Michigan Department of Health and Human Services

HIPAA 5010 EDI Companion Guide for

ANSI ASC X12N 276/ 277

Health Care Claim Status Request and Response

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MDHHS
Michigan Department of Health & Human Services

MSA
MEDICAL SERVICES ADMINISTRATION

This document is the property of the Michigan Department of Health and Human Services (MDHHS). The information contained in this document is for the use of Trading Partners engaging in electronic data interchange (EDI) health care transactions with the State of Michigan's Community Health Automated Medicaid Processing System (CHAMPS). The content of this document may not be altered by external entities. The information in this document is subject to change. The most recent version will be posted on Michigan Department of Health and Human Services website at: www.michigan.gov/tradingpartners

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1. Introduction

This document is intended as a companion to the 005010X212 • 276/277 Health Care Claim Status Request and Response Technical Report 3 (TR3) dated April 2008. This document also includes updates appearing in:

- Errata 005010X212E1 • 276/277 Health Care Claim Status Request and Response dated April 2008
- Errata 005010X212E2 • 276/277 Health Care Claim Status Request and Response dated January 2009

The 5010 TR3 and related Errata documents are available from the Washington Publishing Company at www.wpc-edi.com.

1.1 Scope

This document is expected to be used in conjunction with the TR3 and related Errata for the 276/277 transaction sets. The content of this document follows the guidelines authorized in the version modifications to the Health Insurance Portability and Accountability Act (HIPAA) Final Rule transaction standards published in the Federal Register January 16, 2009. Health plans, covered entities and their business associates that engage in the exchange of eligibility transactions are required by the Affordable Care Act (ACA) to comply with additional operating rule regulations for the 276/277 transactions. These operating rules are maintained by CAQH CORE.

This Companion Guide provides MDHHS-specific instructions regarding certain elements within the TR3 but does not change, supersede, or add to the definitions, data conditions, or use of data elements or segments in the standard. This document provides MDHHS rules regarding:

- Identifiers to use when a national standard has not been adopted
- Parameters in the TR3 and related Errata that provide options

Section 9, Transaction Specific Information, contains provider data clarifications for fields and values. Transaction specific data will be detailed using a table with the following information included:

- Loop
- Segment
- Data Element
- Loop/Segment/Element Name
- Companion Guide Rules

1.2 Overview

The primary purpose of the document is to assist trading partners with the submission and retrieval of valid 276/277 Health Care Claim Status Request and Response transactions and is intended to support use in batch and real-time mode.

This document provides information on the following topics:

- Real-time and batch use
- Search options
- Companion Guide Rules for the 276 and 277 transactions

Technical details for the following topics can be found in the MDHHS Electronic Submissions Manual (ESM). Please see Section 1.3 References for the ESM location.

- Testing with the Payer
- File Transfer Service usage for batch
- Electronic Batch Upload
- Using the ACA CORE Communication Protocols with MDHHS, for real-time and batch, including header requirements, error reporting, and transmission procedures
- Acknowledgements and Reports (999 and TA1)

1.3 References

This section specifies additional on-line sources of helpful information related to electronic data interchange and X12 transactions.

- Technical Reports

  Washington Publishing Company (WPC) at www.wpc-edi.com

- MDHHS Electronic Submissions Manual

  To successfully download HIPAA transactions from the CHAMPS system, it is necessary to comply with the information contained in the MDHHS Electronic Submissions Manual. The most current version of this manual can be downloaded from the MDHHS web site at the following location:

  www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual

- MDHHS Medicaid Policy Manual or Medicaid Provider Manual

  www.michigan.gov/medicaidproviders >> Policy and Forms (green section) >> Medicaid Provider Manual

1.4 Transaction Description

The 276 is used to specifically inquire about the status of one or more claims submitted to a payer for adjudication. The 277 is the payer's response to the 276 request. When the submitter's request is processed successfully without errors, the 277 returns a status on all claims that meet the criteria supplied in the corresponding 276.

