

Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document

American National Standards Institute (ANSI) ASC X12N 276/277 (005010X212)

Health Care Claim Status Request and Response

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Introduction

The Health Insurance Portability and Accountability Act-Administration Simplification (HIPAA-AS) requires Blue Cross Blue Shield of MI and all other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The ASC X12N/005010X212 276/277 Technical Report Type 3 (TR3) for Health Care Claim Status Request and Response has been established as the standard for the exchange of claim status transactions and is available at www.wpc-edi.com.

This document is intended for use as a companion to the HIPAA-mandated ASC X12N/005010X212 276/277 TR3, dated August 2006. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the noted HIPAA TR3 published by Washington Publishing Company.

This companion document is the property of Blue Cross Blue Shield of Michigan (BCBSM) and is for use solely in your capacity as a trading partner of health care transactions with BCBSM. It is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the BCBSM web site: www.bcbsm.com.

Getting Started

Appropriate steps must be taken before submitting production ANSI ASC X12N transactions, such as testing, completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please contact the EDI Help Desk at (248) 486-2292.

Reporting Instruction Clarifications – ASCX12N/005010X212 – 276/277

The 005010X212 version of the ANSI ASC X12N 276/277 transactions was selected as the format to meet HIPAA requirements for electronic submission of claim status requests and responses. They were designed so that inquiry submitters (information receiver) can determine:

- If an information source organization (e.g. payer) has a claim on file for a particular subscriber or dependent.
- The status of the claim on file for a particular subscriber or dependent.

BCBSM Supported Usage and Guidelines of the 276/277 Transaction

The ANSI ASC X12N 276 transaction is used to request the current status of a specified claim(s). The paired 277 transaction provides the response to the health care claim status request. The following provide the BCBSM 276/277 usage and guidelines:

- BCBSM claim status responses only provide the status of claims that were accepted within 2 years of the present date.
- Local responses are limited to 20 claims. All others have a size limitation of 32K.
- BCBSM accepts and responds to ANSI ASCX12N/005010X212 276/277 transactions for Blue Cross Blue Shield of Michigan, Medicare Advantage, Blue Care Network HMO and the Federal Employee Program claims.
- The 276/277 transaction set can be used to obtain claim status for the following lines of business: professional, institutional, vision, hearing, dental and Medicare Advantage.
- Minimally, BCBSM will use the following elements as search criteria on status requests:
 - Payer ID
 - Provider ID
 - Contract Number (must include the three position alphabetic prefix followed by the contract number)
 - Claim service period date range
 - Patient Last Name
 - Patient First Name
 - Patient Date of Birth
- Claim status transactions can be submitted for status of claim(s) from all other Blue Cross and/or Blue Shield plans. These transactions are routed to the home plan through a Blue Cross Blue Shield Association process referred to as BlueExchange. BlueExchange responses can be returned at either the claim or service level and content will vary by home plan.

BCBSM/BCN Nonsupported Usage and Guidelines of the 276/277 Transaction

Claim Status is not available for the following:

- Claims submitted to the DRAMS/Pharmacy Program.
- Dental predetermination of benefits transactions.

Maximums/Limitations

- Submit the 276 transaction as a continuous string to assure proper processing.
- Report one status response for one subscriber or one dependent per 276 submission.
- BCBSM, BCN, Medicare Advantage and NASCO - Responses will be returned for one claim status inquiry.
- Up to twenty claims will be returned per response transaction for BCBSM, BCN, Medicare Advantage and NASCO inquiries. A maximum of 32,000-byte limit will be returned per response transaction for all inquiries.

Rejected Transactions

Transactions that contain an unauthorized submitter identification number, invalid submitter/provider combinations, or are found to be HIPAA non-compliant will result in the return of a TA1 transaction(s) or 999 transaction(s). The TA1 transaction and 999 transaction specify the reason for rejection via error code(s). The error code definitions for both the ASC X12C TA1 transaction and the 999 transaction are found in the ASC X12C/005010X231 999 TR3 and the adopted Type 1 Errata (005010X231A1) published by Washington Publishing Company. If the 276 request transaction is accepted for processing, and a data processing error or a system processing error is encountered, the returned 277 response will specify the applicable error via the 2200D or 2200E STC segment.

