276/277 Health Care Claim Status Request and Response Transactions

For AmeriHealth Administrators

Disclaimer

This AmeriHealth Administrators and Inter-County Health Plan (hereinafter referred to as AHA/ICHP) Companion Guide to EDI Transactions (the "Companion Guide") provides 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 AHA/ICHP's business processes when implementing the HIPAA ASC X12N 4010A1 Implementation Guides.

This Companion Guide does NOT replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of AHA/ICHP that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AHA/ICHP specific codes relevant to AHA/ICHP's business processes and rules and situations that are within the parameters of HIPAA. 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 AHA/ICHP and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to AHA/ICHP'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 AHA/ICHP's business rules or technical requirements regarding the implementation of HIPAA-complaint 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. If there is an inconsistency between the terms of this Companion Guide and any terms of one of the Implementation Guides, the relevant Implementation Guide will governs with respect to HIPAA edits, and this Companion Guide will control with respect to business edits.

1.0 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 Administrators and Inter-County Health Plan, Inc. (hereinafter referred to as AHA/ICHP).

The purpose of this document is to outline AHA/ICHP 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.

2.0 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 transactions **WILL NOT** automatically notify a provider about a change in the claims status. Status information will only be provided upon request in a batch enviornment.

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 AHA/ICHP will only be responding at the claim level on the 277 transaction. AHA/ICHP 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 information contained within the 277 transaction will be a reflection of the information that was provided on the 276 transaction. The STC loop is used to provide the status of the claim from the payer's system. AHA/ICHP will be populating the STC 01 on every 277-response transaction.

The following STC data elements will be returned on the 277 transaction for either a paid, rejected/finalized claims:

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 process 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. This element will only be used for claims that have completed 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.** This element will not be used for claims that are in process, have not completed the adjudication process, or have rejected.

3.0 Claim Search Criteria

Submitting a 276-status request to AHA/ICHP 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 AHA/ICHP to locate a claim status, the following information from the original claim must be populated accurately on the 276 request:

Element Name	Loop ID	Segment Element	Qualifier
• Provider ID Number	2100C	NM109	SV or FI
• Subscriber ID/SSN	2100D/2100E	NM109	MI
• Claim Service Date	2200D/2200E	DTP03	232
• Patient Last Name	2100D/2100E	NM103	QC
• Patient First Name	2100D/2100E	NM104	QC
• Patient Date of Birth	2100D/2100E	DMG02	D8

The provider identified in the Service Provider Level (Loop 2100C) of the 276 request will be assumed to be the billing provider from the original claim. The provider number or the TAX ID on the 276 request must match the billing provider recorded on the bill/claim that was submitted. If the billing provider is not used the 276 will not be able to find the claim status within the payer system, resulting in a claim not found response.

The Provider ID or Provider TAX ID number is required to be submitted on the 276 transaction in order for AHA/ICHP to find the claim that will be used to populate the outbound 277 claim status transaction.

Until the National Provider Identifier is mandated and assigned by X12, 'SV - Service Provider Number' or 'FI – Federal Taxpayer's ID Number' will be the Identification Code Qualifier (NM108 of the Service Provider Level – Loop 2100C). The identifying number of the billing provider (NM109 of the Service Provider Level – Loop 2100C) will be the provider number that is assigned by the health plan or the TAX ID of the provider. The provider ID will most likely be different for different health plans. The provider TAX ID, if used, must include the hyphen (**-**) between the numbers.

When only one date is entered (YYYYMMDD – YYYYMMDD) with the DTP03 of the Claim Submitter Trace Number that date will be assumed to be the claim period start date and end date. AHA/ICHP will attempt to identify and provide a status on claims that were previously submitted using the claim information that was submitted on the 276 request. Finding the right claim upon receipt of the initial 276 will eliminate the need for follow-up electronic interactions and/or telephone calls. Multiple 277 responses can be returned for a single solicited 276 request. 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.

