



Forum Companion Document

For use with ANSI ASC X12N
Health Care Claims Status Request and Response
Implementation Guide

Health Care Claims Status Request and Response (Batch) **276/277**

ANSI ASC X12N 276/277 (004010X093A1)

“Developing, Posting From
& Troubleshooting the
Transactions”

*Version:
December 17, 2004*

Getting an Electronic Version of this Document

An electronic version of this document, and other 276-277 related documents, can be found at www.wahealthcareforum.org/hipaa/work_products.asp. From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

Participants in the 276-277 Companion Document Initiative

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and medical groups. For additional information about The Forum see www.wahealthcareforum.org.

Health plans participating in this initiative include:

- *First Choice Health Administrators*
- *Group Health Cooperative and Option Healthcare*
- *Premera Blue Cross*
- *Regence BlueShield*

Professional provider organizations participating in this initiative include:

- *The Everett Clinic*
- *Children's Hospital & Regional Medical Center*
- *Group Health Cooperative*
- *Wenatchee Valley Medical Center*

Intended Use of the 276-277 Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Health Care Claim Claims Status Request and Response (Batch)Transactions.

A complete version on the Implementation Guide can be accessed at

www.wpc-edi.com/hipaa/HIPAA_40.asp.

This Companion Document is designed to help provider organizations, e.g. medical practices, clinics, hospitals in their efforts to:

- *Become familiar with the HIPAA 276 transaction and how that transaction will be processed by participating health plans*
- *Become familiar with the HIPAA 277 transaction they will receive from participating health plans*
- *Develop software to implement & exchange the HIPAA 276 transaction with participating health plans and to automatically post relevant information into their accounts from the HIPAA 277 transaction.*
- *Develop specification materials for vendors who will implement the HIPAA 276 transaction and who may do any automatic posting from the HIPAA 277 transaction.*
- *Resolve possible issues that might arise in the process of HIPAA 276 transaction exchange and in the process of posting from the HIPAA 277 transaction.*

*This Companion Document should be a useful guide for provider organizations, and others that exchange the 276 & 277 transactions **directly** with participating health plans (previously listed).*

This Companion Document is likely to become one part of any trading partner agreement between a provider organization, or electronic receiver, and a health plan. The term, '*trading partner agreement*', is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

All conventions should be stated clearly in the *trading partner agreement* so that implementation and operations expectations are defined unambiguously. Conventions that are established in a *trading partner agreement* take precedence over any conventions that are contained in this document.

*This Companion Document may be less useful when a provider organization, or their electronic intermediary, is not exchanging transactions directly with participating health plans. Information contained in this document **may not** apply to exchanges between:*

- Provider Organizations and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Provider Organizations and Clearinghouses: Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this Companion Document. The clearinghouse may reformat the health plan's transaction before passing it along to the provider. This reformatting may add unforeseen complexity to the process of transaction exchange.

Scope of the 276-277 Transaction

Within Scope of this Document:

It is expected that providers will use this transaction to get answers to questions such as:

- Did you receive my claim?

- Where is my claim in your system?
- Is there anything I need to do to get my claim processed?

The 276-277 transactions can be used to retrieve information on any submitted claims. This includes claims that were submitted on paper and well as those that were submitted electronically.

Health Plans will provide status information on claims that are on file in their system. Health Plans will attempt to identify a previously submitted claim using the information that is submitted in the 276 request. The likelihood of a Health Plan identifying the right claim the first time around will be increased to the extent that the conventions outlined in this document are followed by providers in preparing a 276 request.

The information provided in the transaction will reflect the status of the claim at the point in time the request is made. The status of the claims may change.

Outside Scope of this Document:

This transaction WILL NOT automatically notify a provider about a change in 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 in the Remittance Advice (835) transaction.

Health plans will continue with their current practices of transmitting reports about claims that were received electronically (e.g. accept/reject reports.) These reporting practices will continue until there is an X.12 specified transaction to communicate this information. More information about these reports can be found in the 837I/837P Companion Document titled 'Developing & Troubleshooting the Transaction', in question #3 of the section heading 'Trouble Shooting Questions and Answers'.

Dictionary of Important 276 & 277 Transaction Terms and Definitions

These definitions relate to data elements/descriptions within the 276 & 277 transactions and are intended to provide more clarity about those data elements.

Term	Definition
Information Source	The health plan who has the status information about the claim
Information Receiver	The provider organization, or their electronic intermediary, who is submitting the request for claims status information.

