Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-106 **Date: AUGUST 1, 2001**

CHANGE REQUEST 1784

SUBJECT: Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Claims Status Request/Response Transaction Standard

This Program Memorandum (PM) provides instructions for carriers, durable medical equipment regional carriers (DMERCs), intermediaries, and their standard systems on Medicare requirements for their implementation of version 4010 of the accredited standards committee (ASC) X12N 276/277 health care claim status request and response format as established in the 004010X093 Implementation Guide (IG). In order to implement the HIPAA administrative simplification provisions, the 276/277 has been named under part 162 of title 45 of the Code of Federal Regulations as the electronic data interchange (EDI) standard for Health Care Claim Status Request/Response. All other EDI formats for health care claims status request and response become obsolete October 16, 2002.

I. X12 Documentation

The version 4010 implementation guide for the 276/277 standard may be found at the following web site: www.wpc-edi.com/HIPAA. The 276/277 is a "paired" transaction (the 276 is an in-bound claim status request and the 277 is an outbound claims status response).

II. Transmission Requirements

Carriers, DMERCs and intermediaries (hereafter called contractors) may continue to operate automated response unit (ARU) capability for providers to request and receive claim status information. ARUs are not considered EDI and are not affected by the HIPAA requirements. Nor do they impact response time requirements for the standard transactions implemented under HIPAA.

A. Batch Transactions - By April 1, 2002, contractors should be able to accept the ASC X12 276 Health Care Claim Status Request Response version 4010 in batch mode, and respond via the ASC X12 277 Health Care Claim Status Response version 4010 in batch mode. By October 16, 2002, you must discontinue use of the X12 276/277 version 3070 (if you had implemented that version), or of any other EDI format you may have implemented that performs this function. If you do currently support batch capability in any EDI batch format for providers to request claim status, your response time for issuance of a 277 version 4010 transaction in response to receipt of a valid 276 must be as fast as or faster than your current batch claim status response time. The 277 response is issued within 1 business day of receipt of a valid 276 inquiry.

B. Online Direct Data Entry (DDE), Professional Provider Telecommunications Network (PPTN) or Equivalent Functionality - HIPAA uses the term "direct data entry" generically to refer to a type of functionality operated by many different payers under a variety of titles. Within this instruction, the acronym DDE is being used to refer to any type of direct data entry system maintained by contractors, or standard systems maintainers, including carrier PPTN, intermediary DDE, or equivalent functionality that may have a different title. Although DDE operates online, DDE does not typically operate on a detailed inquiry and response basis. For claim status purposes, data is maintained within an interactive database that providers may access to view screens containing a wide variety of information on their claims. A provider accesses that data by furnishing certain identifying data for security purposes to establish their right to read the data and to specify those claim records the provider wishes to review.

The information in this database for specific claims or providers is initiated when a provider enters claim data, and is then updated by a contractor to include subsequent actions taken that affect that claim. DDE was specifically permitted to continue in the HIPAA initial transactions final rule (§162.923), with the stipulation that direct data entry is subject to "…the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard."

Data content conformity means that the same information permitted or required by the 277 version 4010 implementation guide must be reported in the claims status screens (the DDE outbound). The DDE outbound may not report a data element for claim status purposes that is not included in the 277, exceeds the maximum length of the data element in the 277, does not meet the minimum length for the data element in the 277, or that does not meet the 277 requirement that the data element be numeric, alpha-numeric, an amount, or meet another characteristic as specified in the 277. On the inbound, your DDE system can require less information than the 276, but not more. The inquirer is not required to furnish information in the DDE inquiry that is available by other means to the contractor. Any data keyed in a DDE system must conform to the requirements. X12 standard implementation guides include data element length and characteristics in their definition of data attributes.

Conformity does not mean that a DDE screen that includes claim status information must display each of the data qualifiers or other means of data identification contained in the 277 version 4010 implementation guide. DDE screens typically identify, explicitly or by context, the type of information being reported in a field, e.g., would identify if a number represents a HCPCS, health insurance claim number, amount, grams, date of birth, etc. DDE screens would not be expected to use a qualifier contained in the 277 to identify data type if that is otherwise evident in the design or content of the DDE screen.

Standard system maintainers must map the DDE claim status data elements to the 276/277 version 4010 implementation guide to determine if the DDE claim status data elements meet the conformity requirements above. If needed, changes must be made to enable your DDE claim status data elements to conform.

