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# Wellmark

## HIPAA Transaction Standard Companion Guide

Refers to the X12N Implementation Guide  
ANSI Version 4010A1

### Section 2, 276-277 Claim Status

#### Version Number 1.01

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**July 1, 2003**

This *Companion Guide* is a work in progress. Wellmark reserves the right to make changes to this Companion Guide at any time without notice. When changes are made, the Change Summary on the last page of this section will identify those changes and give the date and reason for the change. Changes will also appear in blue text on the web and be accompanied by a yellow note in the margin.

# 1 Introduction

Wellmark places a high priority on making it easy for you to do business with us. Using an electronic medium to make an inquiry is one of the ways we can do this. Electronic inquiries facilitate the transfer of information from your organization to ours in a standard data format. This Section 2 of the *Wellmark Companion Guide* provides information about the American National Standards Institute (ANSI) Health Care Claim Status Request and Response 276-277 transaction, Version 4010A1A. This transaction is the accepted standard of the 1996 Health Insurance Portability and Accountability Act (HIPAA-AS).

The *Wellmark Companion Guide* is to be used alongside the *HIPAA-AS Implementation Guide (IG)*, which provides comprehensive information needed to create an ANSI 276 transaction and details the information returned in the ANSI 277 transaction. The *Wellmark Companion Guide* does not change the specifications of the *HIPAA Implementation Guide*; rather, it is intended to clarify the areas where the IG provides options or choices to be made. The *HIPAA-AS Implementation Guide* can be downloaded from the following Internet address:

[http://www.wpc-edi.com/hipaa/HIPAA\\_40.asp](http://www.wpc-edi.com/hipaa/HIPAA_40.asp).

When you send a transaction to Wellmark, it will go through EDS EC Solutions Interactive Network (INet) facility first. Section 1 of the *Wellmark Companion Guide* provides further information about the process of sending electronic transactions to Wellmark via EDS EC Solutions.

## Implementation Considerations

The 276/277 electronic batch transaction works best for employers or healthcare practitioners and facilities with the capability of posting this information to an employee or patient account record. However, it may not be as user-friendly for individual transactions or as convenient as our current web tools for Claim Status Inquiry (CSI). (See the Group or Provider Corner at [www.wellmark.com](http://www.wellmark.com) for information on these services.)

For 277 responses, Wellmark will create the required response format for HIPAA-AS compliance. Like our web transactions, these responses are available for all lines of Blue Cross and Blue Shield business. Batch 277 response transactions will provide claim status only at the summary claim level. Wellmark will not process 276 claim status requests at the claim line level.

The CSI web tool for Claim Status Inquiry will also be HIPAA-AS compliant in content. Because our web site contains greater detail than the 276/277, the additional values that are currently available on the web will be available via links from the HIPAA-AS data content page. When you click on a claim number that is displayed on this page, you will access the same additional claim information pages that were previously displayed.

The web tool search now requires specifying from-to service dates – as does the batch 276 request transaction. This date span is limited to a 31-day period.

Normal hours of availability for web-based requests are between 5:00 a.m. and midnight, Central time. Batch 276 transactions may be sent to Wellmark at any time, but will be processed during the same 5:00 a.m. to midnight period. Normal batch turnaround time will be 45 minutes or less.

Wellmark will process batch 276 transactions for more than one policyholder or dependent as separate requests for each patient. Consequently, multiple 277 transaction responses may be

returned to the requestor. Requestors should use transaction control fields and/or transaction trace numbers to support matching responses from Wellmark to their original requests.

Wellmark uses the Interchange Control Structures found in the HIPAA-AS controlling document for X12.5. Our recommendation is to use the \* (asterisk) for the *element* delimiter and the ~(tilde) for the *segment* delimiter.

Hex and communication control characters may disrupt data flow and should be used with caution. Upper and lower case letters, numbers, space, — (minus sign), and other special characters that occur in transaction data content should not be used as delimiters to avoid confusion and data misunderstandings.

#### For healthcare facilities and practitioners of health services only:

For business done through the traditional BlueCard program, facilities and practitioners of health services will be able to get on-line information on BlueCard claims that are handled direct by the patient's home plan by using the three-digit alpha prefix and other required search fields. This process will be completed through the Blue Cross and Blue Shield's BlueExchange program.

The CSI web tool will enable an office that cannot create batch transactions to make a request for claim status by using a second search page that will be offered if a member's claim information is not found on our system files. For BlueCard members, you will need to complete additional fields so Wellmark can create a 276 request on your behalf and forward to the other Blue Plan for a response. If the other Plan is processing real-time requests at the time of your inquiry, the reply from the other Plan will be displayed on the web page. If the other Plan is not processing real-time requests, a message will be displayed directing you to either submit a batch 276 transaction, or call the 800 number listed on the screen.

What follows is a matrix of the values important to completing a successful transaction. Like most transactions, you should test for submitting requests and receiving transactions. You will want to work with your vendor or clearinghouse to perform the appropriate testing.

Also, facilities and healthcare practitioners who submit directly to Wellmark, should review the *Wellmark Testing Toolkit* mailed to them and found at:  
[www.wellmark.com/HIPAA/hipaa\\_electronic\\_trans.htm](http://www.wellmark.com/HIPAA/hipaa_electronic_trans.htm).

## Matrix for the 276/277 Health Care Claim Status Request and Response

### LEGEND

**SHADED** rows represent “segments;” **NON-SHADED** rows represent “data elements.”

“Loop – specific” comments are found in the first segment of the loop.