1.5 General Information

This document is for Medicaid enrolled providers and/or their contracted billing agents and clearinghouse vendors. Please note that the information contained within this document is based on existing MDHHS Benefit Plan (BP) information and is subject to change. See the Medicaid Provider Manual for more information on program policy and benefit information (Section 1.3 *References*).

2. Getting Started

2.1 Working with MDHHS

An entity (provider, billing agent, clearinghouse, etc.) who wishes to send electronic transactions to MDHHS, as well as retrieve responses, must enroll with MDHHS as a provider or billing agent. Please access the Provider Enrollment section on the web site below for information on provider and billing agent enrollment.

www.michigan.gov/tradingpartners >> Electronic Submissions Transactions >> How to Enroll

Note: Clearinghouse vendors will need to enroll as a Billing Agent in CHAMPS and be associated to their Providers to be able to submit and receive 276/277 transactions on their behalf.

2.2 Certification and Testing Overview

MDHHS has a two-stage testing process, which is described in Section 3, *Testing with the Payer.*

Completion of the testing process is required prior to electronic submission of production data to MDHHS. Once the testing requirements are met, MDHHS will advise the entity when they can submit transactions.

3. Testing with the Payer

The MDHHS Electronic Submissions Manual contains an overview of the testing process (see section 1.3 *References*). More information on testing is available at www.michigan.gov/tradingpartners >> Electronic Submissions Transactions.

In general, the steps to complete testing are as follows.

- Register as an electronic biller
- Obtain authentication credentials appropriate to the mode of electronic billing
- Create a 276 request based on the TR3 and this Companion Guide
- Submit 276 request through the test environment
- Retrieve acknowledgement(s)
- Retrieve response 277 and review content

4. Connectivity with the Payer / Communications

4.1 System Availability

The MDHHS CHAMPS system is available 24 hours 7 days a week apart from a regular monthly maintenance window, which starts at 6:00 p.m. on the second Saturday of each month and ends at 6:00 a.m. on Sunday. For information on unscheduled outages, please check the Biller “B” Aware page at the following link.

www.michigan.gov/mdhhs >> Doing Business with MDHHS >> click on Health Care Providers >> Providers >> Medicaid (upper-left green box) >> Medicaid Alerts >> Biller "B" Aware

4.2 Process Flows

MDHHS supports several options for batch and real-time inquire and response 276/277 transactions, including support for the ACA CORE required communication modes.

For ACA CORE, CHAMPS supports the following envelope standards for batch and real-time transport modes for the 276/277 transaction set.

- HTTP MIME Multipart (Envelope Standard A)
- SOAP+WSDL (normative) (Envelope Standard B)

MDHHS supports other batch options in addition to the ACA CORE transport mode standards. These include the File Transfer Service and Electronic Batch Upload.

4.3 Transmission Administrative Procedures

4.3.1 Structure Requirements

- A real-time 276 inquiry must contain only one status request. The 277 response may return multiple responses depending on the specificity of the request criteria.

- Batch supports the sending and receiving of multiple claim status requests and responses within the transaction.

4.3.2 Response Times

- A response to the real-time inquiry will be provided within 20 seconds during hours of availability.
- The v5010 277 claim status response to a v5010 276 claim status inquiry submitted by 9:00 pm Eastern time of a business day will be returned by 7:00 am Eastern time the following business day.

4.4 Communication Protocols

Please see the Electronic Submissions Manual for additional information on using communication protocols (see Section 1.3 *References*).

4.4.1 HTTP MIME Multipart

MDHHS supports standard HTTP MIME messages. The MIME format used must be that of multipart/form-data. Responses to transactions sent in this manner will also be returned as multipart/form-data.

4.4.2 SOAP+WSDL

MDHHS also supports transactions formatted according to the Simple Object Access Protocol (SOAP) conforming to standards set for the Web Services Description Language (WSDL) for XML envelope formatting, submission, and retrieval.

