# Colorado Medical Assistance Program

## Health Care Claim Status Request and Response (276/277) Transactions Standard Companion Guide

## Companion to Health Care Claim Status Request and Response ASC X12N 276/277 005010X212 Implementation Guide

**March 2023**

## Disclosure Statement

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## Preface

This companion guide to the Health Care Claim Status Request and Response (276/277) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Department of Health Care Policy & Financing (the Department). Transmissions based on this companion guide, used in tandem with the **ASC X12N 276/277 005010X212 Implementation Guide**, are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N implementation guides adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the implementation guides.

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## 1. INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into transaction partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specifications
- Change the meaning or intent of the standards implementation specifications

Effective January 1, 2013, health plans, covered entities and their business associates that engage in the exchange of claim status transaction 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 the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

### SCOPE

The companion guide is to be used with, and to supplement the requirements in the HIPAA Accredited Standards Committee (ASC) X12 implementation guides and CORE Rules, without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guide is to provide trading partners with a guide to communicate information specific to the Colorado Medical Assistance Program that is required to successfully exchange transactions.

The companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claim status request and response transactions to the fiscal agent on behalf of the Department.

### OVERVIEW

This section of the companion guide will provide guidance for establishing a relationship with the Department for the business purpose of exchanging the electronic Health Care Claim Status Request and Response (276/277) transaction.

### REFERENCES

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

Workgroup for Electronic Data Interchange (WEDI) – https://www.wedi.org/

United States Department of Health and Human Services (DHHS) – https://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – https://www.cms.gov
Designated Standard Maintenance Organizations (DSMO) – https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/StandardsSettingandRelatedOrganizations
National Council of Prescription Drug Programs (NCPDP) – https://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – https://www.nubc.org/
Accredited Standards Committee (ASC X12) – https://x12.org
Washington Publishing Company (WPC) – https://wpc-edi.com/

Affordable Care Act (ACA) Section 1104 information is at the Centers for Medicare & Medicaid Services (CMS) website. Visit https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/StandardsSettingandRelatedOrganizations for information on ACA Administrative Simplification information.

### ADDITIONAL INFORMATION

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this companion guide. TR3s can be purchased from the ASC X12 store at https://x12.org/products.

## 2. GETTING STARTED

### TRADING PARTNER REGISTRATION

Any entity intending to exchange electronic transactions with the Department must agree to the Trading Partner Agreement at the end of the trading partner profile process. A trading partner profile can be completed using the Provider Web Portal at https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx.

***Note:*** Providers must be enrolled and approved before registering as a trading partner.

The Web Portal and the Secure File Transfer Protocol (SFTP) will include the ability for file and report retrieval. Billing agents and clearinghouses will have the option of retrieving the transaction responses and reports themselves and/or allowing each individual provider the option of retrieval. The trading partner will access the system using the assigned login and password. Visit https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx for information on the Web Portal.

### CERTIFICATION AND TESTING OVERVIEW

All covered entities who submit electronic transactions are required to certify. This includes clearinghouses, software vendors, provider groups, and managed care organizations (MCOs). If submitting electronic transactions through one of these agencies, the agency will certify on behalf of the covered entity. Otherwise, the covered entity will need to certify. If submitting electronic transactions through an MCO, information should be received from the MCO with certification requirements.

Results of the system's processing of electronic transactions are reviewed and communicated back via email. Once the test files all pass, a production ID and welcome letter will be sent confirming certification.

## 3. TESTING WITH THE PAYER

This section contains a detailed description of the testing phase.

Testing is required for the Health Care Claims Status Request and Response (276/277).

Before exchanging production transactions with the Department, each trading partner must complete production authorization testing.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

Trading partners are encouraged to submit three successful and unique submissions and receive the associated 999 (accepted) acknowledgement in response in order to obtain approval to promote to production.

Trading Partner authorization testing is detailed in the Trading Partner Testing Packet for ASC X12 transactions available on the Colorado Electronic Data Interchange (EDI) Support page at https://hcpf.colorado.gov/edi-support.

Questions may be directed to the Provider Services Call Center, or via the Contact Us link at the top of the Provider Web Portal home page at https://colorado-hcp-portal.coxix.gainwelltechnologies.com/hcp/provider/Home/tabid/135/Default.aspx.

