

**276/277 HIPAA Transaction Standard
Companion Guide
Refers to the X12N Implementation
Guide
ANSI Version 4010A1
Section 2, 276-277 Claim Status**



Simply, the right choice.

COMMUNITY HEALTH PLAN

Version 1.0

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This *Companion* Guide is a work in progress. Community Health Plan reserves the right to make changes to this Companion Guide at any time without notice. When changes are made, the Change Summary on the last page of this section will identify those changes and give the date and reason for the change.

Introduction

Community Health Plan places a high priority on making it easy for you to do business with us. Using an electronic medium to make an inquiry is one of the ways we can do this. Electronic inquiries facilitate the transfer of information from your organization to ours in a standard data format. This Section 2 of the *Community Health Plan Companion Guide* provides information about the American National Standards Institute (ANSI) Health Care Claim Status Request and Response 276-277 transaction, Version 4010A1A. This transaction is the accepted standard of the 1996 Health Insurance Portability and Accountability Act (HIPAA-AS).

The *Community Health Plan Companion Guide* is to be used alongside the *HIPAA-AS Implementation Guide (IG)*, which provides comprehensive information needed to create an ANSI 276 transaction and details the information returned in the ANSI 277 transaction. The *Community Health Plan Companion Guide* does not change the specifications of the *HIPAA Implementation Guide*; rather, it is intended to clarify the areas where the IG provides options or choices to be made. The *HIPAA-AS Implementation Guide* can be downloaded from the following Internet address: http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Implementation Considerations

The 276/277 electronic batch transaction works best for employers or healthcare practitioners and facilities with the capability of posting this information to an employee or patient account record.

For 277 responses, Community Health Plan will create the required response format for HIPAA-AS compliance. Batch 277 response transactions will provide claim status only at the summary claim level.

Community Health Plan will not process 276 claim status requests at the claim line level. Batch 276 transactions may be sent to Community Health Plan at any time, but will be processed during the 5:00 p.m. to midnight period. Community Health Plan will process batch 276 transactions for more than one policyholder or dependent as separate requests for each patient. Consequently, multiple 277 transaction responses may be returned to the requestor. Requestors should use transaction control fields and/or transaction trace numbers to support matching responses from Community Health Plan to their original requests.

Community Health Plan uses the Interchange Control Structures found in the HIPAA-AS controlling document for X12.5. Our recommendation is to use the * (asterisk) for the *element* delimiter and the ~ (tilde) for the *segment* delimiter.

Hex and communication control characters may disrupt data flow and should be used with caution. Upper and lower case letters, numbers, space, — (minus sign), and other special characters that occur in transaction data content should not be used as delimiters to avoid confusion and data misunderstandings.

Trading Partner Acceptance Testing Specifications

Trading partners wishing to submit enrollment electronically to Community Health Plan, must first submit an error free test file and receive verification from Community Health Plan that the file loaded correctly, prior to submitting a production file for processing.

To submit a test file, contact Community Health Plan Client Services at (816) 271-1247 or toll-free at 1-800-990-9247.

The entire file ISA/IEA envelope will either pass (accept) or fail (reject) validation.

Helpful Hint: Create small batches of test enrollment transactions to ensure that you will not have to re-create too many enrollment transactions in the event of an error in the file. Once your files are received and verified to be error-free, you may send files of any size.

Matrix for the 276/277 Health Care Claim Status Request and Response

LEGEND

SHADED rows represent “segments;” **NON-SHADED** rows represent “data elements.”

“Loop – specific” comments are found in the first segment of the loop.

