276/277 Health Care Claim Status Request and Response

Companion Guide

Version 1.1

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INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 276/277 Health Care Claim Status Request and Response transactions implementation guide provides the standardized data requirements to be implemented for all health care claim status inquiries conducted electronically.

PURPOSE

The purpose of this document is to provide the information necessary to submit a claim status request and receive a claim status response electronically to/from ValueOptions, Inc. **This companion guide is to be used in conjunction with the ANSI X12N implementation guides.** The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at www.wpc-edi.com/hipaa/. Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/admnsimp/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov/hipaa/hipaa2/
Designated Standard Maintenance Organizations (DSMO) – http://www.hipaa-dsmo.org/
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 276 Health Care Claim Status Request transaction that the health plan will accept.

- 276 Health Care Claim Status Request – **ASC X12N 276 (004010X093A1)** ☒

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

- TA1 Interchange Acknowledgement ☒
- 997 Functional Acknowledgement ☒
- 277 Health Care Claim Status Response – **ASC X12N 277 (004010X093A1)** ☒

NOTE: The TA1 and 997 acknowledgements will be supported for real-time transactions.

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Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

ValueOptions will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Inquiry Level Supported

The 276 Health Care Claim Status Request transaction allows for claim level and service line level requests. Some adjudication systems cannot accommodate requests for service line status inquiries. ValueOptions can support the following level of inquiry:

- Claim Level Status Request ☒
- Service Line Level Status Request ☐

Maximum Limitations

The 276 Health Care Claim Status transaction is designed to request the status of one or more claims for the patient transmitted within the transaction set. The 277 Health Care Claim Response provides the status for the requested claims. When the 276 transaction does not uniquely identify the claim(s) within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester.

The structure of the transaction is as follows:

- Information Source
  - Information Receiver
    - Service Provider
      - Subscriber
        - Dependent (only provided if the subscriber is not the patient)
        - Claim (request claim identification info. 276, claim status info. 277)

Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide.

Batch Mode:

ValueOptions has no file size limitations. The Interchange Control structure (ISA/IEA envelope) will be treated as one file. Each Interchange Control structure may consist of multiple Functional Groups (GS/GE envelopes). ValueOptions requires that the Interchange Control structure is limited to one type of Functional Group, such as 276 Health Care Claim Status Requests. ValueOptions will validate and accept or reject the entire Interchange Control structure (ISA/IEA envelope).

Batch files will be processed and the response file will be available within 24 hours of receipt.

Real-Time Mode:

ValueOptions expects a single transaction for only one claim in a real-time inquiry; however, they can support a transaction inquiring on more than one claim. Response time will be proportionate to the number of claims included in the claim status request.

Definition of Terms

The participants in the hierarchical level structure described above are as follows:

- **Information Source** – This entity is the decision maker in the business transaction. For this business use, this entity is the payer.
- **Information Receiver** – This entity expects the response from the information source. For this business use, this entity can be a provider, a provider group, billing agent, etc.
- **Service Provider** – This entity delivered the health care service.
- **Subscriber** – This entity is the insured.
- **Dependent** – This entity is entitled to health care benefits because of his or her relationship to the insured.

Telecommunication Specifications

Trading partners wishing to submit electronic Claim Status Requests (276 transactions) to ValueOptions must have a valid ValueOptions Submitter ID/Password. If you do not have a Submitter ID you may obtain one by completing the Account Request form available on the ValueOptions website at http://www.valueoptions.com/provider/handbooks/forms.htm

ValueOptions can accommodate multiple submission methods for the 276 Health Care Claim Status Request transaction. Please refer to the ETS (Electronic Transport System) Electronic Data Exchange Overview document on the ValueOptions website at http://www.valueoptions.com/provider/compliance for further details.

If you have any questions please contact the ValueOptions EDI help desk.
E-mail: e-supportservices@valueoptions.com
Telephone: 888-247-9311 (8am-6pm, Monday-Friday)
FAX: 866-698-6032

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types of HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, and numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.
3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

The WEDI/SNP white paper on Transaction Compliance and Certification and other white papers are found at http://www.wedi.org/snip/public/articles/index.shtml

ValueOptions' Recommendations:

According to the Centers for Medicare and Medicaid Services (CMS), you are responsible for ensuring that your EDI transactions are conducted in compliance with HIPAA regulations. In an effort to help you address your HIPAA EDI obligations as efficiently as possible, we recommend Claredi™, the nation's leading provider of HIPAA transaction and code set testing and certification. Claredi is an independent certifying agency, and the only testing and certification entity selected by CMS for their

own compliance. As an additional benefit, using the same certification organization as ValueOptions greatly reduces the potential for any future discrepancies with transactions.

