Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-141 **Date: SEPTEMBER 26, 2003**

CHANGE REQUEST 2742

SUBJECT: CMS Companion Document for the Accredited Standards Committee (ASC) X12N 276/277 Health Care Claim Status Request And Response

In Change Request (CR) 2385, Transmittal AB-03-026, you were instructed to implement the X12N 276/277 Health Care Claim Status Request and Response (version 4010A1) and through your shared systems, to apply the appropriate implementation guide (IG) edits based on that version of the transaction by April 1, 2003.

This Program Memorandum (PM) provides you with the Medicare requirements (Companion Document) to be shared with users of the 276/277 Implementation Guide version 4010A1. You have the option to add specific items not contained in this PM. However, these items must not contradict any items in this PM or in the Implementation Guide. You are required to insert local information as indicated below and to provide the content of this companion document to users of the 276/277, if you have not already done so.

You have a number of options for distributing the companion document requirements to your Electronic Data Interchange (EDI) submitters including via provider bulletins, educational articles, provider outreach presentations or electronic mail/Web page/electronic bulletin board. Choose from any of these techniques (as well as others) to reach your submitter audience by the most effective and efficient means. Use any of the aforementioned communication techniques timed with the production availability of your companion document.

X12N 276/277 Companion Document

The table provided below indicates those segments or data elements in the X12N 276/277 Implementation Guide version 4010A1 that allow for Medicare to specify its business requirements. The information describes specific requirements used by *[Contractor name] [contractor number]*. The information in this document is subject to change. Changes will be communicated in the *[Contractor newsletter name]* news bulletin and/or on *[Contractor name]* Web site: *[Contractor URL]*.

General Requirements:

Data elements that are defined by a previous qualifier will contain valid and appropriate information for the noted qualifier.

Examples:

o If ISA07 has a value of "28" indicating a fiscal intermediary ID Number, then ISA08 will contain a valid Fiscal Intermediary ID Number.

o If NM108 has a value of "24" indicating an EIN, then NM109 will contain a valid EIN for the identified provider.

[Contractor name] will process your request for claim status information in (*indicate which of the following modes apply*) batch and/or real-time, central processing unit to central processing unit (cpu to cpu).

(For each mode offered, indicate the following as applicable and also specify your timeliness per CR 1784, Transmittal AB-01-106, requirements.) Upon receipt of your 276, we will generate the following:
TA1 or local reject report for interchange control errors within (*specify timeliness*).
997 for syntax errors within (*specify timeliness*).
997 to confirm receipt within (*no interchange control errors or syntax errors--specify timeliness*).
277 (*specify timeliness*).

[Contractor name] will process your 276 as identified in the implementation guide and create a 277 as identified in the implementation guide. At least the minimum response data will be sent.

[Insert this paragraph if it applies to your claims processing environment.] [Contractor name] keeps its online paid claims file for *[insert the amount of time*]. After that time, paid claims are stored in an off-line paid claims history file *[you may replace reference to the off-line paid claims history file with other terminology such as archive, etc.*]. A 276 inquiry for a claim that has reached history, will result in a 277 response with a health care claim status code "35" (claim not found).

The 276 transaction must utilize delimiters as defined in the standard. The delimiters selected must not occur in the transmitted data elements. The delimiters used in a 277 response or in an acknowledgment may not necessarily be the same as the delimiters submitted in the original 276 request transaction.

All alphabetic characters in the 277 transaction will be upper case. If lower case characters are included in the 276 request, they will be converted to upper case for data storage and return processing purposes.

Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments). Multiple 276s or 277s (ST through SE) can be included in a single functional group.

For Medicare the subscriber and patient are the same person. The Dependent Level hierarchical level is never used.

Page		Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
276 Request Transaction					
B.4		Interchange Control Header	ISA05	ZZ	Interchange Identity Qualifier for ISA06 Submitter uses the "ZZ" value.
B.4		Interchange Control Header	ISA06		Interchange sender ID. Submitter chooses and enters a value later used by the contractor for sending back the 277.
B.4		Interchange Control Header	ISA07	27, 28	Carrier submitter uses a "27"; intermediary submitter uses a "28" as the Interchange I.D. Qualifier for ISA08.
B.5		Interchange Control Header	ISA08		Interchange Receiver ID. Submitter uses the CMS assigned Medicare carrier or intermediary number.
28 addenda		Functional Group Header	GS01		Submitter uses code "HR" to designate the 276.
28 addenda		Functional Group Header	GS02		Submitter uses codes agreed to by trading partners.
28 addenda		Functional Group Header	GS03		Submitter uses code agreed to by trading partners.
29 addenda		Functional Group Header	GS05		Submitter uses the recommended HHMM format.
55		Payer Name	NM108	PI	Submitter uses the code "PI" to identify that the carrier or intermediary identifier will follow.
56		Payer Name	NM109		Submitter uses the identifier provided by the carrier or intermediary.
57		Payer Contact Information			This segment is not needed for Medicare.
63		Information Receiver Name	NM108	46	(This is the individual or organization requesting to receive the status information.
63		Information Receiver Name	NM109		Submitter uses identification code as assigned by the carrier or intermediary.
68		Provider Name	NM108	SV	Submitter uses the "SV" qualifier for the Medicare provider number in NM109.
69		Provider Name	NM109		Submitter enters the Medicare provider number.
75		Subscriber Name	NM108	MI	Submitter uses the "MI" qualifier for the patient's Medicare health insurance claim (HIC) number entered in NM109.
76		Subscriber Name	NM109		Submitter enters the patient's Medicare

					health insurance claim (HIC) number.
14 addenda		Group Number	REF		This segment is not used for inquiries to Medicare.

277 Response Transaction

B.4		Interchange Control Header	ISA05	27, 28	Contractor enters the valid code as a qualifier for ISA106 for Carrier or Intermediary Identification Number as assigned by CMS. Carriers enter "27" and intermediaries enter "28."
B.4		Interchange Control Header	ISA06		Contractor enters the Carrier or Intermediary Identification Number as assigned by CMS.
B.4		Interchange Control Header	ISA07	ZZ	Contractor enters the "ZZ" Qualifier for ISA108.
B.5		Interchange Control Header	ISA08		Contractor enters the ID number assigned by the 276 submitter in the 276, ISA06.
28 addenda		Functional Group Header	GS01		Contractor uses code "HN" to designate the 277.
28 addenda		Functional Group Header	GS02		Contractor uses the code agreed to by trading partners.
28 addenda		Functional Group Header	GS03		Contractor uses the code agreed to by trading partners.
29 addenda		Functional Group Header	GS05		Contractor enters the recommended HHMM format.
131		Payer Name	NM108	PI	Contractor enters the "PI" qualifier for NM109.
132		Payer Name	NM109		Contractor enters identification code.

The *effective date and implementation date* for this PM are October 27, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after August 30, 2004. By that date, the requirements for this PM will be included in Chapter 31 of the new Medicare Claims Processing Manual.

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