Telecommunication Options

A direct-line connection with BCBSM is required to utilize this transaction. The telecommunication method supported is:

- MQ Series commercial messaging software

System Availability

- Monday through Saturday: 7:00 a.m. - 1:00 a.m. EST
- Sunday: 7:00 a.m. - 6:00 p.m. EST

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

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Implementation Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA 999 Implementation Guide. Trading partners should also follow the basic character set guidelines as noted above or in the TR3. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for transmitting to BCBSM EDI are:

Transaction Set	Element	Instruction	Imp Gde Pg#
Health Care Claim Status Request 276	ISA05 – Interchange ID Qualifier	Report ZZ	C.4
Health Care Claim Status Request 276	ISA06 – Interchange Sender ID	For institutional and dental claims, report the Federal Tax ID number of the submitter of the claim status inquiry. For professional claims, report the EDI-assigned "Billing Location Code" of the submitter of the claim status inquiry. All sender ID's must be registered with BCBSM EDI.	C.4
Health Care Claim Status Request 276	ISA07 – Interchange ID Qualifier	Report ZZ	C.5
Health Care Claim Status Request 276	ISA08 – Interchange Receiver ID	Report 382069753	C.5
Health Care Claim Status Request 276	GS02 – Application Sender's Code	For institutional and dental claims, report the Federal Tax ID number of the submitter of the claim status inquiry. For professional claims, report the EDI-assigned "Billing Location Code" of the submitter of the claim status inquiry. All sender ID's must be registered with BCBSM EDI.	C.7
Health Care Claim Status Request 276	GS03 – Application Receiver's Code	Report 382069753	C.7
Health Care Claim Status Request 276	GS08 –Version/Release/Industry Identifier Code	Report 005010X212	C.8
Health Care Claim Status Response 277			
Health Care Claim Status Response 277	ISA05 – Interchange ID Qualifier	ZZ will be returned from EDI	C.4
Health Care Claim Status Response 277	ISA06 – Interchange Sender ID	382069753 will be returned from EDI	C.4
Health Care Claim Status Response 277	ISA07 – Interchange ID Qualifier	ZZ will be returned from EDI	C.5
Health Care Claim Status Response 277	ISA08 – Interchange Receiver ID	For institutional and dental claims, the Federal Tax ID number of the submitter of the claim status inquiry will be returned. For professional claims, the EDI-assigned "Billing Location Code" of the submitter of the claim status inquiry will be returned.	C.5
Health Care Claim Status Response 277	GS02 – Application Sender's Code	382069753 will be returned	C.7
Health Care Claim Status Response 277	GS03 – Application Receiver's Code	The value reported on the corresponding 276 will be returned from EDI	C.7
Health Care Claim Status Response 277	GS08 – Version/Release/Industry Identifier Code	005010X212 will be returned	C.8

Health Care Claim Status Request 276 Transaction Set Data Clarifications

276 Loop	276 Segment/Element	Instruction	Industry/Element Name	TR3 Page#
2100A	NM108	Use qualifier 'PI'	Identification Code Qualifier	42
2100A	NM109	Report one of the following payer ID's as applicable: Professional BCBSM, BCN, Medicare Advantage: 00710P Institutional BCBSM, BCN, Medicare Advantage: 00210I BCBSM Dental: 00710D BCBSM Vision: 00710V BCBSM Hearing: 00710H Note: Use the above identifiers for in-state as well as BlueExchange inquiries. FEP: 00710W	Payer Identifier	42
2100B	NM109	For institutional and dental inquiries report the federal tax ID of the organization requesting to receive the status information. For professional, vision, hearing and FEP inquiries, report the BCBSM-EDI assigned billing location code.	Information Receiver Identification Number	46
2100C	NM1	BCBSM recognizes the first iteration of this loop as the billing provider.	Service Provider Name	49
2100C	NM108	Report "XX"	Identification Code Qualifier	51
2100D	NM108	Report "MI"	Identification Code Qualifier	57
2100D	NM109	BCBSM, BCN, and Medicare Advantage: Report the three leading alphabetic characters followed by the nine-digit contract number. If the alpha prefix is not known, report the nine-digit contract number. BlueExchange: When the member is covered by another BCBS plan, report the alphabetic prefix followed by the contract number. FEP: Report R followed by eight numeric digits.	Subscriber Identifier	57
2200D	REF01	When the patient is the subscriber and the applicable payer's claim number is known, report '1K'. Refer to 2200D REF02.	Reference Identification Qualifier	59
2200D	REF02	BCBSM/BCN: If available, report the document number/internal control number assigned to the claim. BlueExchange: If available, report the SCCF number assigned to the Blue Card claim. Otherwise, report the document number if available.	Reference Identification Number	59
2200E	REF01	When patient is a dependent and the applicable payer's claim number is known, report '1K'. Refer to 2200E REF02.	Reference Identification Qualifier	82