Trading Partner Acceptance Testing Specifications

To submit a test file to ValueOptions, you must have a valid Submitter ID/Password. Please refer to the Telecommunications Specifications section on page 7 of this document for details on obtaining a Submitter ID/Password.

When testing the Health Care Claim Status Request transaction (276), for more reliable results, it is recommended to have the transaction inquire against production data. Please set the Usage Indicator (ISA15) to ‘P’ for Production. The status requests will then go to the production area to verify the status of previously transmitted claims.

276 HEALTH CARE CLAIM STATUS REQUEST TRANSACTION SPECIFICATIONS

INTERCHANGE CONTROL HEADER SPECIFICATIONS (276 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: ‘00’ No Authorization Information Present ’03’ Additional Data Identification	Use ‘03’ Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for additional identification or authorization.	Use the ValueOptions submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: ‘00’ No Security Information Present ‘01’ Password	Use ‘01’ Password to indicate that a password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use the ValueOptions submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use ‘ZZ’ Mutually Defined.
	ISA08	Interchange Receiver ID	R		Use ‘FHC &Affiliates’.
	ISA09	Interchange Date	R	Date format YYMMDD.	Refer to the implementation guide specifications.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specifications.
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' U.S. EDI Community of ASC X12	Use the value specified in the implementation guide.
	ISA12	Interchange Control Version Number	R	Valid value: '00401' Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997.	Use the current standard approved for the ISA/IEA envelope. Other standards will not be accepted.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier zero fill this element.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	ValueOptions will send a TA1 Interchange Acknowledgement for real-time inquiries only.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	Use 'P' Production.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	ValueOptions will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS (276 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	Expected Value
			TRAILER		
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups	R	Count of the number of functional groups in the interchange.	This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e. functional identifier code ‘HR’ Health Care Claim Status Request (276).
	IEA02	Interchange Control Number	R	The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

FUNCTIONAL GROUP HEADER SPECIFICATIONS (276 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	Expected Value
				HEADER	
GS		**Functional Group Header**	**R**		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HR' Health Care Claim Status Request (276)	Use the value specified in the implementation guide.
	GS02	Application Sender's Code	R		The sender defines this value. ValueOptions will not be validating this value.
	GS03	Application Receiver's Code	R		This field will identify how the file is received by ValueOptions. Use 'EDI' for electronic transfer.
	GS04	Date	R	Date format CCYYMMDD.	Refer to the implementation guide specifications.
	GS05	Time	R	Time format HHMM.	Refer to implementation guide specifications.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	This value is defined by the sender's system. For real-time inquiries, ValueOptions will use this number to identify the functional group, if a 997 is generated to reject a noncompliant functional group.

Seg	Data Element	Name	Usage	Comments	Expected Value
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' Accredited Standards Committee X12	Use the value specified in the implementation guide.
	GS08	Version/Release Industry ID Code	R	Valid value: Addenda Approved for Publication by ASC X12. '004010X093A1'	Use the current standard approved for publication by ASC X12. Other standards will not be accepted.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS (276 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	Expected Value
			TRAILER		
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

Seg	Data Element	Name	Usage	Comments	Expected Value
				LOOP 2100A – PAYER NAME	
NM1		**Payer Name**	**R**		
	NM103	Payer Name	R	This element will be required until the National payer Identifier is active.	Use 'ValueOptions, Inc.'
	NM108	Identification Code Qualifier	R	Valid values: '21' Health Industry Number (HIN) 'AD' Blue Cross Blue Shield Association Plan Code 'FI' Federal Taxpayer's ID number 'NI' National Association of Insurance Commissioners (NAIC) Identification 'PI' Payer Identification 'PP' Pharmacy Processor Number 'XV' Health Care Financing Administration National PlanID (Required if mandated)	Use 'PI' Payer Identification.
	NM109	Payer Identifier	R	For Medicare use, this is the carrier/fiscal intermediary-assigned code.	Use 'FHC &Affiliates'.
				LOOP 2100B – INFORMATION RECEIVER NAME	
NM1		**Information Receiver Name**	**R**		
	NM108	Identification Code Qualifier	R	Valid values: '46 Electronic Transmitter Identification Number (ETIN) 'FI' FI' Federal Taxpayer's ID number 'XX' Health Care Financing Administration National Provider ID (Required if mandated)	Use '46' Electronic Transmitter Identification Number (ETIN).
	NM109	Information Receiver Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the ValueOptions assigned submitter ID. Maximum 10 characters.

