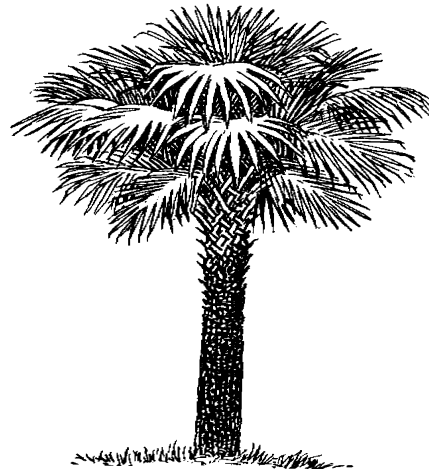




PGBA, LLC

Tricare Companion Document



**276/277 Health Care Claim Status
Request & Response - 005010X212**

ANSI ASC X12N

Revised: January 2011



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Introduction

Note: Production files of the HIPAA implementation standard 276/277 transactions will not be accepted prior to January 01, 2011.

This document is the property of PGBA, LLC and is for the use solely in your capacity as Trading Partner health care transactions with PGBA, LLC.

This document provides information related to specific elements with the ANSI ASC X12N 276/277 transaction. It does not change the definition, data conditions, or use of the data elements or segments in a standard, nor does it add data elements or segments to the maximum defined data set. It will not use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications. (Refer to Standards for Electronic Transactions, *Federal Register*, Vol. 74, No. 11, January 16, 2009.

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ANSI ASC X12N 276/277 transaction set Implementation Guides (IG). Specific payer instructions contained in this document are provided for clarification purposes only. This document should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, companion documents, physician’s manuals, and/or other billing guidelines published by our clearinghouse payers.

The Final Rule adopting updated versions of the standards for electronic transactions was published in the Federal Register on January 16, 2009. The URL Link to the Federal Register is: <http://www.access.gpo.gov>. This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the “senders” and “receivers” are in the descriptions of certain transactions. The updated versions are available and can be downloaded through the Washington Publishing Company website at <http://www.wpc-edi.com>.

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This document is incorporated by reference in the Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated on the TRICARE web site: www.mytricare.com.

Appropriate steps must be taken before submitting production ANSI ASC X12N transactions, such as testing, completion of an EDIG Trading Partner Agreement validation and demographic confirmation with our customer support staff. To begin the process, receive more information or ask questions, please contact the EDI Help Desk at 1-800-325-5920 (Menu Option 2).

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ANSI ASC X12N 276/277 Health Care Claim Status Request & Response (005010X212E1) – Reporting Instruction Clarifications

Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the EDI technology standards for health care as established by the Secretary of Health and Human Services for Administrative Simplification. The use of standard transactions and code sets will improve Federal and Private health care programs, and the effectiveness and efficiency of the health care industry. The ANSI ASC X12N 276/277 transaction set has been selected as the format to meet HIPAA requirements for the electronic requests for Health Care Services and the associated responses.

There are two formats, or views that are used to present the transaction sets in the National Electronic Data Interchange Implementation Guide edits. They are the implementation view and the standard view. The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names. For this reason the implementation view of the transaction set is presented within this document. PGBA, LLC has chosen to implement exchange of the 276/277 transaction sets as both batch and real-time applications as defined on page 3 of the 276/277 Implementation Guide

PGBA, LLC may edit data submitted beyond the requirement defined in the HIPAA Implementation Guide.

- ✓ PGBA, LLC may reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and PGBA, LLC Companion Document requirements
- ✓ PGBA, LLC may reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.

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Hierarchical Structure

The hierarchical structure identifies relationships between the information source, information receiver, subscriber, and dependent and can eliminate repetitious reporting of data.

- The information source is the entity that has the answer to the questions being asked in the inquiry. It is typically an insurer or payer.
- The information receiver is the entity that is asking the questions in an inquiry. It is typically the medical service provider.
- The subscriber is a person who can be uniquely identified to an information source. The subscriber may or may not be the patient.
- The dependent is a person who cannot be uniquely identified to an information source, but can be identified when associated with a subscriber.
- The patient can be either the subscriber or the dependent. When a unique identifier exists for an individual then he/she would be considered the subscriber. Otherwise, related dependents are identified through the subscriber.

