CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 583 | **Date: JUNE 15, 2005**

CHANGE REQUEST 3883

NOTE: ***Transmittal 565, dated May 20, 2005 is rescinded and replaced with Transmittal 583, dated June 15, 2005. The following data was changed in the manual: MCARE email address, McKesson's website URL and removed service type codes 48, 49, 54, 70, AA, AH. All other information remains the same.***

SUBJECT: Access Process for HIPAA 270/271 (Extranet Only)

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized HIPAA compliant 270/271 health care eligibility inquiry and response in real-time.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 20, 2005
IMPLEMENTATION DATE: August 22, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	**Chapter / Section / SubSection / Title**
	Table of Contents
R	31/10/X12N Health Care Eligibility Benefit Inquiry and Response 270/271 Implementation
R	31/10.1/Background
R	31/10.2/Eligibility Workflow
R	31/20.7/Health Care Claim Status Category Codes and Health Care Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277
D	31/10/10.3/Eligibility Query Types
D	31/10/10.4/Intermediary and Carrier Responsibilities

D	31/10/10.5/Data Center Responsibilities
D	31/10/10.6/Provider/Network Service Vendor's Responsibilities
D	31/10/10.7/Supplemental CWF Module Information
D	31/10/10.8/Eligibility Queries Options and Work Flows
D	31/1/Purpose of chapter
D	31/30/Furnishing Claims Information to Complementary Insurers
D	31/40/ANSI X12N 278 - Electronic Referral Certification and Authorization
D	31/50/Related Internet Files Routinely Updated by CMS

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 583	Date: June 15, 2005	Change Request 3883

NOTE: ***Transmittal 565, dated May 20, 2005 is rescinded and replaced with Transmittal 583, dated June 15, 2005. The following data was changed in the manual: MCARE email address, McKesson's website URL and removed service type codes 48, 49, 54, 70, AA, AH. All other information remains the same.***

SUBJECT: Access Process For HIPAA 270/271 (Extranet Only)

I. GENERAL INFORMATION

A. Background:
The Centers for Medicare and Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

B. Policy:
This CR will support the Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	N/A	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3883.1	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **May 20, 2005** **Implementation Date: August 22, 2005** **Pre-Implementation Contact(s):** Shari Kosko Shari.Kosko@cms.hhs.gov 410-786-6159 **Post-Implementation Contact(s):** Robert Huffman	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

Robert.Huffman@cms.hhs.gov 410-786-6176	

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 31 - ANSI X12N Formats Other than Claims or Remittance

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(Rev.583, 06-16-05)

Crosswalk to Old Manuals

10 - X12N Health Care Eligibility Benefit Inquiry and Response 270/271 Implementation

10.2 - Eligibility ***Extranet*** Workflow

10.1 – Background

(Rev. 583, Issued: 06-15-05, Effective: 05-20-05, Implementation: 08-22-05)

This section provides *information on Medicare's* implementation of *the* ANSI *ASC* X12N 270/271, version 4010A1 *implementation guide which was adopted as the national standard for the health care eligibility benefit inquiry and response* under the Health Insurance Portability and Accountability Act (HIPAA). C*urrent carriers, intermediaries and their data centers will not be responding to or processing 270 transactions for Medicare beneficiaries.*

10.2 - Eligibility *Extranet* Workflow

(Rev. 583, Issued: 06-15-05, Effective: 05-20-05, Implementation: 08-22-05)

The Centers for Medicare and Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized HIPAA compliant 270/271 health care eligibility inquiry and response in real-time.

The CMS is using a phased approach for providing this eligibility transaction on a real-time basis:

1. *Extranet: In June of 2005, Clearinghouses, certain providers and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.*

2. *Internet: We expect to provide limited internet access to the 270/271 transaction later this year. Instructions on accessing eligibility data via this method will be provided prior to the time internet access becomes available.*

All electronic 270 files will be processed at the CMS data center. The CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the extranet, Clearinghouses and Providers must complete the 270/271 Access Form that can be found on the CMS website at WWW.CMS.HHS.GOV/IT. The 270/271 Access Form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare Eligibility Integration Contractor (MEIC).

CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the Clearinghouses, providers, and trading partners to authenticate the accessing entity's identity. Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time. Please note that in order to access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller.

The current AT&T resellers and contact numbers are listed below:
IVANS: www.ivans.com
1-800-548-2675

McKesson: www.mckesson.com
1-800-782-7426, option 5, then key option 8

Future Requirement

CMS is developing an Attestation that all Clearinghouses and Providers will be required to agree to provisions concerning adherence of the HIPAA Privacy and Security Rule. This Attestation will be available for review through the Paperwork Reduction Act Process and will be available for public comment in the near future. If you have any questions, please contact Kim Suhr at (410)786-1023 or Kim.Suhr@cms.hhs.gov.

Helpdesk Support

The MEIC will provide help desk support during the hours of 7:00am - 9:00pm eastern time Monday through Friday. The phone number is: 1-866-324-7315. The email address for the helpdesk is: MCAREHD@Webmd.net.

Telecommunications Wrapper

Communications through the extranet to the CMS data center will be via the TCP/IP streaming socket protocol. Trading Partners can submit multiple 270 transactions; it will not be necessary to wait for a response before triggering the next 270. Trading partners must ensure that the session remains connected until all responses are received. Each submitted transmission shall contain one 270 transaction with only one ISA and IEA segment, along with a transmission wrapper around the 270 transaction. There will be no handshake after the connection is accepted with the first submitted transmission.

Outbound response transactions will have the same format transmission wrapper. The response to the submitter will be returned in the same session in which the 270 was submitted.

Standard format of the TCP/IP Transaction Wrapper:

SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX

SOH = Required (1 position), must be EBCDIC or ASCII - 01
LLLLLLLLLL = Required (10 positions), Right justified with zero padded
Note: Length of the HIPAA 270 transaction not including Transmission wrapper data.
STX = Required (1 position), must be EBCDIC or ASCII - 02
<HIPAA 270 Transaction> = Required (HIPAA 270 - ISA - IEA),
ETX = Required (1 position), Must be EBCDIC or ASCII -03

***NOTE**: For more detail about SOH, STX and ETX, see the Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12 Extended Control Set.*

270 Inquiry Requirements

The ISA08 (interchange receiver id) and the GS03 (application receiver's code) on the 270 transactions must contain "CMS", left justified space filled.

CMS will return certain data elements on the 271 response only when certain service type codes are sent on the 270. Other core data elements will be included in each 271 response, regardless of service type codes, when applicable. Both the core and the additional data elements are listed below.

CMS will utilize the search option as listed in the 270/271 implementation guide (section 1.3.8) requiring the patient's member id (HIC number), patient's full first name, patient's full last name, and patient's date of birth.

Proprietary Error Messages

Proprietary error messages will be sent only when the ISA segment of the 270 transaction cannot be read making it impossible to formulate an ISA segment for the response. The format of the proprietary message is described below:

Description	Content	Size	Comments
Transaction	Transaction ID	04 characters	"HETS"
Transaction Reference Number	Reference #	30 characters	Reference Number for tracking
Date Stamp	System Date	08 Characters	CCYYMMDD
Time Stamp	System time	09 Characters	HHMMSSSSS
Response Code	Error Code	02 Characters	See Below
	ISA Response code	" I"	Incoming ISA cannot

			be read
	Delimiter Response code	" D"	Delimiter could not be identified
Message Code	Error Code	08 Characters	Error code
Message Text Description	Error Descriptions	70 Characters	Description of error

271 Response Data Elements

If no service type codes are contained on the 270 transaction, or if a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