## 4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

### PASSWORDS

Passwords are provided during initial enrollment and can be reset by contacting the Provider Services Call Center. These passwords may not be shared.

https://hcpf.colorado.gov/edi-support

## 5. CONTACT INFORMATION

### WORKING WITH THE DEPARTMENT

To assist the community with their electronic data exchange needs, the following options are available for either contacting a help desk or referencing a website for further assistance:

Visit the Department's website at https://hcpf.colorado.gov/ for general information.

### ELECTRONIC DATA INTERCHANGE (EDI) SERVICES

Contact the Provider Services Call Center with any questions.

## 6. OL SEGMENTS/ENVELOPES

### ISA-IEA

This section describes the use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters. (See Section 10 Transaction-Specific Information below.)

**GS-GE**

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how the Department expects functional groups to be sent and how the Department will send functional groups. These discussions will describe how similar transaction sets will be packaged and the use of functional group control numbers. (See Section 10 Transaction-Specific Information below.)

**ST-SE**

This section describes the use of transaction set control numbers. (See Section 10 Transaction-Specific Information below.)

Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.

## 7. PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

If supplied in the X212 claim inquiry, interChange will use all the following values in a search for claims:

- Billing provider ID
- Member ID
- Dates of service
- Total billed amount (AMT02)
- Internal control number (ICN)

The minimum values that must be present are:

- Billing provider ID
- Member ID
- Dates of service

It is strongly recommended that as many values as possible be included to help narrow the number of matches in the search. If there is not an exact match found for a claim identifier, the system will not return claims that closely match or are in the same date range.

If the AMT segment is submitted, it will be used as one of the primary searches when selecting claims to include on the response. Only claims that have an exact dollar amount match will be returned.

Claim status information is provided at the claim level for dental, institutional, and professional claims. The loop 2000D DMG segment is always required because the subscriber is always the patient. The Dependent Loop is not supported since all interChange members can be uniquely identified at the subscriber level (loop 2000D). Service line-specific status requests are not supported because when sent, this data will be ignored, and the request will be processed using the claim level data.

It is recommended that no more than 99 requests per batch transmission be made at one time for a variety of reasons. Processing of small batches is more efficient, and submitters are less likely to receive rejections on smaller batch bundles. This is only a recommendation as there is no max limitation within the query code.

## 8. ACKNOWLEDGEMENTS AND/OR REPORTS

The acknowledgement process will create the TA1 and 999 acknowledgement for the 270 transactions. No acknowledgements are expected for the 271 transactions.

## 9. TRADING PARTNER AGREEMENTS

An Electronic Data Interchange (EDI) trading partner is defined as any customer of the Department (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to or receives electronic data from the fiscal agent on behalf of the Department.

Payers have EDI Trading Partner Agreements (TPA) that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

## 10. TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that contains additional information not found in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the Department

In addition to the row for each segment, one or more additional rows are used to describe the usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

All members of the Department are considered “subscribers,” so they all have individual loops. See the implementation guide for additional information. Dependent loops for eligibility transactions will not be processed.

The Trading Partner ID (TPID) is the number that is assigned to the provider/submitter to uniquely identify their electronic transaction. This may also be referred to as the Electronic Claim Submission (ECS) number or TPID.