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2100C- PROVIDER NAME					
NM1		**Provider Name**	**R**		
	NM108	Identification Code Qualifier	R	Valid values: 'FI' Federal Taxpayer's ID number 'SV' Service Provider Number When the provider does not have a National Provider ID and Payer has assigned a specific ID number to this provider this code is required. 'XX' Health Care Financing Administration National Provider ID (Required if mandated)	Use 'SV' Service Provider Number.
	NM109	Provider Identifier	R		Use the ValueOptions Provider Number.
LOOP 2100D - SUBSCRIBER NAME					
NM1		**Subscriber Name**	**R**		
	NM108	Identification Code Qualifier	R	Valid values: '24' Employer's Identification Number 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	Use 'MI' Member Identification Number.
	NM109	Subscriber Identifier	R		Use the ValueOptions Subscriber ID or Medicaid ID if applicable.

Seg	Data Element	Name	Usage	Comments	Expected Value
		LOOP 2200D – CLAIM SUBMITTER TRACE NUMBER			
TRN		**Claim Submitter Trace Number**	**R**	**This segment is required if the subscriber is the use this segment, use TRN segment in Loop 2200E.** **The TRN segment is required by the ASC X12 syntax when loop ID 2200D is used.**	
	TRN01	Trace Type Code	R	Valid values: '1' Current Transaction Trace Number	Use '1' Current Transaction Trace Number.
	TRN02	Trace Number	R	This data element corresponds to the CLM01 Data element of the ASC X12N transaction. Paper based claims may not require the Patient Account Number for adjudication. When inquiring on paper based claims the trace number is required to be returned in the TRN of the 277 Health Care Claim Status Response transaction TRN02.	To inquire on claims submitted electronically, use Claim Submitter Identifier submitted on 837 professional and institutional transactions. To inquire on paper claims, use the Patient Account Number submitted in box 26 (HCFA) or form locator 3 (UB92).
REF		**Payer Claim Identification Number**	**S**	**Only use this segment if the subscriber is the patient.** **The authors recommend sending this segment on claim inquires when the information is known. It will provide a direct look up key into the payer's adjudication system.**	
	REF01	Reference Identification Qualifier	R	Valid values: '1K' Payer's Claim Number	Use '1K' Payer's Claim Number.
	REF02	Payer Claim Control Number	R	Examples of this number include ICN, DCN, CCN. Submit this element if the payer supplied it previously.	Use ValueOptions claim number.

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Institutional Bill Type Identification**	**S**	**Only use this segment if the dependent is the patient and the bill type is being sent in the inquiry request in connection with an Institutional bill.** **This segment is the Institutional bill type submitted on the original claim.**	
	REF01	Reference Identification Qualifier	R	Valid values: 'BLT' Billing Type	Use 'BLT' Billing Type.
	REF02	Bill Type Identifier	R	Submitted in CLM05 of the 837 or form locator 4 of the UB92.	Use bill type submitted on original claim.
REF		**Medical Record Identification**	**S**	**Only use the segment if the subscriber is the patient.** **This is the medical record number on the original claim.**	**ValueOptions does not store the Medical Record number in their adjudication system.** **Do not send this segment.**
REF		**Group Number**	**S**	**This REF segment is used to identify the location of Application System Number believed to contain the claim being inquired upon.**	**The does not apply to ValueOptions.** **Do not send this segment.**
REF		**Claim Service Date**	**S**	**Required for Institutional claims. The date is the statement coverage from and to date.** **For professional claims this will be the claim from and through date. If claim level date range is not used then the line service date at loop 2210D is required.**	
	DTP03		R		ValueOptions expects the statement coveage dates for inquiry on an Institutional claim. For inquiry on a Professional claim, ValueOptions expects: FROM Date – earliest DOS on claim. TO Date – latest DOS on claim.

