



Health Care Claim Status Request

Companion Guide

ANSI X12 276 (004010X093A1)

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Data submission criteria for electronic health care claim status request

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This Companion Guide is a work in progress. Educators Mutual Insurance Association reserves the right to make changes to this Companion Guide at any time without notice. When changes are made, the document change management table on the last page of this section will identify those changes and give the date of the change.



INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 276/277 Health Care Claim Status Request and Response transactions implementation guide provides the standardized data requirements to be implemented for all health care claim status inquiries conducted electronically.

This implementation guide is designed to assist those who request the health care claim status using the 276 format, those who receive the 276 request, those who respond using the 277 format, and those who receive the 277 format. Entities requesting health care claim status include, but are not limited to, hospitals, nursing homes, laboratories, physicians, dentists, allied professional groups, employers, and supplemental (i.e., other than primary payer) health care claims adjudication processors.

PURPOSE

The purpose of this document is to provide the information necessary to submit an eligibility benefit inquiry and receive an eligibility benefit response electronically from Educators Mutual Insurance Association or its affiliates (hereinafter "Educators"). This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on its web site at <http://www.wpc-di.com/hipaa/>.

Other important websites:

Workgroup for Electronic Data Interchange (WEDI)

<http://www.wedi.org>

United States Department of Health and Human Services (HHS)

<http://aspe.hhs.gov/admnsimp/>

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov/hipaa/hipaa2/>

Accredited Standards Committee (ASC X12)

<http://www.x12.org/>



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DEFINITION OF TERMS USED

The participants in the hierarchical level structure described above are as follows:

- **Information Source** – This entity is the decision maker in the business transaction. For this business use, this entity is the payer.
- **Information Receiver** – This entity expects the response from the information source. For this business use, this entity can be a provider, a provider group, billing agent, etc.
- **Service Provider** – This entity delivered the health care service.
- **Subscriber** – This entity is the insured.
- **Dependent** – This entity is entitled to health care benefits because of his or her relationship to the insured.

HIPAA IMPACT ON CURRENT BUSINESS PROCESSES

The 270 Health Care Eligibility Benefit Inquiry transactions require the provider to submit additional data not present in the pre-HIPAA enrollment transactions. The structure of the 270 may also enable the provider to relay information in a more efficient manner and may impact current business processes.



SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 270 Eligibility Benefit Inquiry transaction that the health plan will accept.

- 270 Health Care Eligibility Benefit Inquiry – ASC X12N 270 (004010X092A1) Response Transactions Supported

Field Definitions

R (Required): This field must always be included in the transmission.

S (Situational): This field is necessary in certain situations. Please review the ASC X12N Implementation Guide for instructions on when this is required.

N/U (Not Used): The shaded areas of the Companion Guide are NOT USED according to the standard and should not be included in transmissions.

Comments: This provides Educators' requirements/recommendations for some fields.

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment terminator	~ Tilde

Educators will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.



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Data Transmission instructions

Educators will be able to receive file submissions from those groups able to submit them. In order for Educators to set up an entity for EDI submission, they must contact the Educators operations department. Educators will need the following information since the **setup could take two to four weeks to accomplish**:

1. Will the file be sent using PGP?
2. Will the file be sent via the UHIN portal? (See www.UHIN.com.)
 - o UHIN accepts HIPAA transactions
3. Does the entity have the EMIA Public PGP key?
4. Has the entity been set up as a user on Educators' FTP network?
5. Does Educators have the entity's IP address to be used for submitting the files?
6. Has the entity agreed to the Educators timeline for acceptance testing?

Inquiry Level Supported

The 276 Health Care Claim Status Request transaction allows for claim level and service line level requests. Some adjudication systems cannot accommodate requests for service line status inquiries. ValueOptions can support the following level of inquiry:

- Claim Level Status Request
- Service Line Level Status Request



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Maximum Limitations

The 276 Health Care Claim Status transaction is designed to request the status of one or more claims for the patient transmitted within the transaction set. The 277 Health Care Claim response provides the status for the requested claims. When the 276 transaction does not uniquely identify the claim(s) within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester.

The structure of the transaction is as follows:

Information Source

 Information Receiver

 Service Provider

 Subscriber

 Dependent (only provided if the subscriber is not the patient) Claim
 (request claim identification info. 276, claim status info. 277)

Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide.