If you continue to support DDE, it must be offered in addition to batch 276/277, but you must take one of two approaches to assure your claim status data content conforms to the requirements:

1. Eliminate claim status data elements from your DDE screens, unless those data elements are also needed for a purpose other than claim status. For example, if a data element is needed in a DDE screen for claim entry or claim correction, and it is also used to help determine claim status, retain the data element so it can continue to be used for claim entry or correction. If a data element is used solely for claim status, and is not essential for an alternate purpose, eliminate it; or

2. If you elect to continue to display claim status-specific data elements in your DDE screens, those data elements must at a minimum contain/report data that conforms to:

a) All required and applicable conditional data elements for those segments in the 277; and

b) Data content as specified for those data elements in the 277, as applicable, including compliance with the data attributes for those data elements as defined in the 277 version 4010 implementation guide.

Preliminary feedback from contractors suggests that existing DDE screens used for Medicare may already conform to the 277 version 4010 implementation guide requirements, but data element mapping is required to verify. For example, since industry input was used to develop the 277 version 4010 implementation guide as well as, presumably the data elements for claim status currently furnished via DDE, it is unlikely that DDE screen field sizes would be larger than the 277 maximum length or shorter than the 277 minimum length. It is also unlikely that a DDE screen would contain a data element considered important for claim status that is not included in the 277, or vice versa.

If a standard system maintainer determines that DDE screen changes are required, the maintainer in conjunction with its users must determine if it would be cost effective to modify the DDE screens to conform to the 277 version 4010 implementation guide. If not cost effective, the maintainer must eliminate the claim status-only data elements from the DDE screens and require the contractors to use the batch 276/277, an ARU, and/or other non-EDI means to obtain claim status information.

If retention is cost effective, the maintainer must modify these screens as necessary to assure that providers are able to access all applicable data content available in the 277. The DDE screens must be able to furnish providers information that conforms to the data that would have been issued to the provider in a 277. See above for the discussion of conformity.

C. Interactive/Online (non-DDE) - You are not required to accept a 276 query or respond with a 277 in an interactive, online mode, and will not be funded by Medicare to begin supporting the 276/277 in an interactive, online mode if you do not already do so. If you do support the 276/277 in an interactive online mode, it must be offered in addition to batch 276/277. If you currently support the interactive/online (non-DDE) functionality, using the 276/277 version 3070 or any other direct claim status query and response EDI (non-DDE) format, you have the option to either:

1. Terminate that support effective October 2002; or

2. If you elect to continue that service beyond the end of September 2002, you must accept 276 version 4010 inquiries and respond in the 277 version 4010 format in an interactive online mode. You may not continue to operate any other format or version for interactive, online (non-DDE) requests/responses for claim status information. Response time for issuance of data in the 277 version 4010 format in response to receipt of a valid 276 must be as fast or faster as your interactive, online response time for claim status information prior to your implementation of version 4010.

III. Summary of the 276/277 Process for Carriers, DMERCs, and Intermediaries

A. The contractor's translator must perform interchange control and syntax edits on the submitted 276 version 4010 data at the X12 standard level, generate a TA1 (or equivalent local reject report) in batch (or interactive mode if supported) if an interchange control error was detected, and generate a 997 in batch (or interactive mode if supported) if a syntax error is detected. In the absence of any interchange control or syntax error, a 997 is issued in the batch mode only, to confirm receipt of a 276 received via batch. Due to the quick response time for interactive, online transactions, a 997 is not issued to confirm receipt of a valid transaction; the 277 response itself signifies receipt of a valid 276. See §V for additional translation requirements. Translation does not apply to DDE screens.

A TA1 (or local reject report) and 997 issued for a 276 submitted in a batch must be issued within 1 business day of receipt of the 276. A TA1 (or local reject report) or 997 for a 276 submitted in an interactive, online mode must be issued as quickly as the 277 would have been issued had the 276 been valid. If a contractor supported interactive, online access to claim status information for providers prior to implementation of version 4010 of the 276/277, the version 4010 277 TA1 (or local reject report) and 997 response time must be as fast or faster than the pre-version 4010 response time for this information. Each contractor must include their anticipated response times for the modes of 276/277 supported in their trading partner agreement. The error report should be made available as quickly as the 277 response would have been (had it been error free) whether the response is the TA1, 997 or the standard system generated error report.

The contractor's translator maps the inbound 276 data that have passed the interchange control and syntax edits to the 276 flat file, and forwards the data in the flat file format to the standard system within 1 business day of receipt of a valid 276.

