Healthcare and Family Services, Bureau of Information Services

HIPAA 5010 - 276/277 Health Care Claim Status Request and Response

Instructions related to Transactions based on ASC X12 Implementation Guide version 005010X212

Companion Guide Version Number: 1.0

Issued November 2011

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 contains provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- 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).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with the ASC X12 version 005010X212 Health Care Claim Status Request and Response (276/277) Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X212	Health Care Claim Status Request and Response (276/277)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

Version 5010 (005010X212) HFS Unique 276 Claim Status Request items

Loop ID	Reference	Name	Codes	Notes/Comments
2100A	NM1	Payer Name		
2100A	NM103	Organization Name		Must be ”ILLINOIS MEDICAID”
2100A	NM109	Identification Code		Must be “37-1320188” for HFS
2100C	NM1	Provider Name		
2100C	NM108	Identification Code Qualifier		Must be “XX” unless the provider is an atypical that does not require an NPI, or a hospital that submits both professional and institutional claims with the same NPI. Atypical and hospital providers should use the “SV” value.
2100C	NM109	Identification Code		Hospital providers must use the HFS assigned provider number and not the NPI.
2000D	HL	Subscriber level		
2000D	HL04	Hierarchical Child Code		Must use “0” (zero)
2100D	NM1	Subscriber Name		
2100D	NM102	Entity Type Qualifier		Must use ‘1’
2100D	NM108	Identification Code Qualifier		Must be “MI”
2100D	NM109	Identification Code		Must be the patient’s 9-digit Recipient ID

Loop ID	Reference	Name	Codes	Notes/Comments
				number.
2200D	TRN	Claim Status Tracking Number		
2200D	TRN02	Reference Identification		This value should be the Patient Control Number (CLM-01) from Loop 2300, Claim Information segment for 837D, I & P. This value will appear in the 277 records for identification purposes. For Pharmacy claims we recommend that the Prescription Number be inserted.
2200D	REF	Payer Claim Control Number		
2200D	REF02	Reference Identification		If used, this field must contain, in the first 15 positions, the Document Control Number (DCN) assigned by HFS. If the DCN is provided, only information about this specific claim will be returned on the 277.
2200D	REF	Application or Location System Identifier		
2200D	REF02	Reference Identification		Must contain "**INST**" if the status request is for an 837I or a paper UB claim; Must contain "**PROF**" if the status request is for an 837P claim. For both 4010 and 5010 billing formats, all Home Health claims require the PROF search key. Must contain "**PHAR**" if the status request is for a Pharmacy claim.
2200D	REF	Pharmacy Prescription Number		
2200D	REF02	Reference Identification		If submitted, this field must conform to NCPDP version D.0 standard of 'all numeric'. All values must be right justified and zero filled.
2000E	Dependent Level			Dependent loops are not used as the patient and subscriber are always the same for HFS.

Version 5010 (005010X212) HFS Unique 277 Status Response Items

Loop ID	Reference	Name	Codes	Notes/Comments
2100A	NM1	Payer Name		
2100A	NM103	Organization Name		Will be ”ILLINOIS MEDICAID”
2100A	NM108	Identification Code Qualifier		“PI” will be returned
2100A	NM109	Identification Code		Will be “37-1320188” for HFS
2000D	HL	Subscriber level		
2000D	HL04	Hierarchical Child Code		Field will contain “0”. Subscriber is always patient for HFS
2100D	NM1	Subscriber Name		
2100D	NM102	Entity Type Qualifier		”1” will always be returned
2100D	NM103, NM104	Name Last, Name First		Field will contain the same value as submitted in the 276
2100D	NM108	Identification Code Qualifier		”MI” will be returned
2100D	NM109	Identification Code		Field will contain the same value as submitted in the 276
2200D	STC	Claim level Status Information		
2200D	STC04	Monetary Amount		Field will contain the same amount as submitted in the 276
2200D	REF	Payer Claim Control Number		
2200D	REF02	Reference identification		Document Control Number + Service Section of claim assigned by HFS. HFS will return the DCN, if submitted in 276. If the DCN is not submitted, but is

Loop ID	Reference	Name	Codes	Notes/Comments
				found on Department's database, then that value will be returned. If DCN is not submitted and not found on database, a "blank" will be returned.
2200D	REF	Pharmacy Prescription Number		
2200D	REF02	Reference Identification		This field will conform to the NCPDP version D.0 value of 'all numeric'. All values will be right justified and zero filled.
2220D	SVC	Service Line Information		
2220D	SVC01-1	Procedure/Service ID Qualifier		Field will contain the same value as submitted in the 276
2220D	SVC02	Monetary Amount		Field will contain the same value as submitted in the 276

4 TI Additional Information

4.1 Payer Specific Business Rules and Limitations

4.1.1 GENERAL INFORMATION

This section contains information on the status of claims based on the 005010X212 version of the ASC X12N Claim Status Request and Response (276/277) Implementation Guide and the Errata (005010X12E1) dated June 2010. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

GETTING HELP

Help may be obtained by:

E-mail: HFS Webmaster Please identify the 276 – 277 transaction in the Subject line of emails for correct routing.

Telephone: (877) 782-5565. Tell the operator that you have a question or problem with the 276 – 277 system.

