KY Medicaid

277 Health Care Payer Unsolicited Claim Status Companion Guide

Cabinet for Health and Family Services
Department for Medicaid Services

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Document Change Log

Version	Changed Date	Changed By	Reason
1.0	10/19/2011	HPES	DMS approved version.
2.0	05/31/2012	HPES	Revised description on Page 11 for TRN02 and TRN04 to note that NCPDP submitted claims, the 277U will return the original MCO Internal Control Number.
3.0	6/15/2012	Kathy Dugan	Revised BHT03 Comments to include new indicator for a failed 5% threshold 'F' or for accepted 5% threshold 'A'. Also included Trading Partner which is sent but not in CG on Page 8.
4.0	7/9/2014	Martha Senn	Rewritten to conform to the ACA required template and ASCX12 authorization guidelines.
4.1	2/24/2015	Martha Senn	Updates for ASCX12 authorization guidelines. ASCX12 approved on 2/27/2015.

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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

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

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading 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 specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guide for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
003070X070	Health Care Payer Unsolicited Claim Status (277U)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent "segments" in the X12N implementation guide.
NON-SHADED rows represent "data elements" in the X12N implementation guide.

003070X070 Health Care Payer Unsolicited Claim Status

4 Companion Guide for the 277U Transaction

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Transaction Structure		
	BHT06	Transaction Type Code	'NO'	Notice
2100A	NM1	Payer Name		
2100A	NM103	Name Last or Organization Name	'KYMEDICAID'	
2100A	NM108	Identification Code	'PI'	Payor Identification
2100A	NM109	Identification Code	'KYMEDICAID'	
2100A	N3	Payer Street Address		
2100A	N301	Address Information	'275 E. MAIN STREET '6W- C	Department for Medicaid Service street
2100A	N4	Payer City/State/Zip		
2100A	N4	City Name	'Frankfort'	
2100A	N4	State or Province Doe	'KY'	
2100A	N4	Postal Code	'40601'	
2100B	NM1	Information Receiver Name		

Loop ID	Reference	Name	Codes	Notes/Comments
2100B	NM108	Identification Code Qualifier	'46'	Electronic Transmitter Identification (ETIN)
2100B	NM109	Identification Code	'Trading Partner ID'	The 10 digit trading partner id assigned by KY Medicaid
2100C	NM1	Provider Information		
2100C	NM109	Identification Code		8 or 10 digit KY Medicaid Provider Number (atypical only) or NPI
2100D	NM1	Subscriber Name		
2100D	NM108	Identification Code Qualifier	'MR'	Medicaid Member Identification Number
2100D	NM109	Identification Code		The 10 digit KY Medicaid Member ID
2200D	TRN	Claim Submitter's Identifier		
2200D	TRN04	Reference Identification	'MC'	Medicaid
2200D	REF	Payer's Claim Control Number		
2200D	REF02	Reference Identification		13-digit ICN assigned by KY Medicaid for this claim.
2200D	SVC	Service Line Information		
2200D	SVC01-1	Product/Service ID Qualifier	'ND', 'AD', 'NU', 'HC'	-Nation Drug Code -American Dental Associates Code -National Health Related Item Codes - Health Care Financing Administration Common Procedural Coding System
2100E	NM1	Patience Name		
2100E	NM103	Name Last or Organization Name		Member last name as stored on KY Medicaid file. If member is not found on file, the value will be the member last name from the claim form.
2100E	NM104	Name First		Member first name as stored on KY Medicaid file. If the member is not found on file, the value will be the member first name from the claim form

2100E	NM108	Identification Code	'MR'	Medicaid member identification number
2100E	NM109	Identification Code		10 digit MAID number assigned by KY Medicaid
2200E	TRN	Claim Submitter's Identifier		
2200E	TRN04	Reference Identification	'MC'	Medicaid
2200E	STC	Claim Line Status Information		
2200E	STC03	Action Code	NA	No Action Required
2220E	STC	Service Line Status Information		
2220E	STC04	Monetary amount		This amount will be returned by KY Medicaid

1.3 Minimum Mandated Processing Requirements

The business purpose described herein is not a HIPAA-mandated business purpose and thus is agreed upon between willing trading partners. The Agency for Health Care Administration requirements are as follows:

1. Information Source Identifier (77027);
2. Information Receiver Identifier (Trading Partner as assigned by the HP EDI area);
3. Service Provider Identifier (NPI or Medicaid Provider ID);
4. Beneficiary Identifier (Recipient Number);
5. Claim Dates of Service (Header and/or Detail); and
6. Header Claim Submitted Charges.

The claim status segment is required at the header of the claim. Therefore, a header status will always be given. Within the status segment, there are certain minimum requirements.

1. The status data element defined in the 277 Transaction Set is a composite data structure that consists of three difference data elements. It is repeated a total of three times within the STC segment. Each status data element consists of the following three data elements:
   a. Health Care Claim Status Category Code – The overall category for where the claim currently is in processing (e.g., P2 – Pending/In Process – The Claim is suspended pending review);
   b. Health Care Claim Status Code – Detailed information as to the reason the claim being in the category defined in the category code (e.g., 450 – Awaiting spend down determination);
   c. Entity Identifier – The identity of the entity from which additional information about the claim has been requested if the claim is pended for additional information (e.g., QC – Patient);
2. The status effective date is always sent within this segment at the Claim Header level. This will consist of the last date that the claim adjudicated in the system;
3. The Action Code is always sent at the Claim Header level. This directs the receiver of the transaction as to what actions are required on their part;
4. The claim header submitted charge is always sent at the Claim Header level; and,
5. A free-form text area is available for specific messages related to the Health Care Claim Status Code 448. The code 448 is not currently utilized, thus STC12 will not be populated.