B. The standard system must include edits to verify that the submitted 276 data complies with IG and Medicare requirements. If edits are failed, the standard system must generate an edit report following the model established for IG and Medicare program edit reporting for the X12 837 version 4010 implementation. The edit report must include any reason(s) for the rejection in a concise but explicit manner that can be understood by provider staff as well as contractor staff. Contractors will forward the edit messages to submitters for correction of the edit condition. The standard system must generate these edit reports within 1 business day.

The IG edits must be performed as defined in the IG segment and data element notes, data element attributes, conditions of use, and overall guiding principals for use of the standards as contained in the introduction section and addenda to the IG. The Medicare program edits must be performed as required by current Medicare program instructions.

C. The standard system either:

1. Stores any 276 data elements required for preparation of a compliant 277 response that are either not retained in the Medicare core system, or exceed the size limits for that type of data in the Medicare core system in a temporary file; or

2. Uses an alternate method if less costly for that individual standard system but still compliant with the 277 IG requirements to complete a compliant 277 in response to that 276. You should attempt to implement these requirements without changing the core system or using a repository to store additional information. However, if your analysis shows it would be more efficient to do either one, you may do so.

D. The standard system searches the claims processing database for the information requested in the 276 and creates a flat file response that is returned to the contractor. (The standard systems maintainers in consultation with their users must develop minimum match criteria for the 276.)

E. The contractor translates the flat file data into the 277 version 4010 format and forwards the 277 to the provider.

IV. Flat Files

To assist with programming and mapping activity, we have developed flat files that maintainers and contractors may use. We are making the files available in two formats - a single file containing both 276 and 277 data elements and separate files for each. Maintainers and their users should select which format they will use. The flat files provide for a one to one correlation between the core system data elements and the 276/277 data elements, and functions as a cross check to assure that necessary 276 data is submitted to the standard system and required 277 data can be extracted from the standard system.

Contractors must be able to accept a 276 transaction that complies with the version 4010 IG at the front-end and translate that data into the established flat file format for use by the standard system. Contractors must also be able to accept a flat file formatted feed from their standard system and create a compliant outbound 277.

You may access the 276/277 flat files at the following web site: www.hcfa.gov/medicare/edi/hipaadoc.htm.

The flat file format is a self-extracting compressed Excel spreadsheet.

V. Translation Requirements

The translation software you previously obtained for implementation of version 4010 of the X12 837 and 835 transactions must also be capable of translation of 276 and 277 data. Your translator is required to validate that the 276 and 277 meet the X12 interchange control and syntax requirements contained in the 276/277 version 4010. Implementation guide and Medicare program edits are standard system, rather than translator, responsibility.

You must accept the basic character set on an inbound X12N 276, plus lower case and the @ sign which are part of the extended character set. Refer to appendix A, page A2 of the implementation guide for a description of the basic character set. Your translator may reject an interchange that contains any other characters submitted from the extended character set.

Your translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) in order that the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure which could cause software failure when mapping to the X12N-based flat file. You are not required to accept multiple functional groups (GS/GE) within one interchange.

Your overall translation process must also:

- Convert lower case to upper case;
- Pass all spaces (default values) to the 276 flat file for fields that are not present on the inbound X12N 276. Do not generate a record on the 276 flat file if the corresponding segment is not present on the inbound X12N 276;
- Map “Not Used” data elements based upon that segment’s definition, i.e., if a data element is never used, do not map it. However, if a data element is “required” or “situational” in some segments but not used in others, then it must be mapped;
- Remove the hyphen from all range of dates with a qualifier of “RD8” when mapping to the X12N-based flat file; and
- Accept multiple interchange envelopes within a single transmission.

All decimal data elements are defined as “R”. Your translator must write these data elements to the X12-based flat file at their maximum field size, which will be initialized to spaces. Use the COBOL picture found under the IG data element name of the flat file to limit the size of the amounts. These positions are right justified and zero-filled. Your translator is to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. T he last position of maximum defined field length of the 276 flat file data element will be used as a placeholder to report an error code if an “R” defined data element exceeds the limitation that the Medicare core system is able to process.

The error code values are:

"X" = value exceeds maximum amount based on the COBOL picture,

"Y" = value exceeds maximum decimal places based on the COBOL picture, and

" b" blank will represent no error.

For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. Your translator must map this amount to the X12-based flat file using the COBOL picture of S9(7)V99. The flat file amount will be 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0". The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	Negative Values
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

VI. Transmission Mode

The 276/277 version 4010 transaction is a variable-length record designed for wire transmission. CMS requires that you accept the inbound and transmit the outbound over a wire connection.

