Responses.* TOP

277 Transactions

The 277 transaction will be a mapping of the inbound 276 transaction. As stated above in the guide, there are some differences between the transactions.

The STC loop will only be provided on the outbound 277. The REF loop, which contains the Group Number and the Payer Claim Identification Number, will not be mapped to the 277. The following an example of how the Trading Partner might receive the STC Loop:

STC*F1>1*20030130127.06*108.00*20030128*NON**

The STC loop will provide claim status information, payment amount, and paid or denied date. TOP

Transaction Acknowledgements

TA1 Interchange Acknowledgement Transaction

All X12 file submissions are pre-screened upon receipt to determine if the ISA or IEA segments are unreadable or do not comply with the HIPAA Implementation Guide. If errors are found, IBC will send a TA1 response transaction to notify the Trading Partner that the file cannot be processed. No TA1 response transaction will be sent for error-free files.

Example: Once the 837I Transaction is received by IBC, the file is checked for compliance. Within IBC, a validation is performed on the ISA loop and the IEA loop information. If these segments are missing required elements or have a non-standard structure, the file will receive a full file reject and the TA1 response transaction will be sent to the trading partner.

997 Functional Acknowledgement

If the file submission passes the ISA/IEA pre-screening above, it is then checked for HIPAA compliance syntactical and content errors. When the compliance check is complete, a 997 will be sent to the trading partner informing them which claims in the file were accepted for processing or rejected.

Example: An X12 file has passed pre-screening, and is then checked against the HIPAA standard. Once the file has been processed against the HIPAA standard, a 997 is generated indicating which claims within the file have passed or failed syntactical/content errors. No further processing of the failed X12 transaction will occur.