5. Contacts

EDI Services	The Michigan Medicaid EDI Department handles all electronic questions related to FFS & Encounter file exchange and FTS problems and questions related to the 276/277 Health Care Claim Status Request and Response transactions.
	Website:www.michigan.gov/tradingpartners
	Email: AutomatedBilling@michigan.gov
Provider Inquiry Unit	The Provider Inquiry Unit handles all billing questions related to paper claims and the 837 and questions regarding provider and billing agent enrollment.
	Website: www.michigan.gov/mdhhs >> Doing Business with MDHHS >> click on Health Care Providers >> Providers >> CHAMPS
	Provider Inquiry Line: 1-800-292-2550
	Email: ProviderSupport@michigan.gov
Encounter Team	The Encounter Team handles questions on encounter billing.
	Email: MDHHS-EncounterData@michigan.gov

6. Control Segments / Envelopes

6.1 ANSI ASC X12 276 - Interchange Control Header Companion Guide Rules

This document uses several text conventions to aid in the interpretation of the Companion Guide Rules. The following table lists the text conventions used in this document for 276 transactions ***submitted*** to MDHHS.

Convention used	Explanation
< >	Text included within < > describes the values MDHHS requires for submission.
“ ”	Text with “ ” around a value represents HIPAA TR3 values.
( )	The HIPAA TR3 description of the value in quotes, described above, is provided parenthetically.
Light yellow shading	Light yellow shading indicates items changed in this revision of the Companion Guide

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Authorization Information Present (No Meaningful Information in I02))
	ISA	ISA02	Authorization Information	10 spaces.
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04))
	ISA	ISA04	Security Information	10 spaces.
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				For FTP, SSL FTP, or HTTPS use the FTS ID. For electronic batch use the CHAMPS Provider ID or NPI. For SOAP+WSDL or MIME Multipart, use the CHAMPS Provider ID, NPI, or FTS ID. This value should always match GS02 <Application Sender's Code>
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	"D00111" left justified followed by spaces
			Functional Group Header	
	GS		**Segment - Functional Group Header**	
	GS	GS02	Application Sender's Code	Trading Partner ID For FTP, SSL FTP, or HTTPS use the FTS ID. For electronic batch use the CHAMPS Provider ID or NPI. For SOAP+WSDL or MIME Multipart, use the CHAMPS Provider ID, NPI, or FTS ID. This value should always match ISA06 <Interchange Sender ID>.
	GS	GS03	Application Receiver's Code	"D00111" for MDHHS

6.2 ANSI ASC X12 277 - Interchange Control Header Companion Guide Rules

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Convention used	Explanation
< >	Text included within < > describes the value sent by MDHHS.
“ ”	Text with “ ” around a value represents HIPAA TR3 values.
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Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Interchange Control Header	
	ISA		**Segment - Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I02)
	ISA	ISA02	Authorization Information	10 spaces
	ISA	ISA03	Security Information Qualifier	"00" (No Security Information Present (No Meaningful Information in I04)
	ISA	ISA04	Security Information	10 spaces
	ISA	ISA05	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA06	Interchange Sender ID	"D00111" left justified followed by spaces.
	ISA	ISA07	Interchange ID Qualifier	"ZZ" (Mutually Defined)
	ISA	ISA08	Interchange Receiver ID	Value received on 276 Request ISA06 < Interchange Sender ID > will be returned.
			Functional Group Header	
	GS		**Segment - Functional Group Header**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	GS	GS02	Application Sender's Code	"D00111"
	GS	GS03	Application Receiver's Code	Value received on 276 Request GS02 <Application Sender's Code> will be returned.

7. Payer Specific Business Rules and Limitations

7.1 Supported Service Types

MDHHS supports the Service Types required by the HIPAA 5010 276/277 TR3 and CAQH CORE.

7.2 Search Options and Responses

The 276 Claim Status Inquiry transaction is supported for the following types of claims (invoice type):

- Professional
- Institutional
- Dental

The following data elements are used by MDHHS as search criteria:

- Provider Billing NPI
- Subscriber (Beneficiary) ID
- Payer's Claim Number (CHAMPS 18-digit Transaction Control Number – TCN)
- Date of Service
- Patient Control Number (optional)

Things to remember when submitting a 276 transaction.

