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of the Blue Cross and Blue Shield Association

December 19, 2008

Dear software developer,

A revised, updated copy of the ANSI ASC X12N 276/277 (004010X093A1) Health Care Claim Status Request and Response BCBSM HIPAA EDI Companion Document is now online at: [www.bcbsm.com/pdf/systems\\_resources\\_edi\\_276.pdf](http://www.bcbsm.com/pdf/systems_resources_edi_276.pdf)

The table below summarizes the changes made.

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<b>Health Care Claim Status Request 276 Transaction Set Data Clarifications</b>		
Loop 2100C, NM108	Added	7
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If you have questions regarding this information, please call the Electronic Data Interchange department at 800-542-0945, option 5.

Sincerely,



Wanda Brideau  
 Manager, ETP Service and Support  
 e-Business Interchange Group



John Bialowicz  
 Manager, ETP Contracting and Relations  
 e-Business Interchange Group



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## **Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document**

American National Standards Institute (ANSI) ASC X12N 276/277 (004010X093A1)

Health Care Claim Status Request and Response

Blue Cross Blue Shield of Michigan  
53200 Grand River Avenue  
New Hudson, MI 48165-9801

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## **Introduction**

This document is the property of Blue Cross Blue Shield of Michigan and is for use solely in your capacity as a trading partner of health care transactions with BCBSM.

This document provides information related to specific elements within the addenda version of the ANSI ASC X12N 276/277 transactions, but:

- It does not change the definition, data condition, or use of a data element or segment in a standard.
- It does not add data elements or segments to the maximum defined data set.
- It does not use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s).
- It does not change the meaning or intent of the HIPAA standards implementation specifications.<sup>1</sup>

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N 276/277 transaction set Addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by the Washington Publishing Company. Implementation Guides can be downloaded from the Washington Publishing Company Web site at [www.wpc-edi.com](http://www.wpc-edi.com). Copyright (c) 2000, Data Interchange Standards Association on behalf of ASC X12.Format (c) 2000, Washington Publishing Company. All Rights Reserved.

This document 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](http://www.bcbsm.com).

Appropriate steps must be taken before submitting production Addenda 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 800-542-0945, option *marketing*.

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<sup>1</sup>Standards for Electronic Transactions, *Federal Register*, Vol. 65, No. 160, August 17, 2000 pg. 50368

## **ANSI ASC X12N Claim Status Inquiry Request and Response 276/277 (004010X093A1) – Reporting Instruction Clarifications**

### **General Overview**

The addenda 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 accepts and responds to ANSI ASC X12N 276/277 addenda version transactions for Blue Cross Blue Shield of Michigan, Medicare Plus Blue, Blue Care Network HMO and the Federal Employee Program. Claim inquiry transactions can also be submitted for members from all other Blue Cross and/or Blue Shield plans. These transactions will be routed to the home plan through a Blue Cross Blue Shield Association process referred to as BlueExchange. **Note:** Claim Status Responses are not available for claims submitted to the DRAMS/Pharmacy Program or for dental predetermination of benefits transactions.

**Please note that data must be transmitted in a continuous string for proper processing of the inbound transaction.**

Entities requesting health care claim status include, but are not limited to:

- Hospitals
- Nursing homes
- Laboratories
- Physicians
- Dentists
- Allied professional groups
- Employers
- Supplemental (other than the primary payer) health care claims adjudication processors.

These transaction sets are supported for the following lines of business: professional, institutional, vision, hearing, dental and Medicare Plus Blue.

- BCBSM may edit data submitted beyond the requirements defined in the HIPAA Implementation Guide.
- BCBSM may reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and BCBSM Companion Document requirements.
- BCBSM may reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.
- Claim responses will be returned based on BCBSM claims data that was processed within the past 90 days from the date the inquiry was submitted. BlueExchange responses will be returned based on claim data available to the home plan at the time the inquiry was processed.

## **Supported Business Functions**

The ANSI ASC X12N 276 transaction is used to request the current status of a specified claim(s). The paired 277 transaction response will be used to provide a response to the health care claim status request. BCBSM claim status responses will only provide the status of claims that were accepted within 90 days of the inquiry date. BlueExchange responses will vary based on the home plan.

