

# **Implementing the HIPAA 276/277 Health Care Claim Status Transactions**

Michigan Department of Community Health  
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# Objectives

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- Introduce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 276/277 health care claim status request and response transaction
- Provide a detailed review of data elements in the 276/277 claim status request and response transaction
- Identify requirements issues where the HIPAA-mandated implementation guide allows flexibility
- Identify design issues associated with implementing the 276/277 transaction

# **Introduction**

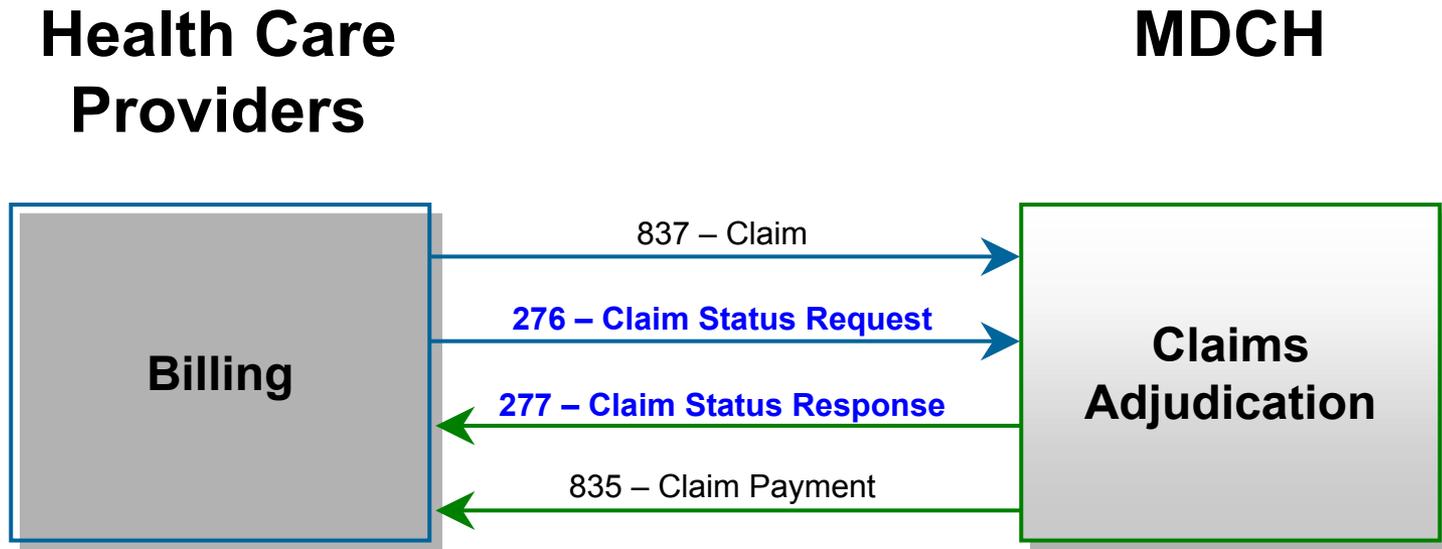
# HIPAA Transactions

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## Claims and related transactions

- Claims (837)
- Remittances (835)
- **Claim Status (276/277)**

# Transaction Flow



# The 276/277 Transaction

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The 276/277 transaction gives providers and payers use a fixed, shared, and streamlined format to communicate about claim status.

It has the potential to reduce phone calls and unneeded re-billing substantially.

While providers use the same format for all payers, the responses will differ, based on business rules.

# **276/277 Overview**

# 276/277 Overview

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- The 276 Query
- The 277 Response
- 276 Search Elements
- 277 Status Data
- Health Care Claim Status Category Code
- Entity Identifier Code
- Interactions with Other Transactions

# The 276 Query

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## 276 Claim Status Request

- An inquiry to determine the status of one or more health care claims
- Used by entities that submit claims (e.g., providers)
- An optional transaction for claim submitters
- Status information can be requested at the claim and line level

# The 277 Response

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## 277 Claim Status Response

- A response about the status of one or more health care claims
- Transmitted by payers to the entity that submitted the 276 request
- Required for each 276 request
- Identifies status of claim(s) within the adjudication process, including
  - Not found
  - Pre-adjudication
  - Pended
  - Finalized

# 276 Search Elements

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- Elements from the 837 to assist the payer in identifying the claim(s) in their adjudication process
- Search elements are related to provider/patient, claim, and service
- **Provider/Patient Search Elements:**
  - Billing Provider Identification
  - Subscriber Date of Birth
  - Subscriber Gender
  - Subscriber Identification

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# 276 Search Elements

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- **Claim Search Elements:**
  - Payer Claim Identification Number (CRN)
  - Bill Type Identification
  - Medical Record Identification
  - Group Number
  - Claim Submitted Charges
  - Claim Service Period or Date

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# 276 Search Elements

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- **Service Search Elements**