ValueOptions has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). ValueOptions requires that the Interchange Control structure is limited to one type of Functional Group, such as 276 Health Care Claim Status Requests. ValueOptions will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope). Batch files will be processed and the response file will be available within 24 hours of receipt.



Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing, as follows:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax, and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements, and segments. This also includes testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice, and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid, and Educators. Compliance testing with these payer-specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at <http://www.wedi.org/snip/public/articles/index%7E12.htm>.

Educators will provide the necessary information for clients to submit a file for testing purposes.

Helpful Hint: Create small batches of test transactions to ensure that you will not have to re-create too many 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.

After receiving clearance to submit production files, contact Educators' provider department when you submit your first "live" eligibility file. Provide your submitter ID and the Educators file tracking number (if available). The information technology department will work with the provider department to ensure that the file uploads properly and gets all the way through the system.



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ELECTRONIC DATA INTERCHANGE (HIPAA 276 format)

ASC X12N Version 004010X093A1

Loop ID	Page # #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
	B.3	ISA	Interchange Control Header			R
			01 – Authorization Info Qualifier	00 = No authorization info present	Relates to no meaningful information in ISA02	R
	B.3	ISA	02 – not used Insert asterisk			R
	B.4	ISA	03 – Security Information Qualifier	00 = No security information present	Relates to no meaningful information in ISA04	R
	B.4	ISA	04 – Security Info Insert	00		R
	B.4	ISA	05 – Interchange ID Qualifier	ZZ = Mutually Defined		R
	B.4-B-6	ISA	06 – Interchange Sender ID	ID code determined by sender	This is a unique ID number (i.e. Federal Tax ID.) Field length = 15	R
	B.5	ISA	07 – Interchange ID Qualifier	ZZ = Mutually Defined	This ID qualifies the receiver in ISA08	R
	B.5	ISA	08 – Interchange Receiver ID	ID=GroupNumber		R
	B.5	ISA	09 – Interchange Date	YYMMDD		R
	B.5	ISA	10 – Interchange	Time HHMM		R
	B.5	ISA	11 – Interchange Control Standards Identifier	U		R
	B.5	ISA	12 – Interchange Control Version Number	0040		R
	B.5	ISA	13 – Interchange Control Number		This number must be identical to the associated Interchange Trailer IEA02	R
	B.6	ISA	14 – Acknowledgement requested	1 = Interchange acknowledgement requested	All senders will receive a 997 upon successful receipt of requested file transfer	R
	B.6	ISA	15 – Usage Indicator	P = Production Data T = Test Data		R
	B.6	ISA	16 – Component Element Terminator	EMIA recommends using “>” as the segment terminator and using the “~”, tilde, as the segment separator.	Note: This value must be different than the data element separator and the segment terminator	
ISA ELEMENT EXAMPLE:						
ISA*00*.....*01*Password.*ZZ*Submitter.ID.*ZZ*Receiver.ID.....*030101*1200*U*00401*123456789*1*T*>~						
Note: The ISA segment is a fixed format. Spaces in the example are presented by “.” for clarity.						
	B.8	GS	01 - Functional Group Header	HS = Eligibility, Coverage or Benefit Inquiry		R
	B.8	GS	02 – Senders ID Code	Insert senders ID Same ID number as ISA06 R		
	B.8	GS	03 – Receivers ID Code	Insert receiver ID Same ID number as ISA08 R		
	B.8	GS	04 – Date of functional group creation date	CCYYMMDD		R
	B.8	GS	05 – Time of creation	HHMM		R
	B.9	GS	06 – Group Control Number		This number must match the data element in the associated functional group trailer in	R