Refer to the 837I & 837P documents, as appropriate, for the definition of other terms related to claims processing.

Helpful Hints for Developing the 276 Transaction

This section of the 276-277 Companion Document provides hints that may be helpful in developing and submitting a 276 transaction. Following these hints should expedite turnaround time on the claim status request.

These hints apply to the batch implementation of the 276 transaction. Batch implementation means that the submitting organization sends the 276 transaction to the health plan through some means of telecommunications and does not remain connected while the health plan processes the transaction.

1. Creating an electronic envelop (ISA-IEA) for the claim transaction

The X12N structure allows for either one or multiple transaction types to be transmitted in an ISA-IEA envelope. Participating health plans prefer that each different type of transaction is contained within its own ISA-IEA envelope. For example, if an electronic transmission between two trading partners contains eligibility inquiries and claim status inquiries, there will be two ISA-IEA sets; one for the eligibility inquiries (270) and one for the claims status inquiries (276).

2. Structuring the transaction (GS-GE & ST-SE)

A separate GS-GE set is preferred for each provider organization that originated a batch of eligibility inquiries.

- The HL structure for the transaction should be Information Source/ Information Receiver/ Provider/Subscriber/Dependent.

3. Formatting Data in the Transaction

- Any character used in a data element cannot be used as a delimiter, separator, or terminator. Ideally, the following characters should not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , # , : , ~).
- By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 should contain a '2' to indicate a non-person entity.

4. Staying Compliant With HIPAA Transaction Versions and Code Sets

- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, only the legally mandated version of the transaction. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.

- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, the medical data code sets that are valid at the time that the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submission date.) This means that health plans must be able to process versions of the code sets that precede the current version.
- Current versions of many of the code sets are available at www.wpc-edi.com/codes/

5. Filling in ‘Information Source’ and ‘Information Receiver’

- The Information Source is a Health Plan.
- The Information Receiver could be a Provider Organization, or an electronic intermediary acting on behalf of a Provider Organization.
 - If the Information Receiver is the provider organization -- the ISA segment, the GS segment and the 2000B and 2100B Loops (Information Receiver Level) will identify the Provider Organization. The individual provider rendering the service will be identified in the 2000C Loop (Service Provider Level).
 - If the Information Receiver is an electronic intermediary acting on behalf of one or more provider organizations -- the ISA segment, the GS segment and the 2000B and 2100 B Loops (Information Receiver Level) will identify the intermediary. It is assumed that there will be only one occurrence of Loop 2000B and Loop 2100B. The health plan will process the first 2000B Loop and the first 2100B Loop that are encountered.

Each Provider Organization would be identified in one occurrence of the 2000C Loop (Service Provider Level). Each individual provider rendering the service will be identified in a second occurrence of the Loop (Service Provider Level).

6. Correctly Identifying the Provider

- The provider identified in the Service Provider Level (Loop 2100C) of the 276 request will be assumed to be the provider that rendered service to the patient. The rendering provider on the 276 request must match the rendering provider recorded on the corresponding bill/claim that was previously submitted, *at the lowest level*. This means that:
 - if an individual was identified to be the rendering provider on the submitted claim, then that individual must be identified on the 276. The organization with which the provider is associated should also be identified on the 276. Two NM1 segments will be required with the organization (facility) in the first NM1 loop and the rendering provider in the second NM1 loop. See Scenarios.

- if an organization was identified to be the rendering provider on the submitted claim, e.g. in the case of Durable Medical Equipment (DME), then that organization must be identified on the 276.
- Until a National Provider Identifier is assigned, ‘SV - Service Provider Number’ will be the Identification Code Qualifier (NM108 of the Service Provider Level – Loop 2100C). The identifying number of the rendering provider (NM109 of the Service Provider Level – Loop 2100C) will be the number that is assigned by the health plan that is the Information Source. This number will most likely be different for different health plans.

7. Correctly Specifying the Claim(s) for which you want Status Information

Health Plans will use the claim information contained in a 276 to find a claim in their production system. Health plans will return status information on all claims in their production system that match the inquiry information contained in the 276. If the inquiry information is general, status information on a broad set of claims is likely to be returned. If the inquiry information is very specific, status information on a more select set of claims is likely to be returned in the 277.

There are slight variations across health plans in what they require as a minimum set of information to match a 276 inquiry to a claim in their production system. So that submitters don't need to keep track of specific differences by health plan, the following list of data elements satisfy all participating health plans' requirements to match a 276 inquiry to a claim in their production system.