**Health Care Claim Status Request (276)**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **HEADER** | **ISA** | **Interchange Control Header** | | **The ISA is a fixed-length record with fixed-length elements.**<br><br>**All inbound files are constrained to a single ISA segment for tracking and balancing.**<br><br>**Note: Deviating from the standard ISA element sizes will cause the Interchange to be rejected.** |
| | ISA01 | Authorization Information Qualifier | 00 | |
| | ISA02 | Authorization Information | | No data is expected in this data element |
| | ISA03 | Security Information Qualifier | 00 | |
| | ISA04 | Security Information | | No data is expected in this data element |
| | ISA05 | Interchange ID Qualifier | ZZ | |
| | ISA06 | Interchange Sender ID | | Enter the Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program |
| | ISA07 | Interchange ID Qualifier | ZZ | |
| | ISA08 | Interchange Receiver ID | COMEDASSIS TPROG | |
| | **GS** | **Functional Group Header** | | |
| | GS02 | Application Sender's Code | | Enter the Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program |
| | GS03 | Application Receiver's Code | COMEDASSIS TPROG | |
| | GS08 | Version/Release/ Industry Identifier Code | 005010X212 | Standards Approved for Publication by ASC X12 Procedures Review Board |
| | **ST** | **Transaction Set Header** | | |
| | ST03 | Version, Release, or Industry Identifier | 005010X212 | |
| **2100A** | **NM1** | **Payer Name** | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | NM103 | Payer Name | COLORADO MEDICAL ASSISTANCE PROGRAM | |
| | NM108 | Identification Code Qualifier | PI | |
| | NM109 | Payer Identifier | CO_TXIX or CO_BHA | |
| **2100C** | **NM1** | **Provider Name** | | |
| | NM108 | Identification Code Qualifier | SV, XX | For Non-Healthcare Providers (Non-Covered Entities), enter the following value: SV<br><br>For Healthcare Providers (Covered Entities), enter the following value: XX |
| | NM109 | Provider Identifier | | For Non-Healthcare Providers (Non-Covered Entities), enter the following value:<br>Enter the Colorado Medical Assistance Program Provider ID assigned<br><br>For Healthcare Providers (Covered Entities), enter the following value:<br>Enter the National Provider ID |
| **2100D** | **NM1** | **Subscriber Name** | | |
| | NM102 | Entity Type Qualifier | 1 | |
| | NM108 | Identification Code Qualifier | MI | |
| | NM109 | Subscriber Identifier | | Enter the Colorado Medical Assistance Program Client ID |

**Health Care Claim Status Response (277)**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **HEADER** | **ISA** | **Interchange Control Header** | | **The ISA is a fixed-length record with fixed-length elements.**<br><br>**Note: Deviating from the standard ISA element sizes will cause the Interchange to be rejected.** |
| | ISA06 | Interchange Sender ID | COMEDASSIST PROG | |
| | ISA08 | Interchange Receiver ID | | The Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program will be sent. |
| | ISA11 | Repetition Separator | ^ | Caret |
| | ISA16 | Component Element Separator | : | Colon |
| | **GS** | **Functional Group Header** | | |
| | GS02 | Application Sender's Code | COMEDASSIST PROG | |
| | GS03 | Application Receiver's Code | | The Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program will be sent. |
| | GS08 | Version/Release/ Industry Identifier Code | 005010X212 | Standards Approved for Publication by ASC X12 Procedures Review Board. |
| | **ST** | **Transaction Set Header** | | |
| | ST03 | Version, Release, or Industry Identifier | 005010X212 | |
| **2100A** | **NM1** | **Payer Name** | | |
| | NM103 | Payer Name | COLORADO MEDICAL ASSISTANCE PROGRAM | |
| | NM109 | Payer Identifier | CO_TXIX or CO_BHA | |
| **2100D** | **NM1** | **Subscriber Name** | | |
| | NM109 | Subscriber Identifier | | The Colorado Medical Assistance Program Client ID will be sent. |
| **2200D** | **STC** | **Claim Level Status Information** | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | STC01-1 | Health Care Claim Status Category Code | F1, F2, P1, E0, E1 | Colorado Medical Assistance Program will use of the following codes:<br>F1 – For claims that have a status of P (Pay)<br>F2 – For claims that have a status of D (Deny)<br>P1 – For claims that have a status of S (Suspend), R (Receive), or X (Super-Suspend)<br>E0<br>E1 |

## APPENDIX 1: Frequently Asked Questions

Q1: Can I send each Health Care Claim Status Request and Response (276) transaction to Medicaid without selecting the transaction on my Trading Partner Agreement?

A1: No. All trading partners must have signed a Trading Partner Agreement and be set up for the transaction types agreed upon.

**APPENDIX 2: Change Summary**

| Date | Change | Responsible Party |
|---|---|---|
| March 2017 | Original Document | EDI Department |
| 3/31/2017 | Added New EDI Service Telephone Number | EDI Helpdesk |
| 8/1/2017 | Rebranding to DXC Technology | DXC, formerly HPE |
| 2/23/2018 | Updated the notes/comments for 276/Header/ISA, the name for 277/2200D/STC, links in the various sections, and verbiage in the Certification and Testing Overview section. | EDI Department |
| 10/26/2022 | Rebranded to Gainwell Technologies (from DXC), updated hyperlinks and general cleanup | Gainwell Technologies (formerly DXC) |
| 3/2/2023 | Added BHA payer information; updated Provider Web Portal links | Gainwell Technologies |