Supported Business Functions

The 276/277 transaction sets will support:

The 276 transaction is used to request the status of a specified claim(s). The paired 277-transaction response will be used to provide a response to the health care claim status request.

Status can be submitted at the claim level, but responses may be returned at the claim level or claim and line level.

The information receiver may create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels.

Some basic information must be supplied in order for the payer to appropriately identify the specific claim in question. Unique identifying elements should be supplied to provide as much inquiry information as possible. Transactions that do not follow the segment and element requirements, as set forth in the HIPAA ASC X12N 276/277 Implementation Guide, will be rejected.

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Minimally, PGBA, LLC will use the following elements as search criteria on status received:
The 276 must include information that is necessary for the payer to identify the specific claim in question. The primary, or unique, identifying element(s) may be supplied to obtain an exact match (such as claim number). However, when the requester does not know the unique element(s), the claim generally is located by supplying several parameters including the provider identifier, patient identifier, date(s) of service and submitted charge(s) from the original claim. Patient control number is not required, but if used as search criteria, it must be an exact match

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Required for all 276 Claim Status Request:

Trace #: Default Zero Amount: Default Zero DOS: Default 00000000-00000000

- QUESTION: Provider Id, Subscriber Id, Patient Name (First, Middle Initial, Last), Patient Date of Birth, and Gender Code
- RETURNED: **Information on all claims, for this Patient and Provider**

- QUESTION: Provider Id, Subscriber Id, Patient Name (First, Middle Initial, Last), Patient Date of Birth, Gender Code, and Claim Number
- RETURNED: **Information on this particular claim, for this Patient and Provider**

- QUESTION: Provider Id, Subscriber Id, Patient Name (First, Middle Initial, Last), Patient Date of Birth, Gender Code, and Service Date Range GT zero's
- RETURNED: **Information on all claims, for this Patient and Provider within this date range**

- QUESTION: Provider Id, Subscriber Id, Patient Name (First, Middle Initial, Last), Patient Date of Birth, Gender Code, and Total Charge (amount greater than zeros), Service Date greater than zero's
- RETURNED: **Information on all claims, for this Patient and Provider for this charge amount**

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Maximum Limitations

- PGBA, LLC will return status responses at the claim line level only.
- A maximum of 999 occurrences of line level information can be returned per HIPAA Documentation.

Information Linkage - Trace Clarifications

The CLAIM STATUS TRACKING NUMBER is used to identify the transaction at a high level and re-associate a 277 Response back to the originating 276 Request. It is particularly useful in reconciling 276 reject transactions that may not contain all of the hierarchical loops and must always be returned.

A patient account number may also be reported at the subscriber/patient level. If reported, it will be returned in the 277-response transaction.

The information source may also create one occurrence of the tracking (TRN) segment at either the subscriber/patient level or the non-subscriber/patient level, which ever is present. It is optional, but gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction. PGBA, LLC will not create an occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels.

A clearinghouse may also create one occurrence of the tracking (TRN) segment at the lower of the subscriber/patient levels. If the information source receives them, they must be returned in the 277 Response transactions. In the event that the 277 transaction passes through more than one clearinghouse, the second (and subsequent) clearinghouse may choose one of the following options.

Option 1: Replace the tracking number with their own and remove it from the 277 responses prior to returning it to the originally reported trace number or report it back as an original tracking number.

Option 2: Do not assign their own tracking number.

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HIPAA Usage

The HIPAA defined implementation guide represents its full functionality but does not necessarily represent the business needs of an individual provider, payer or other trading partner. The guide identifies the framework an information source can utilize. HIPAA requires information sources to support a Health Care Claim Status Request & Response transaction, either directly or through a clearinghouse. The guide also identifies the minimum an information source or clearinghouse is required to support in order to offer a compliant 276/277 transaction set. The minimum requirements are detailed below:

276 – The information source must support a generic request for Health Care Claim Status Request & Response.

