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Electronically Requesting and Receiving Information Regarding Claims Using the ASC X12N276/277 Claims Status Inquiry/Response Transactions

Note: This article was updated on February 26, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and intermediaries.

Provider Action Needed



STOP – Impact to You

This special edition discusses how health care providers may want to implement the ASC X12N 276/277 Claims Status Inquiry/Response Transactions and benefit by being able to request and receive the status of claims **in one standard format, for all health care plans.**



CAUTION – What You Need to Know

Implementing the ASC X12N 276/277 would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.



GO – What You Need to Do

Providers who implement the ASC X12N 276/277 may create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

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Background

Even though there has been a significant increase in the number of providers who use electronic health care transactions, providers have faced the burden of sending information to various health plans in multiple formats. Even when different plans accept information in similar formats, they frequently have additional requirements that further complicate efficient information interchange.

Consequently, providers have been burdened with additional administrative work in order to electronically process healthcare transactions (including claims status requests and responses). This has increased the costs and decreased the efficiency of processing claims status requests and responses.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes administrative simplification provisions meant to reduce and simplify the administrative demands faced by healthcare providers. HIPAA:

- Directed the Federal government to adopt national standards for the transfer of certain health care data; and
- Requires all payers to use national standard transaction formats and code sets, such as the health care claims status category codes and the health care claim status codes issued by the Claim Adjustment Status Code Maintenance Committee.

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claim status codes for use with:

- The Health Care Claim Status Request (ASC X12N 276); and
- The Health Care Claim Response (ASC X12N 277).

The ASC X12N 276 (Claims Status Inquiry Transaction) is used to transmit request(s) for status of specific health care claim(s), and the ASC X12N 277 (Claims Status Response Transaction) can be used for any of the following:

- As a response to a health care claim status request (276);
- As a notification about health care claim(s) status, including front end acknowledgments; and
- As a request for additional information about a health care claim(s).

Most health care providers who are currently using an electronic format and who wish to request claim status electronically using the ASC X12N 276/277 may incur some conversion costs.

However, after implementation, providers will benefit by being able to request and receive the status of claims **in one standard format, from all health care plans**. This would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software; and
- Send and review claim status requests and responses manually.

It is possible that providers who implement the ASC X12N 276/277 can create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

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It's time to start using this transaction.

Medicare can accept transmission of the ASC X12N 276 (your electronic request on the status of a previously submitted claim) and respond with an ASC X12N 277 (our electronic answer back to you).

Currently, CMS sends out over 10,000 responses (277s) per month, and you too can benefit from this process. It could help you reduce the time required to follow up with Medicare as well as with any payer from 20 minutes to a few seconds.

Additional Information

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard), can be reviewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the Centers for Medicare & Medicaid Services (CMS) website.

The X12 276/277 Version 4010A1 Implementation Guide, as well as the claim status codes and category codes, may be downloaded without charge at <http://www.wpc-edi.com/hipaa>.

If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at <http://www.cms.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf> on the CMS website.

If you bill for Medicare Part B services, that number may be found at <http://www.cms.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf> on the CMS website.

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