Page #	Loop ID	Segment	Segment Name	Codes	Length	Notes/Comments
52	2100A	NM1	Payer Name			
55		NM103	Last Name/Organization Name		1/35	Community Health Plan
55		NM108	Identification Code Qualifier	FI	2	
56		NM109	Identification Code	431690582	2/80	Community Health Plan Tax ID
62	2100B	Information Receiver Name				
63		NM108	Identification Code	46 FI	2	Electronic TIN Federal TIN
63		NM109	Identification Code		2/80	
67	2100C	NM1	Provider Name			
68		NM108	Identification Code Qualifier	FI SV	½	Federal TIN Service Provider Number
69		NM109	Identification Code (Provider Identifier)			
70	2000D	DMG	Subscriber Demographic Information			Segment information is required if the policy holder is the patient
72		DMG01	Date Qualifier	D8	2/3	Use CCYYMMDD format
73		DMG02	Subscriber Birth date		8	Policyholder's birth date
73		DMG03	Subscriber Gender Code	F M U	1	Policyholder's gender. CHP does not accept "U" for Unknown
74	2100D	NM1	Subscriber Name			
75		NM103	Name Last or Organization Name		1/35	Policyholder's last name.
75		NM104	Name First		1/25	Policyholder's first name.
75		NM108	Identification Code Qualifier	MI	2	

76		NM109	Identification Code		1/80	The policyholder's identification number as shown on the member's card.
78	2200D	REF	Payer Claim Identification Number			May send this segment, if claim number is known.
78		REF01	Reference Identification Qualifier	IK	2	The claim number used by the payer.
79		REF02	Reference Identification		1/30	
77	2200D	AMT	Claim Submitter Trace Number			Required when the subscriber is the patient
84		AMT01	Amount Qualifier Code	T3	2	Total claim charge amount.
85		AMT02	Monetary Amount		18	CHP does not accept a zero amount.
86	2200D	DTP	Claim Service Date			Used when the policyholder is the patient.
86		DTP01	Date Time Period Qualifier	232	3	Code to identify that the dates given express beginning and ending dates of service.
87		DTP02	Date Time Period Format Qualifier	RD8	3	Range of dates expressed in format CCYYMMDD-CCYYMMDD
87		DTP03	Date Time Period (Claim Service Period)		1/35	CHP supports up to a 31-day date span.
88	2210D	SVC	Service Line Information			Note: CHP does not support requests for the claim status at the service line level.
96	2000E	DMG	Dependent Demographic Information			Segment information is required if the request is about a dependent
96		DMG01	Date Qualifier	D8	2/3	Date expressed in format CCYYMMDD
97		DMG02	Patient Birth Date		8	Dependent's date of birth.

97		DMG03	Patient Gender Code	F M U	1	Dependent's gender. CHP does not accept "U" for Unknown.
98	2100E	NM1	Dependent Name			
99		NM103	Name Last or Organization Name		1/35	Dependent's last name when the dependent is the patient.
99		NM104	Name First		1/25	Dependent's first name when the dependent is the patient.
99		NM108	Identification Code Qualifier	MI	2	
100		NM109	Identification Code		2/80	The policyholder's identification on the member's ID card, including the prefix.
103	2200E	REF	Payer Claim Identification Number			May send this segment, if claim number is known.
103		REF01	Reference Identification Qualifier	IK	2	The claim number used by the payer.
103		REF02	Reference Identification (Payer Claim Control Number)		1/30	
109	2200E	AMT	Claim Submitted Charges			Required when the patient is not the policyholder.
109		AMT01	Amount Qualifier Code	T3	2	The claim total charge amount.
110		AMT02	Monetary Amount		1/18	CHP does not accept a zero amount.
111	2200E	DTP	Claim Service Date			
111		DTP01	Date Time Period Qualifier	232	3	
112		DTP02	Date Time Period Format Qualifier	RD8	3	
112		DTP03	Date Time Period	CCYYMMDD or CCYYMMDD - CCYYMMDD	8	Used when the policyholder is the patient. It can be a single date or date span. We support a 31 day date span.

277 Response

Community Health Plan's response to a 276 request will be made at the claim level, not at the line level.

Community Health Plan will use the following status code categories:

Acknowledgements:

- A1 Acknowledgement/Receipt – The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
- A2 Acknowledgement/Acceptance into adjudication system – The claim/encounter has been accepted into the adjudication system.

Pending

- P1 Pending/In Process – The claim/encounter is in the adjudication system.
- P2 Pending/In Review – The claim/encounter is suspended pending review.

Finalized

- F0 Finalized – The claim/encounter has completed the adjudication cycle and no more action will be taken.
- F3 Finalized/Revised – Adjudication information has been changed.
- F5 Finalized/Cannot Process