277 – The information source must respond with either an acknowledgement that line level claim information meeting the 276 request criteria exist or that the information was not found in their system. The 276/277 transaction set can be as elaborate as the information source wishes to return. The response will be claim status as the transaction is processed. PGBA, LLC's response will be based on current adjudication records at the time of the inquiry. An information receiver can submit a very explicit 276/277 as detailed in the previous Questions and Response. The information source is not required to generate an explicit response to an explicit request if their system is not capable of handling such requests. However, the more information that can be returned within the response the more likely it can reduce phone calls and long interruptions for both parties. The information source is required to at least respond with the minimum compliant response as identified above and may not reject the transaction merely because they cannot process an explicit request. The information source is also required to return any information supplied in the 276 request that was used to determine the 277 responses. Willing trading partners are allowed to use any portion or all of the 276/277 super set, so long as they support the minimum data set, but are not allowed to add to or to change it in order to remain compliant under HIPAA.

Rejected Transactions

A TA1 (Interchange Acknowledgement) transaction will be returned when the Sender ID (ISA06) is invalid on the inbound interchange.

Disclaimers Within the Transactions

The following disclaimers apply to 276/277 transaction sets exchanged between PGBA, LLC and their trading partners: Each transaction can contain only Health Care Claim Status Request at the claim level. All requests at the line level will be rejected as being invalid.

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Provider Identifiers

PGBA, LLC requires an NPI number as the primary identifier for providers. No other secondary identifiers such as payee tax Identification number may be used unless atypical.

In Loop 2100C the following fields require this identifier:

NM108 **(Identification Code Qualifier)** = 'XX' (unless atypical and then use one of the other codes).

NM109 **(Identification Code)** = 'NPI Number'

Health Care Claim Status Request and Response 276/277 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS) and Functional Group Structure (GS) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices B and C. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. Please refer to the PGBA, LLC EDI Gateway user manual for unique instructions for transmissions.

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Data Clarification for Health Care Claim Status Request & Response 276/277 (005010X212) Transaction Set

Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
Header	10	1705	R	ST103	New Segment	Implementation Convention Reference	O AN 1/35	36
2100A	50	66 & 67	R R	NM108 & NM109	NM108 Qualifiers limited to PI (Payor Identification) and XV (Centers for Medicare and Medicaid Services PlanID) : Payer ID will be returned in NM109	NM108: Identification Code Qualifier NM109: Identification Code	X ID 1/2 X AN 2/80	42
2100B	50	66 & 67	R R	NM108 & NM109	46: Electronic Transmitter Identification Number 67: Identification Code	NM108: Identification Code Qualifier NM109: Identification Code	X ID 1/2 X AN 2/80	46
2100C	50	66 & 67	R R	NM108 & NM109	XX: Centers for Medicare and Medicaid Services: National Provider Identifier: Qualifier NM108 SV: Service Provider Number Qualifier NM108 PGBA assigned Provider Number: NM109	NM108: NPI Number Qualifier NM109: NPI Number	X ID 1/2 X AN 2/80	51
2000D& 2000E	40	1251	R	DMG02	Report the date of birth of the subscriber in loop 2000D. If the patient is not the subscriber, report the patient's birth date in loop 2000E.	DMG02: Date Time Period	X AN 1/35	55 & 77
2100D& 2100E	50	1035	R	NM103	Report the subscriber's last name in loop 2100D. If the patient is not the subscriber, report the patient's last name in loop 2100E.	NM103: Name Last or Organization Name	O AN 1/35	57 & 79
2100D& 2100E	50	1036	S	NM104	Report the subscriber's first name in loop 2100D. If the patient is not the subscriber, report the patient's first name in loop 2100E.	NM104: Name First	O AN 1/25	57 & 80

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Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100D	50	66 & 67	R R	NM108 & NM109	MI: Member Identification Number NM108 Subscriber or Patient Number: Subscriber Number if patient is subscriber or Patient Number if patient is not subscriber NM109.	NM108: Identification Code Qualifier NM109: Identification Code	X ID 1/2 X AN 2/80	57
2200D	90	127	R	TRN02	A TRN segment will be returned in the outbound 277 transactions.	TRN02: Reference Identification	M AN 1/50	137
2200D& 2200E	120	1251	R	DTP03	Report the service date or Range of Service dates reported on the claim that the inquiry is for in loop 2200D and/or 2200E. Valid date range CCYYMMDD-CCYYMMDD or single date CCYYMMDD .	DTP03: Date Time Period	M AN 1/35	156 & 196
2100A	50	66 & 67	R R	NM108 & NM109	FI: Identification Code Qualifier will be returned in NM108 571132733: Payer ID's will be returned in NM109	NM108: Identification Code Qualifier NM109: Payer ID	X ID 1/2 X AN 2/80	131
2000D	40		O	DMG segment	This segment was deleted for 2000D	Subscriber Demographic Information		D.4
2200D	90		O	TRN segment	A TRN segment will contain tracking number from the inbound 276 transaction.	Claim Status Tracking Number		177