- The Transaction Control Number (TCN) is optional and, when not included in the request, the submitted date of service or date of service range will be used in combination with the Provider NPI and Subscriber ID to locate the claim(s).
- 276/277 transactions apply for fee-for-service claims submitted to the CHAMPS system. If a 276 Claim Status Request is submitted for an encounter, then a 277 Claim Status Response will be returned with a Health Care Claim Status Category Code D0 with Health Care Claim Status Code 35 (D0:35), which means "Claim-Encounter not found."

- 276 Health Care Claim Status Request transactions are processed daily. When the 276 Health Care Claim Status Request is submitted by 9:00 pm on a business day, the 277 Health Care Claim Status Response will be returned by 7:00 am the following business day.
- Header Date of Service (DOS) or Line DOS is required on the 276 Claim Status Request. If the DOS is not submitted, then "Claim not found" will be returned on the 277 Claim Status Response.
- When a 276 Claim Status Request is submitted and finds a match on more than one claim, then the 277 Claim Status Response will be returned for all the matched claims based on the claim search criteria described above. If only Header information is submitted on the 276 Claim Status Request, then the 277 Claim Status Response will be returned with both Header and Line information. If only Line information is submitted on the 276 Claim Status Request, the 277 Claim Status Response will be returned with both Header and all Line information.
- MDHHS will return either a positive or a negative 999 Acknowledgement when a 276 Claim Status Request transaction is accepted or when syntactical errors are encountered.
- Sender ID and Receiver ID submitted at the Interchange (ISA06 and ISA08) or Functional (GS02 and GS03) level must be present in CHAMPS and must be a valid FTS ID, CHAMPS Provider ID, or NPI. If not, the file will be rejected and a negative 999 Acknowledgement will be returned.

8. Trading Partner Agreements

An EDI Trading Partner is defined as any MDHHS customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits directly to, or receives electronic data directly from MDHHS.

If you are not already submitting electronic transactions to MDHHS, you will need to enroll with MDHHS. Please refer to Section 2.1 for information on enrolling with MDHHS as a provider or billing agent. Enrollment is required to send or retrieve electronic transactions.

Note: Electronic submitters will need to be associated to their Providers (or to themselves) within CHAMPS to be able to submit and receive 276/277 transactions on the Provider's behalf.

9. Transaction Specific Information

9.1 ANSI ASC X12 276 – Transaction Set Companion Guide Rules

This document uses several text conventions to aid in the interpretation of the Companion Guide Rules. The following table lists the text conventions used in this document for 276 transactions ***submitted*** to MDHHS.