LOOP 2100E – DEPENDENT NAME					
NM1		**Dependent Name**	**R**	**Required when the patient is not the same entity as the subscriber.**	
	NM108	Identification Code Qualifier	S	Valid values: ‘MI’ Member Identification Number ‘ZZ’ Mutually Defined HIPAA Individual Identifier (once adopted)	Use ‘MI’ Member Identification Number.
	NM109	Patient Primary Identifier	S	Required if the dependent is assigned a unique identification number that is separate from the subscriber number.	Use the ValueOptions Member ID or Medicaid ID if applicable.
LOOP 2200E – CLAIM SUBMITTER TRACE NUMBER					
TRN		**Claim Submitter Trace Number**	**R**	**Required if the patient is someone other than the subscriber.** **The TRN segment is required by the ASC X12 syntax when loop ID 2200E is used.**	
	TRN01	Trace Type Code	R	Valid values: ‘1’ Current Transaction Trace Number	Use ‘1’ Current Transaction Trace Number.
	TRN02	Trace Number	R	This data element corresponds to the CLM01 Data element of the ASC X12N transaction. Paper based claims may not require the Patient Account Number for adjudication. When inquiring on paper based claims the trace number is required to be returned in the TRN of the 277 Health Care Claim Status Response transaction TRN02.	To inquire on claims submitted electronically, use Claim Submitter Identifier submitted on 837 professional and institutional transactions. To inquire on paper claims, use the Patient Account Number submitted in box 26 (HCFA) or form locator 3 (UB92).

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Payer Claims Identification Number**	**S**	**Use this segment only if the patient is someone other than the subscriber.** **The authors recommend sending this segment on claim inquiries when the information is known. It will providr a direct look up key into the payer's adjudication system.**	
	REF01	Reference Identification Qualifier	R	Valid Values: '1K' Payer's Claim Number	Use '1K' Payer's Claim Number.
	REF02	Payer Claim Control Number	R	Examples of this number include ICN, DCN, CCN. Submit this element if the payer supplied it previously.	Use ValueOptions claim number.
REF		**Institutional Bill Type Identification**	**S**	**Only use this segment if the dependent is the patient and the bill type is being sent in the inquiry request in connection with an institutional bill.** **This segment is the Institutional bill type submitted on the original claim.**	
	REF01	Reference Identification Qualifier	R	Valid Values: 'BLT' Billing Type	Use 'BLT' Billing Type
	REF02	Bill Type Identifier	R	Submitted in CLM05 of the 837 or form locator 4 of the UB92.	Usebill type submitted on claim.

Seg	Data Element	Name	Usage	Comments	Expected Value
REF		**Medical Record Identification**	**S**	**Use this segment only if the patient is someone other than the subscriber.** **This is the medical record number on the original claim.**	**ValueOptions does not store the Medical Record number in their adjudication system.** **Do not send this segment.**
AMT		**Claim Submitted Charges**	**S**	**Use this segment if the service line SVC segment, loop 2210E is not used.**	**ValueOptions expects the Total Claim Charges Amount to be submitted in this segment when the patient is not the Subscriber.**
	AMT02	Total Claim Charge Amount	R	This data element corresponds to CLM02 on the 837 Institutional and Professional transaction. On paper based claims this would be Box 28 (HCFA) or Revenue Code 0001 (UB92).	Use Total Claim Charge Amount.
AMT		**Claim Service Date**	**S**	**Required for Institutional claims. The date is the statement coverage from and through date.** **For professional claims this will be the claim from and through date. If claim level date range is not used, then the line service date at loop 2210D is required.**	
	DTP03	Claim Service Period Date	R		ValueOptions expects the statement coverage dates for inquiry on an Institutional Claim. For inquiry on a Professional claim, ValueOptions expects: FROM Date – earliest DOS on claim TO Date – latest DOS on claim.

277 HEALTH CARE CLAIM STATUS RESPONSE TRANSACTION SPECIFICATIONS

INTERCHANGE CONTROL TRAILER SPECIFICATIONS (277 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
				HEADER	
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: '00' No Authorization Information Present '03' Additional Data Identification	ValueOptions will use '00' No Authorization Information Present.
	ISA02	Authorization Information	R	Information used for additional identification or authorization.	ValueOptions will zero fill.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	ValueOptions will use '00' No Security Information Present.
	ISA04	Security Information	R	Additional security information identifying the sender.	ValueOptions will zero fill.
	ISA05	Interchange ID Qualifier	R		ValueOptions will use 'ZZ' Mutually Defined.
	ISA06	Interchange Sender ID	R		ValueOptions will use 'FHC &Affiliates'.
	ISA07	Interchange ID Qualifier	R		Valueoptions will use the Interchange ID Qualifier sent in the status request (ISA05).
	ISA08	Interchange Receiver ID	R		Valueoptions will use the Interchange Sender ID sent in the status request (ISA06).