- Identification number of provider rendering services (NM109 of Provider Name Loop – 2100C)
- Last Name of provider rendering services (NM103 of Provider Name Loop – 2100C)
- Member Identification (NM109 of Subscriber Loop – 2100D)
- If patient is Subscriber
 - Identification Number -- NM109 of Subscriber Loop – 2100D
 - Name -- NM103-104 of Subscriber Loop – 2100D
 - Date of Birth -- DMG01-02 of Subscriber Loop – 2000D
 - Gender -- DMG03 of Subscriber Loop – 2000D
 - Date(s) of Service -- Either DTP-01-03 of Trace Number Loop – 2200D, or DTP01-03 of Service Line Information Loop – 2210D
 - Claim Submitted Charges -- AMT01-02 of Trace Number Loop – 2200D
- If patient is Dependent
 - Identification Number -- NM109 of Subscriber Loop – 2100E
 - Name -- NM103-104 of Subscriber Loop – 2100E
 - Date of Birth -- DMG01-02 of Subscriber Loop – 2000E
 - Gender -- DMG03 of Subscriber Loop – 2000E
 - Date(s) of Service -- Either DTP-01-03 of Trace Number Loop – 2200E, or DTP01-03 of Service Line Information Loop – 2210E
 - Claim Submitted Charges -- AMT01-02 of Trace Number Loop – 2200E

For status information on a specific claim, ALSO include the Payer Claim Identification Number information in the 2200D Loop (if patient is subscriber) or 2200E Loop (if patient is dependent).

Health plans DO NOT USE line item detail, e.g. line item number, procedure codes, etc., in their match criteria. All line items for a matched claim will be returned.

8. Testing the Transaction

When testing the transaction, limit the number of inquiries in the batch to 50 or less. Once the testing process has been completed, the number of inquiries can be increased.

Understanding How 276 Requests are Processed by Health Plans

This section of the 276-277 Companion Document is intended to provide useful information about how health plans match 276 requests to claims, about how a 277 is created and about what types of status information is reported.

How Health Plans will try to match a 276 inquiry with a claim that is in their system:

The Health Plans claims processing system will try to match a 276 inquiry with a previously submitted claim. Matches can be made in one of two ways based upon information contained in the 276:

Case 1: If you submit a 276 inquiry that DOES NOT REFERENCE the health plan’s identifying claim number (Payer’s Claim Identification Number in REF02 of the 2200D Loop of the 276 Request)

These 276 inquiries must contain **service provider, patient AND a date or date range**. The health plan will use this information to match this inquiry to a claim (or line items) that is in their production system.

Note: Some health plans will incorporate a provider identifying claim number (**patient control number**) into their match criteria, and only return those claims that match service provider, patient, date range AND patient control number. The patient control number contained in the 276 Request will be matched to the patient control number that was contained in CLM01 of Loop 2300 of the 837. The following table presents if/how participating health plans incorporate use of a 276 patient control number into their match criteria.

Matching to Patient Control #	FCHA	GHC	Premera	Regence
Health plan will match using the number that was contained in TRN02 of Loop 2200 of the 276 Request. Will not match on any number that was contained in the REF segment of Loop 2200 of the 276 (i.e. Medical Record Number)	X	X	X	
Health Plan will match using the number contained in the REF segment of Loop 2200 of the 276 (i.e. Medical Record Number) Will not match on any number that was contained in TRN02 of Loop 2200 of the 276 Request.				X

Patient – The person specified as the patient in the 276 with a ‘QC’ in NM101 of Loop 2100D OR in NM101 in Loop 2100E.

Date or Date Range – The date or date range specified in the 276 - either DTP03 of Trace Number Loop – 2200D/E, or DTP03 of Service Line Information Loop – 2210D/E

- A combination of a patient AND a service provider AND date(s) of service on the 276 MUST MATCH a combination of a patient AND service provider AND date(s) of service on a submitted claim. Multiple matches by dates of services are possible.
 - *When matching for a patient*, the health plan will check for that patient within their claims system as both a subscriber and a dependent, regardless of whether the patient was indicated as a subscriber or dependent in the 276. More specifically, if a match on patient and date exists, a 277 response will contain status information for that claim even if the 276 specifies the patient as a dependent and the health plan system has the patient as the subscriber, or visa versa.