When to Submit a 276 (Status Request)

The intent of the 276 - 277 transactions is NOT to provide information explaining how a claim was processed or why certain amounts were paid. Answers to these types of questions are contained in the electronic HIPAA Remittance Advice (835) transaction.

The Claims Status Request and Response (276 - 277) Transaction set will be used to convey claims status information on claims received by the Department. The intent of this transaction is to answer questions such as:

• Did you receive my claim?

• Where is my claim in your system?

• What is the status of my claim (paid, rejected, in process, suspended, etc.)?

• If my claim was rejected, why?

The Department will provide status information only on claims that are on file in the HFS system. The information provided in the transaction will reflect the status of the claim at the time the request was made. The status of the claim may change from inquiry to inquiry.

4.1.2 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This document will identify only those data elements, that the Department requires, that are not clearly identified in the HIPAA 276 – 277 Implementation Guide.

The likelihood of identifying the correct claim will be increased, if the conventions outlined in this document are followed, in preparing the 276 request.

System Access

For HFS, the Patient is always the Subscriber.

The Dependent level segments in both the 276 and 277 transactions are not used.

Please ensure that you select the proper value for Loop 2200D (Application or Location System Identifier segment), element REF02. The available values are:
PROF for Professional
INST for Institutional
PHAR for Pharmacy

HFS has developed the Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet. Providers will have the ability to submit single claims as well as batch files utilizing the MEDI system. The MEDI system supports Claims submission, Claim Status inquiries, Eligibility inquiries, and an option to obtain an electronic Remittance Advice. Access the MEDI system and click the login option.

Real Time vs. Batch Processing

The MEDI system has the capability to process either a Real Time Inquiry or a Batch inquiry.

REAL TIME:

A Real-Time inquiry is defined as a single transaction with only one claim level request or one service line level request. For real-time, if additional transactions and service lines are sent, HFS will process only the first request and ignore all others. Under normal conditions, the response to any real-time inquiry will return in a matter of seconds.

The Real Time 276 – 277 transaction is available only during regular business hours (8:00 AM to 5:00 PM Central Time) on normal State of Illinois business days. The system is not available on weekends or State holidays.

Due to system limitations, Real Time queries for NIPS and Pharmacy claims will return only data for 90 days from the Voucher Creation Date. To receive additional information it will be necessary to submit a batch request. Note that this limitation does not apply to Institutional claims.

BATCH:

For a batch inquiry request, multiple transactions and service lines are processed. Batch transactions will be accumulated throughout the day and, under normal conditions, the response will occur within 24 hours.

MEDI users should have their batch 276 file to HFS no later than 10:30 AM Central Time. Please give yourself sufficient time in submitting a batch file to allow for delays caused by intermediary handling. If an incoming batch file has not completed processing by cutoff time, the batch will not go into search processing until the following day. Submitters should check the MEDI website after 6:00 AM Central Time, on the next State workday, following the submission, to see if there are any files to be downloaded.

Illinois HFS recommends limitation of batch files to 5,000 records per ST/SE loop. Only one 276 batch query file should be submitted per day.

SEARCH CRITERIA

In submitting a 276 (Claims Status Request), the requester needs to understand that the information returned to them will be based on the data elements submitted. While all submissions will require certain data elements, the inclusion of the Department's

Document Control Number (DCN) in Loop 2200D, Payer Claim Identification Number segment, Reference Identification field (REF02) of will cause the return of only data associated with that DCN. If the particular claim / service had an adjustment processed against it or a void / re-bill was successfully completed, these additional transactions will not be displayed using the DCN as part of the search key.

Users may also enter other data elements to further refine the information returned. Examples of other data elements are Pharmacy Prescription Number, National Drug Code or Procedure Code / Revenue Code. If the Procedure Code is used in the search criteria, any modifiers submitted on the claim must be used in the search criteria.

NOTE: If data elements beyond Provider Identifier, Recipient Identifier and Date of Service are used to restrict the number of records returned, please be aware that the data elements submitted must match exactly to Department records in order to find the requested claims/services. If the data elements do not match, the Department will return a D0 message (Data Search Unsuccessful – The payer is unable to return status on the requested claim(s) based on the submitted search criteria).

When submitting a 276, the requester must insert the Identification Code Qualifier of “XX” in field NM108 and the National Provider Identifier (NPI) of the provider, who rendered the service, in field NM109 (Provider Identifier), in Loop 2100C (Provider Name), Provider Name segment. The only exceptions are for atypical providers, or hospitals that submit both professional and institutional claims with the same NPI, who will submit a value of “SV” in the Identification Code Qualifier field and their Medicaid assigned Provider Number in the Provider Identifier field.

4.1.3 Frequently Asked Questions

5 TI Change Summary

Revision Date: April 2018	**Revision Description:** First update since CG issuance 11/2011. Loop ID 2100C, Ref NM108, added hospitals to the providers who must use Identification Code Qualifier “SV”. Loop ID 2100C added Ref NM 109 Identification Code that hospitals must complete with HFS assigned provider number and not the NPI. Loop 2100D Ref NM109 revised to remove reference to the Medical Card. Section 4.1.2, revised text to add that hospitals that submit both professional and institutional claims with the same NPI must submit a value of “SV” in the Identification Code Qualifier field and their Medicaid assigned Provider Number in the Provider Identifier field.
Revision Date:	**Revision Description:**
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