Convention used	Explanation
< >	Text included within < > describes the values MDHHS requires for submission.
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Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100A			**Loop - Payer Name**	
2100A	**NM1**		**Segment - Segment - Payer Name**	
2100A	NM1	NM103	Name Last or Organization Name	<Payer Name> “Michigan Department of Health and Human Services” or “MDHHS”
2100A	NM1	NM108	Identification Code Qualifier	“PI” (Payer Identification)
2100A	NM1	NM109	Identification Code	<Payer Identifier> “D00111” for MDHHS
2100B			**Loop - Information Receiver Name**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100B	**NM1**		**Segment - Information Receiver Name**	
2100B	NM1	NM108	Identification Code Qualifier	“46” (Electronic Transmitter Identification Number (ETIN))
2100B	NM1	NM109	Identification Code	<Information Receiver Identification Number> For FTP, SSL FTP, or HTTPS use the FTS ID. For electronic batch use the CHAMPS Provider ID or NPI. For SOAP+WSDL or MIME Multipart, use the CHAMPS Provider ID, NPI, or FTS ID. This value should always match ISA06 <Interchange Sender ID> and GS02 < Application Sender's Code >.
2100C			**Loop - Provider Name**	
2100C	**NM1**		**Segment - Provider Name**	
2100C	NM1	NM108	Identification Code Qualifier	"XX" (Centers for Medicare and Medicaid Services National Provider Identifier)
2100C	NM1	NM109	Identification Code	<Provider Identifier> Billing Provider NPI should be submitted.
2100D			**Loop - Subscriber Name**	
2100D	**NM1**		**Segment - Subscriber Name**	
2100D	NM1	NM108	Identification Code Qualifier	“MI” (Member ID)
2100D	NM1	NM109	Identification Code	<Subscriber Identifier> Report the MDHHS beneficiary 10-digit identification number.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2200D			**Loop - Claim Status Tracking Number**	
2200D	**REF**		**Segment - Payer Claim Control Number**	
2200D	REF	REF01	Reference Identification Qualifier	"1K" (Payer Claim Number)
2200D	REF	REF02	Reference Identification	<Payer Claim Control Number> 18-digit CHAMPS TCN
2200D	**REF**		**Segment - Patient Control Number**	
2200D	REF	REF01	Reference Identification Qualifier	"EJ" (Patient Account Number)
2200D	REF	REF02	Reference Identification	<Patient Control Number> Patient Control Number may be submitted if it is known and present on the claim for which the status request is being submitted.
2200D	**DTP**		**Segment - Claim Service Date**	
2200D	DTP	DTP03	Date Time Period	<Claim Service Period> 1. From - To Date span cannot be greater than 30 days. 2. Date of service cannot be older than 5 years from the system date. 3. To Date cannot be less than From Date. 4. When there is a 276 status inquiry on suspended claim(s) due to invalid DOS (From/To) then "Claim not Found" will always be returned on 277. 5. Header DOS should always be submitted in the 276 request if Line DOS is not submitted, else "Claim not found" will be returned on the 277 response.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2210D			**Loop - Service Line Information**	
2210D	**DTP**		**Segment - Service Line Date**	
2210D	DTP	DTP03	Date Time Period	<Service Line Date> 1. From - To Date span cannot be greater than 30 days. 2. Date of service cannot be older than 5 years from the system date. 3. To Date cannot be less than From Date. 4. When there is a 276 status inquiry on suspended claim(s) due to invalid DOS (From/To) then "Claim not Found" will always be returned on 277. 5. Line DOS should always be submitted in the 276 request if Header DOS is not submitted, else "Claim not found" will be returned on 277 the response.

9.2 ANSI ASC X12 277 - Transaction Set Companion Guide Rules

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Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	
	ST	ST02	Transaction Set Control Number	<Transaction Set Control Number> MDHHS will assign a unique number within the transaction set to indicate the start of the transaction. MDHHS will transmit identical transaction set control numbers in ST02 and SE02.
2100A			**Loop - Payer Name**	
2100A	**NM1**		**Segment - Segment - Payer Name**	
2100A	NM1	NM103	Name Last or Organization Name	<Payer Name> “Michigan Department of Health and Human Services” or “MDHHS”
2100A	NM1	NM108	Identification Code Qualifier	“PI” (Payer Identification)
2100A	NM1	NM109	Identification Code	<Payer Identifier> “D00111” for MDHHS

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2100B			**Loop - Information Receiver Name**	
2100B	**NM1**		**Segment - Information Receiver Name**	
2100B	NM1	NM108	Identification Code Qualifier	“46” (Electronic Transmitter Identification Number (ETIN))
2100B	NM1	NM109	Identification Code	<Information Receiver Identification Number> Value received on 276 NM109 (Loop - 2100B Information Receiver Name) will be returned.
2200B			**Loop - Information Receiver Trace Identifier**	
2200B	**STC**		**Segment - Information Receiver Status Information**	
2200B	STC	STC01-1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.)
2200B	STC	STC01-2	Industry Code	<Status Code> The following code is returned when the submitted data is invalid: "153" (Entity's ID number)
2200C			**Loop - Provider of Service Trace Identifier**	
2200C	**STC**		**Segment - Provider Status Information**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2200C	STC	STC01-1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.)
2200C	STC	STC01-2	Industry Code	<Status Code> The following codes are returned as applicable when the submitted data is invalid: "21" (Missing or Invalid Information) "562" (Entity's National Provider Identifier (NPI))
2200D			**Loop - Claim Status Tracking Number**	
2200D	**STC**		**Segment - Claim Level Status Information**	
2200D	STC	STC01 - 1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.) When the submitted data is valid and finds a match based on the claim (s) search criteria, one of the following codes are returned based on CHAMPS Business Status present on claim: Business Status – Paid