In the case where a subscriber and a dependent are patients with the same provider on the specified date, a 277 will only contain information about the claim(s) for the individual that was specified as the patient in the 276 request.

- *When matching for service provider*,
 - * The system will first determine if the service provider identification in the 276 matches an 'individual' provider on a submitted claim for that patient.
 - * If not, the system will determine if the provider identification in the 276 matches a provider 'organization' on a submitted claim for that patient.
- *When matching for date*,
 - * If a **single date** of service was entered in the 276 inquiry and it exactly matches a date of service of a line item on a submitted claim for that patient-provider combination, a 277 response will be created for that claim and for any other claims that may be a result of a claims split.

(This situation typically arises when the provider is looking for status on a specific claim.)

- * If a **date range** was entered in the 276 inquiry and any of the dates in that range match the date(s) of service of a line item on a submitted claim for that patient-provider combination,
 - If a bill amount is entered in AMT01 of the Trace Number Loop – 2200D/E that exactly matches a claim with a date of service that falls within the range entered in the 276, a 277 response will be created for that claim.
 - Otherwise, a 277 response will be created for all claims with a date of service that falls within the range entered in the 276.

(This situation typically arises when the provider is looking for status on all claims for a patient that fall within a month of service).

Remember – the more specific the inquiry, the fewer the number of matches and the less information is likely to be returned. For example, if a claim amount is entered, only claims that match that amount will be returned.

Case 2: If you submit a 276 inquiry using the health plan’s identifying claim number (Payer’s Claim Identification Number in REF02 of the 2200D Loop of the 276 Request)

Note: This match will only return status information on the line items that are associated with the health plan’s identifying claim number.

Health plans will use TRN02 in Loop 2200D of the 277 Response to return the claim number that was assigned by the provider organization. Some health plans will return the provider assigned claim number that was in the 276 inquiry. Others will return the provider assigned claim number that was in 837 claim. See table below

Returning Provider Assigned Claim #	FCHA	GHC	Premera	Regence
TRN02 will contain the number that was contained in TRN02 of Loop 2200D of the 276 Request	X		X	X
TRN02 will contain the patient control number that was contained in CLM01 of Loop 2300 of the 837		X		

If the health plan cannot match the claim number contained in the 276 to a claim within their system, a ‘not found’ status will be returned.

Generating 277s

Reasons why there is not always a one-to-one correspondence between the 276s submitted and the 277s received:

1. Health Plans **split some of the claims** that they receive. For example, claims for services that cross months are typically split into one claim for each month. In those cases when a health plan splits a claim, claims status will be provided for each separate part of the split claim. This means that a single claim inquiry within a 276 may return statuses on multiple claims within a 277 response.

Note: If the 276 Request contains a health plan’s identifying claim number in REF02 of the 2200D Loop AND that claim number was one part of a split claim, health plans may also return status on the other parts of the split. The following table identifies what participating health plans will do.

Returning Status Info on Split Claims	FCHA	GHC	Premera	Regence
Will only return status on the part of the split that is associated with the health plan identifying claim number				
Will return status on all parts of the split.	X	X	X	X

Reminder - To increase the probability of finding all of the split claims, do not enter a claim amount into the 276 inquiry

- In situations when the status of multiple splits are returned, the Health Plan intends to return a 277 Response that loops on the Claims Submitter Trace Number (2200D if the patient is the subscriber or 2200E if the patient is the dependent.) There would be one 2200 loop for each claim that meets the selection criteria.
 - Note that technical issues and/or business scenarios may require the health plan to generate a complete 277 Response for each claim that meets the selection criteria. This convention may be refined after there is more experience with implementing this transaction.
2. Most of the time, claim status inquiries contained in a 276 will all appear on the same 277. However in the following situations, depending upon the health plan, claim **status inquiries contained in a 276 may appear on different 277s**
- The 276 contains claims status inquiries that are processed by different system platforms.
 - The 276 contains a status inquiry for a claims that has dual coverage within the health plan, e.g. a husband and wife are both covered by the health plan, but under different contracts
3. Regence and Premera will forward 276 inquiries about patients that are out of state members of some other Blue Cross/ Blue Shield plan, to the appropriate Blue Cross/Blue Shield plan. A 277 response should be returned by that plan. A response will be returned within 72 hours.

Reporting Status Information

Health Plans maintain and can report claims status information for an entire claim. Some Health Plans maintain and can report status information about individual line items as well. All Health Plans will provide status information at the claim level within a 277 response. Health Plans that can provide additional detail about the status of line items on the claims will do so in the 277 response.