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	ISA09	Interchange Date	R	Date format YYMMDD.	Creation Date.
	ISA10	Interchange Time	R	Time format HHMM.	Creation Time.
	ISA11	Interchange Control Standards Identifier	R	Code to identify the agency responsible for the control standard used by the message. Valid value: 'U' - U.S. EDI Community of ASC X12	ValueOptions will use 'U' U.S. EDI Community of ASC X12.
	ISA12	Interchange Control Version Number	R	Valid value: '00401' - Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997.	ValueOptions will use the current standard approved for the ISA/IEA envelope.
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	ValueOptions will use the Interchange Control Number specified by the sender in the status request (ISA13).
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' - No Acknowledgement Requested '1' - Interchange Acknowledgement Requested	ValueOptions will use '0' No Acknowledgement Requested.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	ValueOptions will use a 'P' Production.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	ValueOptions will use the default delimiters specified in the 276/277 Implementation Guide. See Delimiters Supported on page 5.

INTERCHANGE CONTROL TRAILER SPECIFICATIONS (277 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
			TRAILER		
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups	R	Count of the number of functional groups in the interchange.	This is the count of the GS/GE functional groups included in the interchange structure. ValueOptions will return the same number of functional groups in the 277-response transaction as was received in the 276-status request transaction.
	IEA02	Interchange Control Number	R	The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	ValueOptions will use the same value as the value in ISA13.

FUNCTIONAL GROUP HEADER SPECIFICATIONS (277 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
HEADER					
GS		**Functional Group Header**	**R**		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HN' Health Care Claim Status Notification (277)	ValueOptions will use 'HN' Health Care Claim Status Notification (277).
	GS02	Application Sender's Code	R		ValueOptions will use 'FHC &Affiliates'.
	GS03	Application Receiver's Code	R		ValueOptions will zero fill.
	GS04	Date	R	Date format CCYYMMDD.	Creation Date.
	GS05	Time	R	Time format HHMM.	Creation Time.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02. .	ValueOptions will generate a unique sequential number for each functional group in the ISA/IEA envelope.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' - Accredited Standards Committee X12	ValueOptions will use 'X' Accredited Standards Committee X12.
	GS08	Version/Release Industry ID Code	R	Valid value: Addenda Approved for Publication by ASC X12. '004010X093A1'	ValueOptions will use the current standard approved for publication by ASC X12.

FUNCTIONAL GROUP TRAILER SPECIFICATIONS (277 TRANSACTION)

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
			TRAILER		
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	This is the count of the ST/SE transaction sets included in the functional group. ValueOptions will return the same number of transaction sets, per functional group, in the 277response transaction as was received in the 276-status request transaction.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	ValueOptions will use the same value as the value in GS06.