If 276 transaction is received for AHA/ICHP groups that perform their own claims inquiry processing, AHA/ICHP will return a 277 transaction stating the following in the STC loop:

- STC01-1 : HIPAA Claim Category Code = A4 = Acknowledgement not found
- STC01-2: HIPAA Claim Status Code = 0 = Cannot provide a further status electronically.

4.0 Transmission Size/Type

AHA/ICHP will be supporting Batch Mode processing for all incoming 276 transactions. Batch Transaction will have file size limitations that are documented below. All incoming 276 transactions will receive a negative (reject) or positive (accept) acknowledgement via the 997 transaction. Trading Partners will only receive a negative TA1 transaction when the transmitted file's Interchange is corrupted and/or can not be processed by AHA/ICHP.

5.0 Real Time Transaction

N/A at this time

6.0 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 per ST/SE. The TRN segment identifies a request within the transaction (ST/SE). When the batch transaction is received by AHA/ICHP, if there are more then 99 requests, the EDI system will return a 277 transaction stating the following:

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

Upon receipt of 276 batch transaction, if some or all of the enveloping segments are unreadable or do not comply with the Implementation Guide **AND** there is sufficient routing information that can be extracted from the envelope, AHA/ICHP will respond with the appropriate TA1 transaction. Otherwise, the health plan will be unable to respond. In either case, the batch will not be processed.

In all other cases, the health plan will respond with an appropriate 997 transaction to acknowledge receipt of the file. The 997 transaction will indicate whether or not the batch file can be processed. If the GS segment of the batch does not comply with the Implementation Guide, the health plan may not be able to process the transaction.

If the health plan is able to process the batch, a batch of Claims Status Responses (277s) will be sent when processing is complete. Typical response time for a batch transaction will be two business days.

7.0 Functional Acknowledgments

AHA/ICHP intends to respond, with some type of acknowledgment, to every batch request 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 Batch Claims Status Request (276), if the enveloping is unreadable or does not comply with Implementation Guide or AHA/ICHP 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 Batch Claim Status Request (276), If the Functional Group is unreadable or does not comply with Implementation Guide or AHA/ICHP standards, we will not able to process the request, AHA/ICHP will respond with a 997. The 997 transaction will also report the claim status requests that have been accepted for processing by AHA/ICHP. This action will occur for Batch file requests.

Segment: GS Functional Group Header

Loop: GS

Level: Header

Usage: Required – Provide control info.

Notes: Due to AHA business practices, this information is needed on Inbound Functional Group Header Information for the 276 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
GS-02	App Sender Id Code	**"R"** or **"B"** appended to Trading Partner FTIN (Federal TAX ID Number)
GS-03	App Receiver Id Code	Enter value: **54763** (AHA NAIC Number)

Segment: NM1 Payer Name

Loop: 2100A Payer Name

Level: Detail

Usage: Required

Notes: Due to AHA business practices, this information is needed on Inbound 276 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Payer Identification Code	Enter code value: **PI** (Payer ID)
NM109	Payer Id	Enter value: 54763 (AHA NAIC Number)

Segment: NM1 Receiver Name

Loop: 2100B Receiver Name

Level: Detail

Usage: Required

Notes: Due to AHA business practices, this information is needed on Inbound 276 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Receiver ID Qualifier	Enter code value: **46** (Payer ID)
NM109	Receiver Id	Electronic Transmitter ID Number (ETIN)

Segment: NM1 Provider Name

Loop: 2100C Provider Name

Level: Detail

Usage: Required

Notes: Due to AHA business practices, this information is needed on Inbound 276 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Provider Identification Qualifier	Enter code value: **FI** (Provider TAX ID) **SV** (Provider Number)
NM109	Provider Id Code	Enter value: **Provider Tax ID including ('-')** character or AHA assigned Provider Number

NM1 Subscriber Name

Loop: 2100D Subscriber Name

Level: Detail

Usage: Required

Notes: Due to AHA business practices, this information is needed on Inbound 276 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: **MI** (Member ID Number)
NM109	Primary Identifier	Enter the value from the subs identification card (ID card) including alpha characters.