1. The following ‘short list’ of Claims Status Category Codes will be used in STC – 01 field of STC segments in the 277 Response. (The other codes are not applicable to the information that is available in the respective health plans’ systems.)

An ‘X’ indicates that the code will be used by the respective health plan

Claim Status Category Code – (Subset of STC - 1 codes)	First Choice	Group Health	Premera	Regence
Acknowledgment: A0 – Acknowledgment/Forwarded	X			X

Claim Status Category Code – (Subset of STC - 1 codes)	First Choice	Group Health	Premera	Regence
A1 – Acknowledgment/Receipt				X
A3 – Ack/Returned as unprocessable	X			
A4- Acknowledgment/Not found	X	X	X	X
D0 – Change search criteria		X		
Error:				
E0 – Error in Submitted Request Data	X	X	X	X
E1 – Response not possible - System Status	X	X	X	X
E2 – Information Holder is Not Responding – resubmit at a later time				X
Finalized:				
F0 – Finalized - The claim encounter has completed the adjudication cycle and no more action will be taken	X	X	X	X
F1 – Finalized/Payment	X		X	X
F2 – Finalized/Denial	X		X	X
F3 – Finalized/Revised			X	X
F4 - Finalized/adjudication complete - No payment forthcoming	X			
Pending:				
P1 – Pending/In Process	X	X	X	X
P2 – Pending/In Review			X	X
P3 – Pending/Requested Information			X	X
P4 – Pending/Patient Requested Information				X
R4 – Requests for additional Information/Documentation-Requests for additional supporting documentation. Examples certification, x-ray, notes.	X	X	X	

2. The following ‘short list’ of Claims Status Codes will be used in STC – 02 field of STC segments in the 277 Response.

Claim Status Code – (Subset of STC - 2 codes)	First Choice	Group Health	Premera	Regence
0 Cannot provide further status electronically	X	X	X	X
1 For more detailed information, see remittance advice.			X	X
3 Claim has been adjudicated and is awaiting payment cycle.	X	X	X	X
6 Balance due from the subscriber				X
8 No payment		X	X	X
9 No payment will be made for this claim	X		X	

Claim Status Code – (Subset of STC - 2 codes)	First Choice	Group Health	Premera	Regence
12 One or more originally submitted procedure codes have been combined			X	
15 The originally submitted procedure code has been modified.				X
16 Claim/encounter has been forwarded to entity.	X	X	X	X
19 Entity acknowledges receipt of claim/encounter.				X
20 Accepted for processing.(A20)	X	X	X	X
21 Missing or invalid information	X		X	X
22 Missing or invalid information before entering the adjudication system.			X	
26 Entity not found.			X	X
32 Subscriber and policy number/contract number not found	X		X	X
33 Subscriber and subscriber ID not found	X			
35 Claim/encounter not found.	X	X	X	X
37 Predetermination is on file, awaiting completion of services			X	X
38 Awaiting next periodic adjudication cycle			X	X
41 Special handling required at payer site.			X	X
42 Awaiting related charges.			X	X
44 Charges pending provider audit.				X
45 Awaiting benefit determination.			X	X
46 Internal review/audit.			X	
48 Referral/authorization. Changed as of 2/01				X
49 Pending provider accreditation review.				X
51 Investigating occupational illness/accident.			X	X
52 Investigating existence of other insurance coverage.		X	X	X
54 Duplicate of a previously processed claim/line	X		X	X
55 Claim assigned to an approver/analyst			X	
56 Awaiting eligibility determination.			X	X
57 Pending COBRA information requested.				X
59 Non-electronic request for information			X	
60 Electronic request for information.				X
64 Re-pricing information.				X
65 Claim/line has been paid.	X	X	X	X
81 Contract/plan does not cover pre-existing conditions.				X
83 No coverage for newborns.				X
84 Service not authorized	X			X