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Loop ID	Page # (s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
					GE02	
	B.9	GS	07 – Responsible Agency Code Identifier	X = Accredited Standards Committee X12		R
	B.9	GS	08 – Version Release/Industry Identifier Code	004010X093A1	Must use full code	R
GS ELEMENT EXAMPLE: GS*HS*SENDER CODE*EMIA777777*20030101*1200*1*X*004010X093A1~						
	49	ST	01 – Transaction Set Identifier Code	276		R
	49	ST	02 -Transaction Set Control Number		Group Specific Control Number to identify transaction set. Must match number in SE02	R
ST ELEMENT EXAMPLE: ST*276*0001~						
	50	BHT	01- Hierarchical Structure Code	0010 – Information Source		R
	50	BHT	02 - Transaction Set Purpose	13 – Request		R
	50	BHT	03 - Reference ID			R
	50	BHT	04 – Date	Transaction Created	CCYYMMDD	R
BHT ELEMENT EXAMPLE: BHT*0010*13**20070630~						
2000A	52	HL	01 - Hierarchical ID Number	1		R
	52	HL	03 – Hierarchical Level Code	20		R
	53	HL	04 - Hierarchical Child Code	1		S
HL ELEMENT EXAMPLE: HL*1**20*1~						
2100A	54	NM1	01 – Entity Identifier Code	PR – Payer		R
	55	NM1	02- Entity Type Qualifier	2 = Non-Person Entity		R
	55	NM1	03- Name Last		Organization Name	R
	55	NM1	08- Identification Code Qualifier	XX – NPI Number		R
	56	NM1	09- Identification Code		NPI	R
NM1 ELEMENT EXAMPLE: NM1*PR*2*Educators Mutual*** **XX*0123456789~						
2000B	60	HL	01 - Hierarchical ID Number	1		R
	60	HL	02 - Hierarchical Parent ID			R
	61	HL	03 – Hierarchical Level Code	21		R
	61	HL	04 - Hierarchical Child Code	1		S
HL ELEMENT EXAMPLE: HL*2*1*21*1~						
2100B	62	NM1	01 – Entity Identifier Code	41 – Submitter		R
	63	NM1	02- Entity Type Qualifier	1 – Person 2 = Non-Person Entity		R
	63	NM1	03- Name Last		Organization or Last Name	S
	63	NM1	04- Name First		First Name	S
	63	NM1	05- Name Middle		Middle Name	S
	63	NM1	08- Identification Code Qualifier	XX – NPI Number		R
	63	NM1	09- Identification Code		NPI	R
NM1 ELEMENT EXAMPLE: NM1*41*1*Smith*John*Q * **XX*0123456789~						
2000C	65	HL	01 - Hierarchical ID Number			R
	65	HL	02 - Hierarchical Parent ID			R
	66	HL	03 – Hierarchical Level Code	19		R
	66	HL	04 - Hierarchical Child Code	1		S
HL ELEMENT EXAMPLE: HL*3*2*19*1~						
2100C	67	NM1	01 – Entity Identifier Code	1P – Provider		R
	68	NM1	02- Entity Type Qualifier	1 – Person 2 = Non-Person Entity		R
	68	NM1	03- Name Last		Organization or Last Name	S
	68	NM1	04- Name First		First Name	S
	68	NM1	05- Name Middle		Middle Name	S
	68	NM1	08- Identification Code	XX – NPI Number		R



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Loop ID	Page # (s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
			Qualifier			
	69	NM1	09- Identification Code		NPI	R
NM1 ELEMENT EXAMPLE: NM1*1P*2*Doctor's Office** **XX*0123456789~						
2000D	70	HL	01 – Hierarchical ID Number	1		R
	70	HL	02 – Hierarchical Parent ID			R
	71	HL	03 – Hierarchical Level Code	22		R
	71	HL	04 – Hierarchical Child Code	0 or 1	If Subscriber is Patient Then 0 Else 1	S
HL ELEMENT EXAMPLE: HL*4*3*22*1~						
2000D	72	DMG	01 – Date Time Format	D8 – Date		R
	73	DMG	02 – Date of Birth		CCYYMMDD	R
	73	DMG	03 – Gender	F – Female M – Male U – Unknown		R
DMG ELEMENT EXAMPLE: DMG*D8*20010911*M~						
2100D	74	NM1	01 – Entity Identifier Code	IL – Subscriber		R
	75	NM1	02- Entity Type Qualifier	1 – Person		R
	75	NM1	03- Name Last		Last Name	S
	75	NM1	04- Name First		First Name	S
	75	NM1	05- Name Middle		Middle Name	S
	75	NM1	08- Identification Code Qualifier	MI – Membership Number		R
	76	NM1	09- Identification Code			R
NM1 ELEMENT EXAMPLE: NM1*IL*1*Smith*John*D * **MI*12345678901~						
2200D	77	TRN	01 – Trace Type Code	1 – Current Trace Numbers		O
	77	TRN	02 – Reference Identification			O
TRN ELEMENT EXAMPLE: TRN*1*9877281234~						
2200D	78	REF	01 – Reference ID Qualifier	1K – Payor's Claim Number		R
	79	REF	02 – Reference ID	Payor's Claim Control Number		R
REF ELEMENT EXAMPLE: REF*1K*07201R000123~						
2200D	80	REF	01 – Reference ID Qualifier	BLT – Billing Type		R
	81	REF	02 – Reference ID	Bill Type Identifier		R
REF ELEMENT EXAMPLE: REF*BLT*00123~						
2200D	84	AMT	01 – Amount Qualifier Code	T3 – Total Submitted Charges		R
	85	AMT	02 – Total Claim Charge Amount			R
AMT ELEMENT EXAMPLE: AMT*T3*19~						
2200D	86	DTP	01 – Date/Time Qualifier	232 – Claim Statement Period Start		R
	87	DTP	02 – Date/Time Format	D8 – CCYYMMDD RD8 - CCYYMMDD- CCYYMMDD		R
	87	DTP	03 – Date			R
DTP ELEMENT EXAMPLE: DTP*D8*20010911~						
2000E	94	HL	01 – Hierarchical ID Number			R
	94	HL	02 – Hierarchical Parent ID			R
	95	HL	03 – Hierarchical Level Code	23		R
	95	HL	04 – Hierarchical Child Code	0		S
HL ELEMENT EXAMPLE: HL*5*4*23*0~						
2000E	96	DMG	01 – Date Time Format	D8 – Date		R
	97	DMG	02 – Date of Birth		CCYYMMDD	R
	97	DMG	03 – Gender	F – Female M – Male U – Unknown		R
DMG ELEMENT EXAMPLE: DMG*D8*20010911*M~						