277 HEALTH CARE CLAIM STATUS RESPONSE TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
HEADER					
BHT		**Beginning of Hierarchical Transaction**	**R**		
	BHT03	Originator Application Transaction Identifier	R	BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.	Currently, ValueOptions is defaulting this value to '01'. However, in the future a unique identifier may be assigned to this element.
LOOP 2100A – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM103	Payer Name	R	This element will be required until the National payer Identifier is active.	ValueOptions will use 'ValueOptions, Inc.'
	NM108	Identification Code Qualifier	R	Valid values: '21' Health Industry Number (HIN) 'AD' Blue Cross Blue Shield Association Plan Code 'FI' Federal Taxpayer's ID number 'NI' National Association of Insurance Commissioners (NAIC) Identification 'PI' Payer Identification 'PP' Pharmacy Processor Number 'XV' Health Care Financing Administration National PlanID (Required if mandated)	ValueOptions will use 'PI' Payer Identification.
	NM109	Payer Identifier	R	For Medicare ValueOptions will use, this is the carrier/fiscal intermediary-assigned code.	ValueOptions will use 'FHC &Affiliates'.
LOOP 2100C- PROVIDER NAME					
NM1		**Provider Name**	**R**		
	NM108	Identification Code Qualifier	R	Valid values: 'FI' Federal Taxpayer's ID number 'SV' Service Provider Number When the provider does not have a National Provider ID and Payer has assigned a specific ID number to this provider this code is required. 'XX' Health Care Financing Administration National Provider ID (Required if mandated)	ValueOptions will use the Provider Identifier Qualifier received in the 276-status request transaction.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	NM109	Provider Identifier	R		ValueOptions will use the Provider Identifier received in the 276-status request transaction.
		LOOP 2100D - SUBSCRIBER NAME			
NM1		**Subscriber Name**	**R**		
	NM103	Subscriber Last Name	R		ValueOptions will use the Subscriber's Last Name from their Eligibility file. The value, if present, from the 276 request will be returned on rejection responses.
	NM104	Subscriber First Name	S	Required when value in NM102 is '1' and person has a first name.	ValueOptions will use the Subscriber's First Name from their Eligibility file. The value, if present, from the 276-status request will be returned on rejection responses.
	NM105	Subscriber Middle Name	S	Required when value in NM102 is '1' and person has a middle name.	ValueOptions will use the Subscriber's Middle Name from their Eligibility file. The value, if present, from the 276-status request will be returned on rejection responses.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	NM108	Identification Code Qualifier	R	Valid values: '24' Employer's Identification Number 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	ValueOptions will use 'MI' Member Identification Number.
	NM109	Subscriber Identifier	R		ValueOptions will use the Member Number received in the 276-status request transaction.
LOOP 2200D – CLAIM SUBMITTER TRACE NUMBER					
TRN		**Claim Submitter Trace Number**	**R**	**This segment is required if the subscriber is the patient. If the subscriber is not the patient do not use this segment, use TRN segment in Loop 2200E.** **The TRN segment is required by the ASC X12 syntax when loop ID 2200D is used.**	
	TRN01	Trace Type Code	R	Valid values: '1' Current Transaction Trace Number	ValueOptions will use '1' Current Transaction Trace Number.
	TRN02	Trace Number	R	This trace number is the trace or reference number from the originator of the transaction that was provided at the corresponding level within the 276 Health Care Claim Status Request transaction.	ValueOptions will use the Trace Number received in the 276-Status Request transaction.
STC		**Claim Level Status Information**	**R**	**Required if the Subscriber is the patient**	**The following elements will be valued if the claim has been paid.**
	STC05	Payment Method Code	**S**	Valid values: 'ACH' Automated Clearing House (ACH) 'BOP' Financial Institution Option 'CHK' Check 'FWT' Federal Reserve Funds/Wire Transfer 'NON' Non-Payment Data	ValueOptions will use 'CHK' Check.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	STC08	Date	S	Use this element for the check issue date or for the date that EFT funds were released to the ACH.	ValueOptions will use the Check Issue Date.
	STC09	Check Number	S	Required with a finalized and paid claim.	ValueOptions will use the ValueOptions Check Number.
REF		**Payer Claim Identification Number**	**S**	**Only use this segment if the subscriber is the patient.**	
	REF01	Reference Identification Qualifier	R	Valid values: '1K' Payer's Claim Number	ValueOptions will use '1K' Payer's Claim Number.
	REF02	Payer Claim Control Number	R	Examples of this number include ICN, DCN, CCN. Submit this element if the payer supplied it previously.	ValueOptions will use the claim number received in the 276-Status Request transaction, if present. Otherwise, if the claim number was not sent as an identification parameter but the claim has been adjudicated, ValueOptions will return the claim number from the adjudication system.
REF		**Institutional Bill Type Identification**	**S**	**Only use this segment if the subscriber is the patient and this is an Institutional claim.** **This segment is the Institutional bill type submitted on the original claim.**	

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	REF01	Reference Identification Qualifier	R	Valid values: 'BLT' Billing Type	ValueOptions will use 'BLT' Billing Type.
	REF02	Bill Type Identifier	R	Submitted in CLM05 of the 837 or form locator 4 of the UB92.	ValueOptions will use bill type received in the 276-Status Request transaction, if present.
REF		**Medical Record Identification**	**S**	**Only use this segment if the subscriber is the patient.** **This is the medical record number on the original claim.**	**ValueOptions does not store the Medical Record number in their adjudication system.** **This segment will not be sent.**
DTP		**Claim Service Date**	**S**	**Required for Institutional claims. The date is the statement coverage from and through date.** **For professional claims this will be the claim from and through date. If claim level date range is not used than the line service date at loop 2210D is required.**	
	DTP03	Claim Service Period Date	R		ValueOptions will use the claim dates received in the 276-Status Request transaction.
LOOP 2100E – DEPENDENT NAME					
NM1		**Dependent Name**	**R**	**Required when the patient is not the same entity as the subscriber.**	