Claim Status Code – (Subset of STC - 2 codes)	First Choice	Group Health	Premera	Regence
87 Denied: Entity not found				X
91 Entity not eligible/not approved for dates of service				X
93 Entity is not selected primary care provider				X
95 Requested additional information not received				X
98 Charges applied to deductible	X	X	X	X
101 Claim was processed as adjustment to previous claim.			X	X
102 Newborn's charges processed on mother's claim.				X
105 Claim/line is capitated.	X	X	X	X
107 -Processed according to contract/plan provisions	X			
108 Coverage has been canceled for this entity.				X
109 - Entity not eligible	X			
122 Missing/invalid date prevents payer from processing claim.				X
123 Additional information requested from entity.		X	X	X
125 Entity's name.			X	
126 Entity's address.			X	
128 Entity's tax id			X	
131 Entity's Medicare Provider ID	X			
153 Entity's ID number	X			
157 Entity's gender			X	
158 Entity's date of birth			X	
162 Entity's health insurance claim number (HICN)	X			
164 Entity's contract/member number			X	
171 Other insurance coverage information (health, liability, auto, etc			X	X
173 Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.			X	
174 Entity's student status.			X	X
187 Date(s) of service			X	
197 Effective coverage date(s).			X	
238 Separate claim for mother/baby charges.				X
239 Dental information			X	
248 Accident date, state, description and cause			X	

Claim Status Code – (Subset of STC - 2 codes)	First Choice	Group Health	Premera	Regence
250 Type of service			X	
251 Total anesthesia minutes			X	
254 Primary diagnosis code			X	
277 Paper claim			X	
286 Other payer's Explanation of Benefits/payment information		X	X	
290 Pre-existing information.			X	X
297 Medical notes/report.				X
298 Operative report				X
317 Patient's medical records			X	
345 Treatment plan for service/diagnosis				X
361 Is there other insurance?			X	X
363 Will worker's compensation cover submitted charges?				X
364 Is accident/illness/condition employment related?				X
365 Is service the result of an accident?			X	X
366 Is injury due to auto accident?				X
396 Date home dialysis began				
446 Documentation from prior claim(s) related to service(s)			X	
483 - Maximum coverage amount met or exceeded for benefit period	X			
484 Business Application Currently Not Available				X

- More specific information about cross-walking from status codes in a health plan system to the codes in the above tables can be found in a document titled 'Guidelines for Crosswalking Health Care Insurance Payer Edits to Health Care Claims Status (277) Codes'. As of the writing of this Companion Document, those Guidelines could be found at www.wpc-edi.com/Crosswalk_40.asp

Helpful Hints for Posting From the 277 Transaction

This section of the 276-277 Companion Document provides hints that may be helpful in posting from a 277 transaction.

1. Structure of the transaction (GS-GE & ST-SE)

- There will be at least one GS-GE set and one or more ST-SE sets.
- Each ST-SE set will correspond to a single 'payment' for a specified provider organization (N1 segment in Loop 1000A) at a specified location (N3-N4 segments in Loop 1000B). The payment amount may be \$0.00 or a positive dollar amount, but will not be a negative dollar amount. This payment will be related to services from one billing provider (as designated on the 837)
- The Transaction Set Control Numbers in ST02 and SE02 will be identical. The number will be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.
- The HL structure for the transaction will be Information Source/ Information Receiver/ Provider/Subscriber/Dependent.
- Contact information for the Information Source will not be populated within the PER segment

2. Formatted Data in the Transaction

- Any character used in a data element will not be used as a delimiter, separator, or terminator. The following characters will not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , #, :, ~).
- By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 will contain a '2' to indicate a non-person entity.

3. Compliance With HIPAA Transaction Versions and Code Sets

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- Per HIPAA regulations, health plans must submit, and provider organizations must be able to process, the medical data code sets that are valid at the time the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submission date.) This means that health plans must be able to process versions of the code sets that precede the current version.
- Current versions of many of the code sets are available at www.wpc-edi.com/codes/

4. Matching the 277 to a 276

As described in the table below, the Reference Identification Number in BHT03 of the 277 response (Page 126 of the IG) will be set:

Setting the Value of BHT03 in 277	FCHA	GHC	Premera	Regence
To a health plan assigned number	X			X
To ST02 of the 276 request.		X	X	

5. Health plan system information will take precedence over information submitted on the 276 . . .

For data elements such as patient name, address etc., the health plan will populate the 277 with the data that is in their system, rather than the information that was submitted on the 276

Trouble Shooting Questions and Answers

This section of the 276-277 Companion Documents provides answers to commonly asked questions that may arise during the process of exchanging claim status requests and responses.