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Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
STC01-1 & STC01-2 & STC01-3 STC01-4	100	C043	R		<p>Health Care Claim Status Category Codes (Code Source 507) are used to organize the Health Care Claim Status Codes (Code Source 508) into logical groupings. The Claim Status Code identifies the status of an entire claim. Both lists are available for downloading from the Washington Publishing Company web site at www.wpc-edi.com. Please note the following responses that BCBSSC will be returning:</p> <p>A Claim Status Category Code of E0 and a Claim Status Code of 478 will be returned when the contract number was missing on the inbound 276.</p> <p>A Claim Status Category Code of E0 and a Claim Status Code of 482 will be returned when the service date was missing on the inbound 276.</p> <p>A Claim Status Category Code of E0 and a Claim Status Code of 481 will be returned when a compliance error is found on the 276 submitted. BCBSSC will not return a 997 for compliance errors.</p> <p>A Claim Status Category Code of E0 and a Claim Status Code of 24 will be returned when a request is received from a provider other than that which originated on the claim.</p> <p>A Claim Status Category Code of E0 and a Claim Status Code of 484 will be returned when the transaction receives a time out or other system error.</p> <p>A claim Status Category Code of D0 and a Claim Status Code of "26" will be returned if the patient cannot be found or no claim matching the selection criteria was found.</p>	<p>STC01-1: Industry Code STC01-2: Industry Code STC01-3: Entity Identifier Code Stc01-4: Code List Qualifier Code</p>	<p>M AN 1/30 M AN 1/30 O ID 2/3 O ID 1/3</p>	184

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EDIG Glossary of Terms

ANSI X12 276/277 V5010

HIPAA standardized ANSI X12Ns transaction format. The 276/277 transaction set is for the electronic requests for Health Care Services and the associated responses.

Data Segment

Corresponds to a record in data processing terminology and consist of logically related fields (data elements). These records and elements are structured in a defined sequence (defined by X12). Each segment begins with a segment identifier and one or more related data elements that are preceded by a data element separator and ends with a segment terminator.

Data Element

Relates to a field in data processing terminology and are assigned an individual reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data Element types are:

Nn	Numeric	Implied number of decimal positions and for this representation Nn; the N indicates numeric and n is the number of decimal positions to the right of the implied decimal point. Used when the position of the decimal within the data is permanently fixed and will not be transmitted with the data
R	Decimal Real Number	Used for numeric values that have a varying number of decimal positions. For negative values, the leading (-) minus sign is used. Absence of a sign indicates a positive value. The (+) plus sign should not be transmitted.
ID	Identifier	Always contains a value from a predefined list of codes.
AN	Alphanumeric string	Sequence of any characters from a basic or extended character set.
DT	Date	States the standard date in CCYYMMDD. CC (first two digits of calendar year), YY (last two digits of calendar year), MM (month 01 – 12), DD (day in the month 01 – 31)
TM	Time	The ISO standard time HHMMSSd, 24-hour clock. HH (Hour 00 - 23), MM (minute 00 – 59), SS (second 00 – 59), d (decimal seconds)

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Delimiter

A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI

An acronym for Electronic Data Interchange.

EDIG

An acronym for Electronic Data Interchange Gateway.

Electronic Data Interchange

The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner agreement, an application file/form, translator (mapper), communications and value-added service provider.

HCFA

An acronym for Health Care Finance Administration.

Implementation Guides

Documents that provide standardized data requirements and content permitting the specification of consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: www.wpc-edi.com.

Interface

The connection point that two systems pass data.

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Loops

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Routing

Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading Partners

Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Translation Software

Commercial computer software that, with input instructions, converts a standard format to an application format and vice-versa. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt of translation status of a file. Some products also offer translation capability from any format to any format.

X12 Transaction Set

A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837- transaction set is equivalent to one claim file.

X12N

An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standard for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDIO standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

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