VII. Restricting and Controlling Access to Claims Status Information

Provide claims status information to providers, suppliers and their agents when an EDI Enrollment Form is on file (see MIM Part 3, §3601.4 for intermediaries and MCM Part 3, §3021.4 for carriers) for that entity, and to network service vendors if there is an EDI Enrollment Form and EDI Network Service Agreement on file (see MIM Part 3 §3601.8 for intermediaries and MCM Part 3, §3021.8 for carriers).

VIII. Testing and Implementation

By the time the standard systems release is installed, contractors should have completed local system front end and back end programming and internal testing to enable successful interface with their standard system for accurate use of the 276 and to generate compliant version 4010 277 transactions.

Contractors should be able to conduct system compatibility testing on version 4010 of the 276/277 with any Medicare provider or clearinghouse that applies for testing, and to accept 276 version 4010 transactions and to issue 277 version 4010 transactions in production mode. Contractors may not discourage any provider, billing agent or clearinghouse from requesting 276/277 version 4010 testing. If a provider, billing agent, clearinghouse, or a contractor has any doubt about a provider's or clearinghouse's ability to submit a valid 276 or to process a valid 277, the contractor should encourage that entity to test use of version 4010 of the 276/277 prior to full use in production.

Standard systems must support contractor testing of providers and clearinghouses on 276/277 version 4010. Providers and clearinghouses may elect to test prior to use in production, but are not required to do so unless the contractor determines that testing is advisable. Contractors must have a means of identifying submitters operating in test mode. Actual claims production data may be used for testing, as long as the access restrictions described in §VII are observed. Upon successful completion of testing, the contractor must be able to change the submitter to full production status.

IX. Provider and Clearinghouse Outreach

By November 1, 2001, contractors should notify their providers, third party provider billing services, provider clearinghouses, and vendors that:

- EDI requests for claim status must be submitted via a 276 version 4010 query effective October 2002, and that each valid 276 will be issued a 277 version 4010 response. Prior claim status formats will be discontinued effective October 2002, although the information will still be available via DDE, ARU, or other non-EDI method a contractor has elected to continue to support;

- A provider that prefers to obtain claim status data in an EDI format but who does not choose to support the 276/277 may contract with a clearinghouse to translate the information on their behalf; however, that provider would be liable for those clearinghouse costs;

- The version 4010 276/277implementation guide can be downloaded without charge from www.wpc-edi.com/HIPAA.

- Providers, agents, and clearinghouses are not required, in most cases, to be tested on their 276/277 interface prior to initial submission of a 276 or request for receipt of a 277, although they are required to notify their Medicare contractors when they plan to begin submitting 276 version 4010 queries. Those who prefer advance testing, to assure system compatibility of version 4010 of the 276/277, must schedule testing with their contractor as soon as possible to obtain a testing appointment prior to October 2002. Appointment slots will be assigned on a first come basis. Contractors will not be able to guarantee completion of testing by the end of September 2002 for any entities that delay requesting a testing appointment until late in the transition period;

- There is no Medicare charge for this system testing; and

- Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for use of a HIPAA standard, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

X. Cost Issues

Since Medicare had not previously required use of any version of the 276/277, contractors are entitled to reasonable costs for implementation, testing, and transition to the 276/277 version 4010. In FY 2002, contractors should submit supplemental budget requests for these costs.

HIPAA established requirements binding on all health care payers, not only on Medicare. HIPAA did not provide for Federal funding of implementation of the administrative simplification provisions by health care payers. As with other system and program changes that impact a Medicare contractor's parent company's private/commercial lines of business, as well as their Medicare processing activities, direct and indirect costs related to such changes must be proportionately shared by the impacted lines of business, and not charged to Medicare in total. Programming, transition, and operational costs related to a corporate clearinghouse operated by a Medicare contractor's parent company, or any other profit or non-profit line of business of the parent company not required to

support Medicare processing under the terms of their Medicare contract, may not be charged in total or in part to the Medicare program.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

See §XI, Cost Issues, for implementation cost information.
For DMERCs only: CMS is preparing a contract modification to cover these requirements. Do not begin work on this PM until the modification is executed.

This PM may be discarded after December 31, 2002.

Medicare contractor questions concerning this PM may be directed to Lafaithia Womack, (410) 786-0954 or e-mail LWOMACK@CMS.HHS.GOV (or alternately to James Krall, (410) 786-6999, or e-mail JKRALL@CMS.HHS.GOV).

Any provider, clearinghouse or other vendor questions related to this PM should be directed to their servicing carrier(s), DMERC(s), and/or intermediary (s).