- Claim status requests can be submitted at the claim or service level, but BCN and Medicare Crossover responses will only be returned at the claim level. All others will be returned at the claim and service level when claim(s) are found. BlueExchange responses will be returned at either the claim or service level and content will vary by home plan.
- The information receiver may create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels.
- BlueExchange transactions routed to a home plan that process ANSI ASC X12N 276/277 addenda version transactions in a batch environment will result in an interim real-time 277 response followed by a final batch 277 response. The interim 277 response will contain default values in place of originally submitted data. Some basic information must be supplied in order for the payer to appropriately identify the specific claim in question. Unique identifying elements should be supplied to provide as much inquiry information as possible. Transactions that do not follow the segment and element requirements as set forth in the addenda version of the HIPAA ASC X12N 276/277 Implementation Guide will be rejected. Minimally, BCBSM will use the following elements as search criteria on statuses received:

## **Search Options**

- Payer ID
- Provider ID
- Contract Number (BlueExchange inquiries 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

Please see the data clarifications table for more specific information about each of the above elements.

## **Maximums/Limitations**

- Only one 276 inquiry can be submitted per 276 envelope (for one subscriber or one dependent).
- BCN and Medicare Crossover will return status responses at the claim level only.
- BCBSM, BCN and NASCO - Responses will be returned for one claim status inquiry.
- BCBSM responses will be returned at the claim and service level when claims are found. Up to twenty claims will be returned per response transaction for BCBSM, BCN and NASCO inquiries. A maximum 32,000-byte limit will be returned per response transaction for all inquiries.
- BlueExchange responses will be returned at either the claim or service level and content will vary by home plan.
- BlueExchange transactions routed to home plans that may process claim status transactions in a batch environment will result in an interim real-time 277 response transaction followed by a final 277 response which will be returned as a batch transaction.

### **Rejected Transactions**

The 277 response will include at least one STC segment. Reported submitter and provider identification numbers will be validated. Transactions submitted for unauthorized submitter/provider combinations will be rejected.

The following conditions will result in a 277 response in which some data elements will contain default values in place of originally submitted data:

- Noncompliant transactions
- Transactions submitted for non-authorized providers
- BCBSM system error
- Time out error

### **Telecommunication Options**

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

- MQ Series commercial messaging software

Note: All delayed BlueExchange responses will be returned based on your registered batch connection with BCBSM.

### **System Availability**

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

### **Character Set Requirement**

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field. All transactions must be submitted in upper-case characters.

A...Z	0...9	!	“	&	,	(	)	+
'	-	.	/	;	?	=	@	Space

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

Trading partners should follow the Interchange Control Structure (ICS) and Functional Group Structure (GS) guidelines for HIPAA that are located in the HIPAA implementation guides in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for transmitting to BCBSM EDI are:

<b>Transaction Set</b>	<b>Element</b>	<b>Instruction</b>	<b>Imp Gde Pg#</b>
Health Care Claim Status Request 276	ISA05 – Interchange ID Qualifier	Report ZZ	B.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.	B.4
Health Care Claim Status Request 276	ISA07 – Interchange ID Qualifier	Report ZZ	B.4
Health Care Claim Status Request 276	ISA08 – Interchange Receiver ID	Report 382069753	B.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.	B.8
Health Care Claim Status Request 276	GS03 – Application Receiver's Code	Report 382069753	B.8
Health Care Claim Status Request 276	GS08 – Version/Release/Industry Identifier Code	Report 382069753 Report 004010X093A1	B.8 B.9
Health Care Claim Status Response 277	ISA05 – Interchange ID Qualifier	ZZ will be returned from EDI	B.4
Health Care Claim Status Response 277	ISA06 – Interchange Sender ID	382069753 will be returned from EDI	B.4
Health Care Claim Status Response 277	ISA07 – Interchange ID Qualifier	ZZ will be returned from EDI	B.4
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.	B.5
Health Care Claim Status Response 277	GS02 – Application Sender's Code	382069753 will be returned	B.8
Health Care Claim Status Response 277	GS03 – Application Receiver's Code	The value reported on the corresponding 276 will be returned from EDI	B.8
Health Care Claim Status Response 277	GS08 – Version/Release/Industry Identifier Code	004010X093A1 will be returned	B.9