- Service Identification Code (HCPCS, CDPN, Revenue Code)
- Procedure Modifier
- Line Item Charge Amount
- Billed Quantity
- Service Line Identification (Professional & Dental only)
- Service Date

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# 277 Status Data

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- The 277 repeats data from the 276 request to allow provider to locate the claim in their system
- The 277 then reports claim status with three elements, which form the “Health Care Claim Status composite”
  - Health Care Claim Status Category Code
  - Health Care Claim Status Code
  - Entity Identifier Code

# Health Care Claim Status Category Code

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## Health Care Claim Status Category Code

- Required element in 277 Response
- Uses 26 codes to indicate the level of processing achieved by the claim, including
  - Not found
  - Pre-adjudication (i.e., accepted/rejected)
  - Pended (e.g., incorrect/incomplete claim)
  - Finalized (e.g., rejected, denied, approved pre-payment, approved post-payment)
- Payer is required to submit the most applicable code

# Health Care Claim Status Code

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## Health Care Claim Status Code

- Required element in 277 response
- ***Minimum requirement:*** Transmit one of three codes detailing why claim is in a particular status category
  - **0 Cannot provide further status electronically**
  - **1 For more detailed information, see remittance advice**
  - **2 More detailed information in letter**
- ***Optional:*** Payer is encouraged to transmit full information with one of 400 detailed codes

# Entity Identifier Code

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## Entity Identifier Code

- Situational element in 277 response
- Further clarifies the message of the Health Care Claim Status Code
- Over 200 codes exist to identify types of providers, services, facility types, & other health care-related entities
- Used only when payer's system supports sending more than the minimum requirements for the Health Care Claim Status Code

# Interactions with Other Transactions

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- An 837 claim is a prerequisite to a 276/277 inquiry into that claim's status
- A 277 response is required for each 276 request
- The 276 and 277 contain “search elements” from the 837 to facilitate matching the request to the claim and the response to the request
- Additionally, a Trace Number element can be used in the 276 to simplify the matching of response to request

# Requirements Issues

# Requirements Overview

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If possible, derive requirements from your current system:

- **If your organization provides claim status today, assess that framework**
- **The Final Rule says that you cannot penalize trading partners who use the standard transactions**
- **This implies that the response, timeliness, and granularity of data in the 276/277 must meet or exceed that in current interactive voice response (IVR), direct data entry (DDE), or Web-based systems**

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# Requirements Overview

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## Start from Scratch:

- **Use a process that involves business proponents and technical staff**
- **Consider joint rapid application design (JRAD) or similar methods**
- **Consider coordinating with other payers or WEDI SNIP regional groups**

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# Requirements Issues

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Issues to Consider:

- **Authorization**
- **Frequency of Queries**
- **Timeliness and Granularity of Response**
- **Data Completeness**
- **Responses to Queries**

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# Requirements Issues

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## Issues to Consider:

- **Authorization (who can receive the claim status)**
  - Many providers submit both electronic and paper claims
  - Some providers may use more than one clearinghouse
- **Frequency or volume of queries**
  - Some providers may query every claim every day
- **Timeliness and granularity of response**
  - Providers will react to the response

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# Requirements Issues

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## Issues to Consider:

- **Data Completeness**

- The status of some claims (paper, replacement, or void/cancel) may be hard to capture

- **Responses to queries**

- Will you return the whole claim if a single line is queried
- Will you respond to a non-specific query (for example, if only the patient name is supplied)

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# Overview of Design Issues

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Issues to Consider:

- **Loading claims**
- **Updating internal status**
- **Processing queries**
- **Purging claims**

# Design Issues

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## Loading Claims:

- **After receipt**
- **After translation**
- **After optical character reading (OCR) or key entry**
- **After front-end edits**
- **After acceptance into adjudication**

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# Design Issues

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## Updating Internal Status:

- **After internal edit and validation**
- **After pended for review**
- **After denial or approval**
- **After payment**

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# Design Issues

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## Processing Queries:

- **Once per Claim Input cycle**
- **Once per Edit/Validation cycle**
- **Once per Adjudication cycle**
- **Once per Payment cycle**

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# Design Issues

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## Purging Claims:

- **After close of period for replacement or void/cancel**
- **After legally-mandated retention period**
- **After arbitrary time period defined in policy or trading-partner agreement**

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# **276/277 Status Request and Response Recap**

# 276/277 Status Request and Response Recap

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- The 276/277 is the HIPAA-mandated transaction to be used to transfer health care claim status requests and responses electronically between providers and payers. Payers are required by law to possess this capability.
- HIPAA provides flexibility regarding the mode for receiving and responding to 276 Status Requests and the timeliness of the response.

“All health plans, including State Medicaid plans, must have the capability to accept, process, and send the ASC X12N 276/277 transactions”

— *Federal Register*, August 17, 2000, p. 50371

**Questions?**

**Further questions? Contact  
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