276 Loop	276 Segment/Element	Instruction	Industry/Element Name	TR3 Page#
2200E	REF02	<p>BCBSM/BCN: If available, report the document number/internal control number assigned to the claim.</p> <p>BlueExchange: If available, report the SCCF number assigned to the Blue Card claim. Otherwise, report the document number if available.</p>	Reference Identification Number	82

Health Care Claim Status Response 277 Transaction Set Data Clarifications

277 Loop	277 Segment/Element	Instruction	Industry/Element Name	TR3 Page#
2100A	NM108	Qualifier 'PI' will be reported.	Identification Code Qualifier	112
2100A	NM109	<p>One of the following payer ID's will be returned as applicable:</p> <p>Professional BCBSM, BCN, Medicare Advantage: 00710P</p> <p>Institutional BCBSM, BCN, Medicare Advantage: 00210I</p> <p>BCBSM Dental: 00710D</p> <p>BCBSM Vision: 00710V</p> <p>BCBSM Hearing: 00710H</p> <p>Note: Use the above identifiers for in-state as well as BlueExchange inquiries.</p> <p>FEP: 00710W</p>	Payer Identifier	112
2100C	NM108	Qualifier "XX" will be returned	Identification Code Qualifier	128
2100D	NM108	Qualifier "MI" will be returned	Identification Code Qualifier	136

277 Loop	277 Segment/Element	Instruction	Industry/Element Name	TR3 Page#
2200D & 2200E	STC01-1, STC01-2 & STC01-3	<p>Applicable Claim Status information will be reported for claims accepted for processing (pending, paid, denied). The following responses will be returned when a 276 data error or an internal BCBSM or affiliated system process error occurs:</p> <ul style="list-style-type: none"> • A Claim Status Category Code of E0, a Claim Status Code of 164 and an Entity Identifier of IL will be returned when the contract number was missing on the inbound 276. • A Claim Status Category Code of E0 and a Claim Status Code of 187 will be returned when the service date was missing on the inbound 276. • A Claim Status Category Code of E0 and a Claim Status Code of 33 will be returned when the subscriber is not found. • A Claim Status Category Code of E0, a Claim Status Code of 97, and an Entity Identifier of G0 will be returned when the patient is not found. • A Claim Status Category Code of E0, a Claim Status Code of 25, and an Entity Identifier of 1P will be returned when a request is received from a provider other than that which originated the claim. • A Claim Status Category Code of E0, a Claim Status Code of 562 and an Entity Identifier of 1P will be returned when the transaction receives an NPI error. • A Claim Status Category Code of D0 and a Claim Status Code of 485 will be returned when the transaction size exceeds 32,000 bytes. • A Claim Status Category Code of A4 and a Claim Status Code of 35 will be returned when no claims are found. • A Claim Status Category Code of E1 and a Claim Status Code of 0 or 484 will be returned when BCBSM is experiencing system errors. • A Claim Status Category Code of E2 and a Claim Status Code of 0 will be returned when the transaction receives a time-out or other system error. 	Health Care Claim Status Category Code, Health Care Claim Status Code and Entity Identifier	138 (2200D) 178 (2200E)

General EDI Terminology

ANSI X12N 276/277 v5010 – HIPAA standardized ANSI X12N transaction format for claims status inquiry request and response data.

BlueExchange – A Blue Cross Blue Shield Association (BCBSA) process through which non-claim HIPAA transactions for members from all other Blue Cross and/or Blue Shield plans that are governed by BCBSA can be accepted by a local host plan and routed to the home plan for processing.

Canned response – Informational response to the submitter for exception processing.

Data Segment – Corresponds to a *record* in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12N). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

Data Element – Corresponds to a *field* in data processing terminology. Assigned unique 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 (with an assumed number of decimal positions)
R	Decimal Real Number (including decimal or negative sign)
ID	Identifier
AN	Alphanumeric string
DT	Date
TM	Time

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.

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, an application file/form, translator (mapper), communications and value added network or value-added service provider.

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

Technical Reports Type 3 (TR3s) – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA TR3s on their web site: www.wpc-edi.com.

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.

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.

X12N – An Accredited Standards Committee commissioned by the American National Standards Institute to develop standards for Electronic Data Interchange. While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI 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.