1. What acknowledgment should we receive from health plans?

For those 276 transactions that are readable and HIPAA compliant, health plans will respond to the submitter as described in following table

Does the health plan . . .	FCHA	GHC	Premera	Regence
Acknowledge receipt with a 997?	Only if there is an error in the 276	Immediately upon receipt of the 276	Immediately upon receipt of the 276	Only if there is an error in the 276
Respond with a 277?	Within 5 mintues	By close of the first business day following receipt of the 276.	By close of the first business day following receipt of the 276.	Within 5 minutes

Per HIPAA regulations, if the information associated with any of the inquiries in the 276 ST-SE batch is not correctly formatted from a syntactical perspective, all inquiries between the ST-SE will be rejected. The health plan will notify the submitting organization of the file rejection via a 997 transaction, or other method agreed upon in the trading partner agreement. Providers should consider this possible response when determining how many inquiries they will submit in a single 276.

If a 997 shows a rejected batch or batches, the provider organization should fix the error and resend everything that was contained within the ST-SE of the rejected 276 transaction.

If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide and Addenda, AND there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction or will contact the institutional provider organization *via* phone/fax whenever possible. In this case, the batch is not processed.

2. What are some likely situations when a 277 response may be different than expected?

- **SITUATION:** A claim was submitted to a health plan. However, the health plan responds with a 277 that indicates that they don't have that claim.

Health plans can only provide status information on claims that are in their production system. There are a number of reasons why a health plan may report on a 277 that they don't have a submitted claim in their production system.

- The 276 was submitted before the corresponding claim made it into the production system.

By close of the first business day following receipt of the claim by the health plan, the claim will have been posted in their production system. At that time, the health plan will be able to respond to a claim status inquiry on that claim.

- The 276 was submitted for a corresponding claim that was deleted before being posted into the production system, e.g. the patient is not a covered member of the health plan

- Some Health Plans do not track deleted claims. In these cases, the 277 response will indicate that the claim specified in the 276 was never received

- Some Health Plans track claims that were deleted. However, the HIPAA code set does not yet specify a message that can be used to indicate that a claim was deleted. The health plan and the trading partner will need to agree upon how to handle this situation if and when it arises. Agreeing upon a message for incorporation into the STC segment at the subscriber level may be the best approach.

- The 276 was submitted for a corresponding claim that is no longer in the production system

Health plans will retain claim information on-line for at least 18 months after the claim has been adjudicated. However, providers are encouraged to follow-up on claims within 12 months of their submission

- **SITUATION:** There is a difference between information contained in the 276 and information the health plan has on file.

ACTION: The 277 response will always reflect the information that the health plan has on file

EXAMPLE: Subscriber Name is identified in the 276 as a Fred Flintstone, but the health plan system has the Subscriber Name as Frederick Flintstone. The health plan will return a 277 response with the name Frederick Flintstone.

- **SITUATION:** The health plan cannot reply to a 276 with a complete 277 because one or more of their systems are not operational.

ACTION: The health plan will reply with a 277 that contains an STC segment in the 2200D Loop. The STC01-1 field will contain an ‘E1’ (Response not possible - System Status) and STC01-2 field will contain a ‘484’ (Business Application Currently Not Available).

- **SITUATION:** The health plan cannot uniquely match a claim identified in the 276 to a claim in their database because all of the required inquiry fields have not been completed.

ACTION: The health plan will reply with a 277 that contains an STC segment in the 2200D Loop. The STC01-1 field will contain a ‘E0’ (Error in Submitted Request Data) and the STC01-2 field will contain a ‘123’ (Additional information requested from entity) and the STC01-03 field will contain a ‘1P’ (Provider).

- **SITUATION:** The health plan will not be able to uniquely match a claim identified in the 276 to a claim in their database even if/when all of the required inquiry fields are completed.

ACTION: The health plan will reply with a 277 that contains that contains the following information.

	FCHA	GHC	Premera	Regence
What will be the value of STC-01?	A4	D0	E0	A4
What will be the value of STC-02?	35	35	35	35
How will Required Data Fields be populated, eg. with data from the 276, with “dummy data”, etc.?	Required 277 fields will be populated with the corresponding values contained in the 276	Required 277 fields will be populated with the corresponding values contained in the 276	Required 277 fields will be populated with the corresponding values contained in the 276	Required 277 fields will be populated with the corresponding values contained in the 276

- **SITUATION:** There are various other reasons why a 276 Request could not be processed by the health plan. These reasons include, but are not limited to, the rendering provider is not known to the health plan or the patient is not covered by the health plan

ACTION: The health plan will return a 277 Response with STC segment(s) that indicates the reason.