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Loop ID	Page # #(s)	Seg ID	Element ID	Elements Values	Element Description	Req (R/S)
2000D	112	TRN	01 – Trace Type Code	1 – Current Trace Numbers		O
	113	TRN	02 – Reference Identification			O
	113	TRN	03 – Originating Company ID			O
	113	TRN	04 – Reference Identification			O
TRN*1*98175-012547*9877281234*RADIOLOGY~						
2100E	98	NM1	01 – Entity Identifier Code	QC – Patient		R
	98	NM1	02- Entity Type Qualifier	1 – Person		R
	99	NM1	03- Name Last		Last Name	S
	99	NM1	04- Name First		First Name	S
	99	NM1	05- Name Middle		Middle Name	S
	99	NM1	08- Identification Code	MI – Membership Number		R
	100	NM1	09- Identification Code			R
NM1 ELEMENT EXAMPLE: NM1*03*1*Smith*Jane*D****MI*012378945603~						
2200E	78	REF	01 – Reference ID Qualifier	1K – Payor’s Claim Number		R
	79	REF	02 – Reference ID	Payor’s Claim Control Number		R
REF ELEMENT EXAMPLE: REF*1K*07201R000123~						
2200E	80	REF	01 – Reference ID Qualifier	BLT – Billing Type		R
	81	REF	02 – Reference ID	Bill Type Identifier		R
REF ELEMENT EXAMPLE: REF*BLT*00123~						
2200E	109	AMT	01 – Amount Qualifier Code	T3 – Total Submitted Charges		R
	110	AMT	02 – Total Claim Charge Amount			R
AMT ELEMENT EXAMPLE: AMT*T3*19~						
2210E	118	DTP	01 – Date/Time Qualifier	472 – Service		R
	118	DTP	02 – Date/Time Format	D8 – CCYYMMDD RD8 - CCYYMMDD- CCYYMMDD		R
	119	DTP	03 – Date			R
DTP ELEMENT EXAMPLE: DTP*D8*20010911~						
	120	SE	01 – Number of included segments			R
	120	SE	02 – Transaction set control number		This data element must be identical to ST02	R
SE ELEMENT EXAMPLE: SE*39*0001~						
	B.10	GE	01 – Number of transaction sets included			R
	B.10	GE	02 – Group control number		This data element must be identical to GS06	R
GE ELEMENT EXAMPLE: GE*1*123456~						
	B.7	IEA	01 – Number of included functional groups			R
	B.7	IEA	02 – Interchange control number		This data element must be identical to ISA13	R
IEA ELEMENT EXAMPLE: IEA*1*123456~						



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Document Change Management

Date	Who	Description of Change
07/12/2007	Loren	Initial document creation