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	NM103	Dependent Last Name	R		ValueOptions will use the Dependent's Last Name from their Eligibility file. The value, if present, from the 276-status request will be returned on rejection responses.
	NM104	Dependent First Name	S	Required when value in NM102 is '1' and person has a first name.	ValueOptions will use the Dependent's First Name from their Eligibility file. The value, if present, from the 276-status request will be returned on rejection responses.
	NM105	Dependent Middle Name	S	Required when value in NM102 is '1' and person has a middle name.	ValueOptions will use the Dependent's Middle Name from their Eligibility file. The value, if present, from the 276-status request will be returned on rejection responses.
	NM108	Identification Code Qualifier	S	Valid values: 'MI' Member Identification Number 'ZZ' Mutually Defined HIPAA Individual Identifier (once adopted)	ValueOptions will use 'MI' Member Identification Number.
	NM109	Patient Primary Identifier	S	Required if the dependent is assigned a unique identification number that is separate from the subscriber number.	ValueOptions will use the Member Number received in the 276-status request transaction

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
LOOP 2200E – CLAIM SUBMITTER TRACE NUMBER					
TRN		**Claim Submitter Trace Number**	**R**	**Required if the patient is someone other than the subscriber.** **The TRN segment is required by the ASC X12 syntax when loop ID 2200E is used.**	
	TRN01	Trace Type Code	R	Valid values: ‘1’ Current Transaction Trace Number	ValueOptions will use ‘1’ Current Transaction Trace Number.
	TRN02	Trace Number	R	This trace number is the trace or reference number from the originator of the transaction that was provided at the corresponding level within the 276 Health Care Claim Status Request transaction.	ValueOptions will use the Trace Number received in the 276-Status Request transaction.
STC		**Claim Level Status Information**	**R**	**Use if the patient is someone other than the Subscriber.**	**The following elements will be valued if the claim has been paid.**
	STC07	Payment Method Code	S	Valid values: ‘ACH’ Automated Clearing House (ACH) “BOP’ Financial Institution Option ‘CHK’ Check ‘FWT’ Federal Reserve Funds/Wire Transfer ‘NON’ Non-Payment Data	ValueOptions will use ‘CHK’ Check.
	STC08	Date	S	Use this element for the check issue date or for the date that EFT funds were released to the ACH.	ValueOptions will use the Check Issue Date.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
	STC09	Check Number	S	Required with a finalized and paid claim.	ValueOptions will use the ValueOptions Check Number.
REF		**Payer Claim Identification Number**	**S**	**Use this segment only if the patient is someone other than the subscriber.**	
	REF01	Reference Identification Qualifier	R	Valid values: '1K' Payer's Claim Number	ValueOptions will use '1K' Payer's Claim Number.
	REF02	Payer Claim Control Number	R	Examples of this number include ICN, DCN, CCN. Submit this element if the payer supplied it previously.	ValueOptions will use the claim number received in the 276-Status Request transaction, if present. Otherwise, if the claim number was not sent as an identification parameter but the claim has been adjudicated, ValueOptions will return the claim number from the adjudication system.
REF		**Institutional Bill Type Identification**	**S**	**Only use this segment if the dependent is the patient and this is an Institutional claim.** **This segment is the Institutional bill type submitted on the original claim.**	
	REF01	Reference Identification Qualifier	R	Valid values: 'BLT' Billing Type	ValueOptions will use 'BLT' Billing Type.
	REF02	Bill Type Identifier	R	Submitted in CLM05 of the 837 or form locator 4 of the UB92.	ValueOptions will use bill type received in the 276-Status Request transaction, if present.

Seg	Data Element	Name	Usage	Comments	ValueOptions 277 Implementation
REF		**Medical Record Identification**	**S**	**Use this segment only if the patient is someone other than the subscriber.** **This is the medical record number on the original claim.**	**ValueOptions does not store the Medical Record number in their adjudication system.** **This segment will not be sent.**
DTP		**Claim Service Date**	**S**	**Required for Institutional claims. The date is the statement coverage from and through date.** **For professional claims this will be the claim from and through date. If claim level date range is not used than the line service date at loop 2210D is required.**	
	DTP03	Claim Service Period Date	R		ValueOptions will use the claim dates received in the 276-Status Request transaction.