Page #	Loop ID	Segment	Segment Name	Codes	Length	Notes/Comments
52	2100A	NM1	Payer Name			
55		NM103	Last Name/Organization Name		1/35	Wellmark Blue Cross Blue Shield
55		NM108	Identification Code Qualifier	AD	2	
56		NM109	Identification Code	88848	2/80	Wellmark Blue Cross and Blue Shield Payer Identifier
62	2100B	NM1	Information Receiver Name			
63		NM108	Identification Code Qualifier	46 FI	2	Electronic TIN Federal TIN
63		NM109	Identification Code (Information Receiver Identification Number)		2/80	Your electronic submitter number from EC Solutions
67	2100C	NM1	Provider Name			
68		NM108	Identification Code Qualifier	FI SV	1/2	Federal TIN Service Provider Number
69		NM109	Identification Code (Provider Identifier)		5 7	Iowa providers use 5-digit provider number. South Dakota providers use 7-digit provider number. Providers from other states should use their local provider number when submitting to BlueExchange.
70	2000D	DMG	Subscriber Demographic Information			Segment information is required if the policy holder is the patient.
72		DMG01	Date Qualifier	D8	2/3	Use CCYYMMDD format.
73		DMG02	Subscriber Birth Date		8	Policyholder's birth date.
73		DMG03	Subscriber Gender Code	F M U	1	Policyholder's gender. Wellmark does not accept “U” for Unknown.

Page #	Loop ID	Segment	Segment Name	Codes	Length	Notes/Comments
74	2100D	NM1	Subscriber Name			
75		NM103	Name Last or Organization Name		1/35	Policyholder's last name.
75		NM104	Name First		1/25	Policyholder's first name.
75		NM108	Identification Code Qualifier	MI	2	
76		NM109	Identification Code		1/80	The policyholder's identification number as shown on the member's card including the prefix. In some cases, your request will be forwarded to another Blue Plan to supply the information for a response. The level of information you receive back may vary by Plan.
78	2200D	REF	Payer Claim Identification Number			May send this segment, if Claim Number (ICN) is known
78		REF01	Reference Identification Qualifier	IK	2	The claim number used by the payer.
79		REF02	Reference Identification (Payer Claim Control Number)		1/30	For Wellmark claims, this would be the 14 number ICN (internal claim number).
77	2200D	AMT	Claim Submitter Trace Number			Required when the subscriber is the patient.
84		AMT01	Amount Qualifier Code	T3	2	Total claim charge amount.
85		AMT02	Monetary Amount		18	Wellmark does not accept a zero amount.
86	2200D	DTP	Claim Service Date			Used when the policyholder is the patient.
86		DTP01	Date Time Period Qualifier	232	3	Code to identify that the dates given express beginning and ending dates of service
87		DTP02	Date Time Period Format Qualifier	RD8	3	Range of dates expressed in format CCYYMMDD-CCYYMMDD
87		DTP03	Date Time Period (Claim Service Period)		1/35	Wellmark supports up to a 31-day date span.
88	2210D	SVC	Service Line Information			Note: Wellmark does not support requests for claim status at the service line level.

Page #	Loop ID	Segment	Segment Name	Codes	Length	Notes/Comments
96	2000E	DMG	Dependent Demographic Information			Segment information is required if the request is about a dependent.
96		DMG01	Date Qualifier	D8	2/3	Date expressed in format CCYYMMDD.
97		DMG02	Patient Birth Date		8	Dependent's date of birth.
97		DMG03	Patient Gender Code	F M U	1	Dependent's gender. Wellmark does not accept "U" for Unknown.
98	2100E	NM1	Dependent Name			
99		NM103	Name Last or Organization Name		1/35	Dependent's last name when the dependent is the patient.
99		NM104	Name First		1/25	Dependent's first name when the dependent is the patient.
99		NM108	Identification Code Qualifier	MI	2	
100		NM109	Identification Code		2/80	The policyholder identification on the member's ID card, including the prefix.
103	2200E	REF	Payer Claim Identification Number			May send this segment, if Claim Number (ICN) is known
103		REF01	Reference Identification Qualifier	IK	2	The claim number used by the payer.
103		REF02	Reference Identification (Payer Claim Control Number)		1/30	For Wellmark claims, this would be the 14-digit ICN (internal claim number).
109	2200E	AMT	Claim Submitted Charges			Required when the patient is not the policyholder.
109		AMT01	Amount Qualifier Code	T3	2	The claim total charge amount.
110		AMT02	Monetary Amount		1/18	Wellmark does not accept a zero amount.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
111	2200e	DTP	Claim Service Date			
111		DTP01	Date Time Period Qualifier	232	3	.
112		DTP02	Date Time Period Format Qualifier	RD8	3	
112		DTP03	Date Time Period	CCYYMMDD or CCYYMMDD — CCYYMMDD	8	Used when the policyholder is the patient. It can be a single date or date span. We support a 31-day date span.
113	2210E		Service Line Information			Use this segment for BlueExchange transactions.



## 277 Response

Wellmark's response to a 276 request will be made at the claim level, not at the line level. For example, a pended claim can have a mixture of paid, denied and pended service lines, but is considered pended until all lines have completed processing and a remittance is created. A response to a given line will not convey an accurate status for the claim.

Wellmark will use the following status code categories:

### Pended claims:

- P1 - Pending/In Process-The claim or encounter is in the adjudication system.
- P2 - Pending/In Review-The claim/encounter is suspended pending review.
- P3 - Pending/Requested Information-The claim or encounter is waiting for information that has already been requested.
- P4 - Pending/Patient Requested Information

### Finalized claims:

- F1 - Finalized/Payment-The claim/line has been paid.
  - If actual payment is made
- F2 - Finalized/Denial-The claim/line has been denied
  - If entire claim is denied
- F4 - Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.
  - For capitated claims

# Change Summary for 276-277

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Sequence number: 1

Author: Update

Date: 6/19/2003 11:42:39 AM

Type: Note

Added information on our response.