271 INFORMATION RETURNED	LOOP	SEGMENT	ELEMENT	DATA VALUE
Part A/B Entitlement/Term Dates	2110C	EB	EB01 EB02 EB04	1 IND MB or MA
	2110C	DTP	DTP01 DTP02 DTP03	307 RD8 or D8 Date(s)
Beneficiary Address	2100C	N3 N4	N301 N302 N401 N402 N403	Address Address City State Code Zip Code
Deductible - Part B	2110C	EB	EB01 EB03 EB04 EB06 EB07	C 96 MB 29 Amount
	2110C	DTP	DTP01 DTP02 DTP03	292 RD8 Applicable Calendar Year

MCO Data	*2110C*	*EB*	*EB01* *EB03* *EB04*	*R* *30* *HN*
	2110C	*REF*	*REF01* *REF02*	*18* *MCO ID*
	2110C	*DTP*	*DTP01* *DTP02* *DTP03*	*290* *RD8 or D8* *Date(s)*
	2120C	*NM1*	*NM101* *NM102* *NM103*	*PRP* *2* *Insurer Name*
	2120C	*N3*	*N301* *N302*	*Address* *Address*
	2120C	*N4*	*N401* *N402* *N403*	*City* *State Code* *ZIP Code*
MSP Data	*2110C*	*EB*	*EB01* *EB02* *EB03* *EB04*	*R* *Ind* *30* *12, 13, 14, 15, 16, 41, 42, 43, 47*
	2110C	*REF*	*REF01* *REF02*	*IG* *Policy Number*
	2110C	*DTP*	*DTP01* *DTP02* *DTP03*	*290* *RD8 or D8* *Date(s)*
	2120C	*NM1*	*NM01* *NM102* *NM103*	*PRP* *2* *Name*
	2120C	*N3*	*N301* *N302*	*Address* *Address*
	2120C	*N4*	*N401* *N402* *N403*	*City* *State Code* *Zip Code*
Home Health Data	*2110C*	*EB*	*EB01* *EB03* *EB04* *EB06*	*X* *42* *MA* *26*
	2110C	*DTP*	*DTP01* *DTP02* *DTP03*	*193 or 194* *D8* *Date(s)*
	2110C	*MSG*	*MSG01*	*HHEH Start Date* *HHEH End Date* *HHEH DOEBA* *HHEH DOLBA*

If one or more of the following service type codes are submitted in a 270, the following additional data elements will be returned in the 271, as applicable.

Service Type Code	LOOP	SEGMENT	ELEMENT	DATA VALUE
14	2110C	EB	EB01 EB03 EB04	D 14 MB
	2110C	DTP	DTP01 DTP02 DTP03	356 D8 Date
	2110C	DTP	DTP01 DTP02 DTP03	198 D8 Date
	2120C	MSG	MSG01	Transplant Discharge Date
15	2110C	EB	EB01 EB03 EB04	D 15 MA
	2110C	DTP	DTP01 DTP02 DTP03	356 D8 Date
	2110C	DTP	DTP01 DTP02 DTP03	198 D8 Date
	2120C	MSG	MSG01	Transplant Discharge Date
42	2110C	EB	EB01 EB03 EB04	X 42 MA
	2120C	NM1	NM101 NM102 NM103 NM108 NM109	PR 2 Name of RHHI PI 00011, 00180, 00380, 00450, 00454
	2120C	PRV	PRV01 PRV02 PRV03	HH 9K Provider number
47	2110C	EB Part A Deductible	EB01 EB03 EB04 EB06 EB07	C 47 MA 29 Amount

		DTP Hospital Admission	DTP01 DTP02 DTP03	435 RD8 Dates
	2110C	EB Hospital Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F 47 MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB07 EB09 EB10 DTP01 DTP02 DTP03	A 47 MA 29 Amount Per Day DY Days 435 RD8 Dates
	2110C	EB Lifetime Reserve Days	EB01 EB03 EB04 EB06 EB09 EB10	K 47 MA 33 LA Days
AG	2110C	EB Hospital Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F 47 MA 29 DY Days 435 RD8 Dates
	2110C	EB	EB01	A