**Health Care Claim Status Request 276 Transaction Set Data Clarifications**

Loop	Segment/Element	Instruction	Industry/Element Name
2100A	NM108 & NM109	Use qualifier PI in NM108 and report one of the following payer ID's as applicable: 00710P – Professional BCBSM, BCN, Medicare Plus Blue 00210I – Institutional BCBSM, BCN, Medicare Plus Blue 00710D – BCBSM Dental 00710V – BCBSM Vision 00710H – BCBSM Hearing Use the above values for in-state as well as BlueExchange inquiries. 00710W – FEP	Payer ID
2100B	NM108 & NM109	For institutional and dental inquiries use qualifier FI in NM108 and report the federal tax ID of the organization requesting to receive the status information in NM109. For professional, vision, hearing and FEP inquiries, report 46 in NM108 and the BCBSM-EDI assigned billing location code in NM109.	Information Receiver ID Number
2100C	NM108	Report XX (National Provider Identifier NPI)	Identification Code Qualifier
2100C	NM109	<u>Professional</u> <b>BCBSM and BCN:</b> Report the 10 digit National Provider Identifier (NPI) Medicare Plus Blue: Report the 10 digit National Provider Identifier (NPI) <u>Institutional</u> <b>BCBSM, BCN:</b> Report the 10 digit National Provider Identifier (NPI) Medicare Plus Blue: Report the 10 digit National Provider Identifier (NPI) <u>Dental</u> Report the 10 digit National Provider Identifier (NPI)	Provider Identifier
2000D & 2000E	DMG02	Report the date of birth of the subscriber in loop 2000D. If the patient is not the subscriber, report the dependent's birth date in loop 2000E.	Subscriber & Dependent Date of Birth
2100D & 2100E	NM103	Report the subscriber's last name in loop 2100D. If the patient is not the subscriber, report the dependent's last name in loop 2100E.	Subscriber & Dependent Last Name
2100D & 2100E	NM104	Report the subscriber's first name in loop 2100D. If the patient is not the subscriber, report the dependents first name in loop 2100E.	Subscriber & Dependent First Name

Loop	Segment/Element	Instruction	Industry/Element Name
2100D	NM109	Report the contract number of the subscriber in Loop 2100D excluding punctuation and spaces. <b>BCBSM and BCN:</b> Some BCBSM/BCN identification cards include three leading alphabetic characters. If so, report them followed by the nine-digit contract number. If not, report the nine-digit numeric contract number. For BlueExchange claim status inquiries (when the member is covered by a BCBS plan other than BCBSM) report the alphabetic prefix followed by the contract number. <b>Medicare Plus Blue:</b> Report the BCBSM assigned contract number. It is recommended that the alpha prefix be included as part of the contract number. <b>FEP:</b> Must be an R followed by eight numeric digits.	Identification Code
2200D & 2200E	REF01 & REF02	When available, report the document number/internal control number assigned to the claim by BCBSM/BCN. For BlueExchange inquiries, if available report the SCCF number assigned to the Blue Card claim. Otherwise, report the document number if available.	Reference Identification Number
2200D & 2200E	DTP03	Report the service date reported on the claim that the inquiry is for in loop and 2200D or 2200E.	Claim Service Date

### **Health Care Claim Status Response 277 Transaction Set Data Clarifications**

<b>Loop</b>	<b>Segment/Element</b>	<b>Instruction</b>	<b>Industry/Element Name</b>
2100A	NM108 & NM109	<p>Qualifier PI will be returned in NM108 and one of the following payer ID's will be returned in NM109, as applicable:</p> <p>00710P – Professional BCBSM                      00210I – Institutional BCBSM                      00710D – BCBSM Dental                      00710V – BCBSM Vision                      00710H – BCBSM Hearing</p> <p>The above values will be returned for in-state as well as BlueExchange inquiries.                      00710W – FEP</p>	Payer ID
2200D	STC01-1, STC01-2 & STC01-3	<p>Health Care Claim Status Category Codes (Code Source 507) are used to organize the Health Care Claim Status Codes (Code Source 508) into logical groupings. The Claim Status Code identifies the status of an entire claim. Both lists are available for downloading from the Washington Publishing Company web site at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>.</p> <p>Please note the following responses that BCBSM will be returning:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• A Claim Status Category Code of E0 and a Claim Status Code of 481 will be returned when a compliance error is found on the 276 submitted. BCBSM will not return a 997 for compliance errors.</li> <li>• A Claim Status Category Code of E0 and a Claim Status Code of 25 will be returned when a request is received from a provider other than that which originated the claim.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• A Claim Status Category Code of A4 and a Claim Status Code of 35 will be returned when no claims are found.</li> <li>• A Claim Status Category Code of E1 and a Claim Status Code of 0 will be returned when BCBSM is experiencing System errors.</li> </ul>	Health Care Claim Status Category Code, Health Care Claim Status Code and Entity Identifier

## **General EDI Terminology**

**Addenda** – Refers to a version of the HIPAA mandated transaction sets that correct identified implementation issues noted in the original implementation guides.

**ANSI X12N 276/277 v4010** – 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

**Delayed Response** – BlueExchange transactions that are routed to a home plan that process ANSI ASC X12N 276/277 addenda version transactions in a batch environment will result in an interim real-time 277 response followed by a final batch 277 response.

**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.

**Implementation guides** – 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 implementation guides on their web site: [www.wpc-edi.com](http://www.wpc-edi.com).

**Interface** – The point at which two systems connect to pass data.

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

**Routing** – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

**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.

**Translation Software** – Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

**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.