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				"F1" = (Finalized / Payment - The Claim / line has been paid.) Business Status – Denied "F2" = (Finalized / Denial - The Claim / line has been denied.) Business Status – Credit "F3" = (Finalized/Revised - Adjudication information has been changed.) Business Status – Suspended "P2" = (Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, repricing, Third Party Administrator processing).) Business Status – Adjusted "F3" = (Finalized/Revised - Adjudication information has been changed.) Business Status – In-process "P1" = (Pending/In Process-The claim or encounter is in the adjudication system.) Business Status - Void "F4" = (Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming) When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned:

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				"D0" (Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.)
2200D	STC	STC01 - 2	Industry Code	<Status Code> The following codes are returned as applicable when the submitted data is invalid: "21" (Missing or Invalid Information) NOTE: At least one other status code is required to identify the missing or invalid information. "33" (Subscriber and Subscriber ID not found) "187" (Dates(s) of Service) "464" (Payer Assigned Claim Control Number) When the submitted data is valid and finds a match based on the claim (s) search criteria, the standard status code(s) present on claim(s) are returned as applicable. When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "35" (Claim/encounter not found.)
2220D			**Loop - Service Line**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Information	
2220D	**STC**		**Segment - Service Line Status Information**	
2220D	STC	STC01 - 1	Industry Code	<Health Care Claim Status Category Code> The following code is returned when the submitted data is invalid: "E0" (Response not possible - error on submitted request data.) When the submitted data is valid and finds a match based on the claim (s) search criteria, one of the following codes are returned based on CHAMPS Business Status present on claim: Business Status – Paid “F1” = (Finalized / Payment - The Claim / line has been paid.) Business Status – Denied “F2” = (Finalized / Denial - The Claim / line has been denied.) Start: 01/01/1995 Business Status – Credit “F3” = (Finalized/Revised - Adjudication information has been changed.) Business Status – Suspended “P2” = (Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, repricing, Third Party Administrator processing.)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				Business Status – Adjusted “F3” = (Finalized/Revised - Adjudication information has been changed) Business Status – In process “P1” = (Pending/In Process-The claim or encounter is in the adjudication system.) Business Status - Void “F4” = (Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.) When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "D0" (Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2220D	STC	STC01 - 2	Industry Code	<Status Code> The following code is returned when the submitted data is invalid: "188" (Statement from-through dates.) When the submitted data is valid and finds a match based on the claim (s) search criteria, the standard status code(s) present on claim(s) are returned as applicable. When the submitted data is valid and does not find a match based on the claim (s) search criteria, the following code is returned: "35" (Claim/encounter not found.)

10. Revision Log

Version Date	Effective Date	Revision Description
February 22, 2011 (Draft)	January 1, 2012	This document replaces *Companion Guide For The HIPAA 276/277 Health Care Claim Status Request & Response Addenda, Version 4010A1* dated November 17, 2009.
June 20, 2011	January 1, 2012	Add to last bullet on page 3 “If only Line information is submitted on the 276 Claim Status Request, the 277 Claim Status Response will be returned with both Header and all Line information.”
November 30, 2011	January 1, 2012	This document includes changes identified as part of business to business testing and reflects the 5010-implementation effective January 1, 2012. Updated location and link for Electronic Submitter’s Guide.
April 22, 2013	July 1, 2013	Reformatted to conform with ACA CORE companion guide requirements. Added information on the new ACA CORE required transport modes: MIME Multipart and SOAP+WSDL. Updated transaction specific information for ACA CORE changes. Updated links for new website design.