		Co-Insurance Days Remaining *DTP* *Hospital Admission*	*EB03* *EB04* *EB06* *EB07* *EB09* *EB10* *DTP01* *DTP02* *DTP03*	*47* *MA* *29* *Amount Per Day* *DY* *Days* *435* *RD8* *Dates*
	2110C	*EB* *Lifetime Reserve Days*	*EB01* *EB03* *EB04* *EB06* *EB09* *EB10*	*K* *47* *MA* *33* *LA* *Days*
	2110C	*EB* *SNF Days Remaining* *DTP* *SNF Admission*	*EB01* *EB03* *EB04* *EB06* *EB09* *EB10* *DTP01* *DTP02* *DTP03*	*F* *AG* *MA* *29* *DY* *Days* *435* *RD8* *Dates*
	2110C	*EB* *Co-Insurance SNF Days Remaining* *DTP* *SNF Admission*	*EB01* *EB03* *EB04* *EB06* *EB07* *EB09* *EB10* *DTP01* *DTP02* *DTP03*	*A* *AG* *MA* *29* *Amount Per Day* *DY* *Days remaining* *435* *RD8* *Dates*

20 - ANSI X12N 276/277 Claims Status Request/Response Transaction Standard

(Rev. 1, 10-01-03)

AB - 01-106

These instructions apply to intermediaries, carriers, durable medical equipment regional carriers (DMERCs), and their shared systems on Medicare requirements for their implementation of the current HIPAA compliant version 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, 2003.

The current HIPAA compliant version of the implementation guide for the 276/277 standard may be found at the following website: http://www.wpc-edi.com/hipaa/HIPAA_40.asp. The 276/277 is a "paired" transaction (the 276 is an in-bound claim status request and the 277 is on outbound claims status response).

20.1 - Transmission Requirements

(Rev. 1, 10-01-03)

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.

20.1.1 - Batch Transactions

(Rev. 1, 10-01-03)

Contractors must be able to accept the current ANSI X12N 276 Health Care Claim Status Request Response version 4010 in batch mode, and respond via the ANSI X12N 277 Health Care Claim Status Response version 4010 in batch mode. If a contractor currently supports batch capability in any EDI batch format for providers to request claim status, the response time for issuance of a 277 transaction in response to receipt of a valid 276 must be as fast as or faster than the current batch claim status response time. The 277 response is issued within one business day of receipt of a valid 276 inquiry.

20.1.2 - Online Direct Data Entry (DDE)

(Rev. 1, 10-01-03)

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 shared system maintainers, including 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 (45 CFR 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 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, the 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 element keyed in a DDE system must conform to the requirements. ANSI X12N 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 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.

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

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

1. Eliminate claim status data elements from the 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 a contractor elects to continue to display claim status-specific data elements in their DDE screens, those data elements must at a minimum contain/report data that conforms to:

   - All required and applicable conditional data elements for those segments in the 277; and
   - 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 implementation guide.

Preliminary feedback from contractors suggests that existing DDE screens used for Medicare may already conform to the 277 implementation guide requirements, but data element mapping is required to verify. For example, since industry input was used to develop the 277 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 shared 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 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.

20.1.3 - Interactive/Online (Non-DDE)

(Rev. 1, 10-01-03)

Contractors are not required to accept a 276 query or respond with a 277 in an interactive, online mode if they do not already do so. If contractors do support the 276/277 in an interactive online mode, it must be offered in addition to batch 276/277. If they 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, they have the option to either:

- Terminate that support effective October 2003; or
- If they elect to continue that service beyond the end of September 2003, they must accept version 276inquiries and respond in the 277 format in an interactive online mode. Contractors 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 format in response to receipt of a valid 276 must be as fast or faster as the interactive, online response time for claim status information prior to the contractor's implementation of version 4010.

20.2 - Summary of the 276/277 Process for Carriers, DMERCs and Intermediaries

(Rev. 1, 10-01-03)

A. The contractor's translator must perform interchange control and syntax edits on the submitted 276 data at the ANSI X12N 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 §20.4 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 the HIPAA compliant version of the 276/277, the HIPAA compliant version of the 277 TA1 (or local reject report) and 997 response time must be as fast or faster than the pre-version response time for this information. Each contractor must include its 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 shared 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 shared system within 1 business day of receipt of a valid 276.

B. The shared system must include edits to verify that the submitted 276 data complies with IG and Medicare requirements. If edits are failed, the shared system must generate an edit report following the model established for IG and Medicare program edit reporting for the HIPAA compliant version of the ANSI X12N 837 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 shared 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 shared system either:

- 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
- Uses an alternate method if less costly for that individual shared system but still compliant with the 277 IG requirements to complete a compliant 277 in response to that 276.

These requirements are implementing without changing the core system or using a repository to store additional information. However, if the carrier analysis shows it would be more efficient to do either one, the carrier may do so.

D. The shared 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 shared 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 HIPAA compliant version of the 277 format and forwards the 277 to the provider.

20.3 - Flat Files

(Rev. 1, 10-01-03)

The CMS developed flat files that maintainers and contractors may use. The files are 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 shared system and required 277 data can be extracted from the shared system.

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

Access the 276/277 flat files at the following website: http://cms.hhs.gov/providers/edi/hipaadoc.asp. The flat file format is a self-extracting compressed Excel spreadsheet.

20.4 - Translation Requirements

(Rev. 1, 10-01-03)

The translation software contractors previously obtained for implementation of HIPAA compliant version of the ANSI X12N 837 and 835 transactions must also be capable of translation of 276 and 277 data. A contractor translator is required to validate that the 276 and 277 meet the ANSI X12N interchange control and syntax requirements contained in the HIPAA compliant version of the 276/277. Implementation guide and Medicare program edits are shared system, rather than translator, responsibility.

Contractors must accept the basic character set on an inbound ANSI 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. The carrier translator may reject an interchange that contains any other characters submitted from the extended character set.

Contractor 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 that could cause software failure when mapping to the ANSI X12N-based flat file. Contractors are not required to accept multiple functional groups (GS/GE) within one interchange.

A contractor's 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 ANSI X12N 276. Do not generate a record on the 276 flat file if the corresponding segment is not present on the inbound ANSI 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 ANSI X12N-based flat file; and
- Accept multiple interchange envelopes within a single transmission.

All decimal data elements are defined as "R." A contractor's 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. The 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. The 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. The 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

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 = }

20.5 - Transmission Mode

(Rev. 1, 10-01-03)

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

20.6 - Restriction and Controlling Access to Claims Status Information

(Rev. 1, 10-01-03)

Provide claims status information to providers, suppliers and their agents when an EDI Enrollment Form is on file for that entity, and to network service vendors if there is an EDI Enrollment Form and EDI Network Service Agreement on file. (See Medicare Claims Processing Manual, Chapter 24, EDI Support Requirements for instructions on the enrollment form and the EDI Network Service Agreement.)

20.7 – Health Care Claim Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

(Rev. 583, Issued: 06-15-05, Effective: 05-20-05, Implementation: 08-22-05)

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee as applicable. At each X12 trimester meeting (generally held the months of February, June and October), the Committee may update the claim status category codes and the claim status codes. When instructed, Medicare contractors must update their claims systems to assure that the current version of these codes is used in their claim status responses. The codes sets are available at http://www.wpc-edi.com/codes/Codes.asp. Included in the code lists are specific details, including the date when a code was added, changed or deleted.

CMS will issue *recurring, one-time change requests* regarding the need for *and deadline for* future updates to these codes. Contractor and shared system changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes that may impact Medicare. Shortly after the release of each code update, a provider education article will be available at http://www.cms.hhs.gov/medlearn/matters for contractors to use to conduct provider outreach.