HIPAA Transaction Companion Guide: Health Care Claim Status Request and Response

Refers to the Implementation Guide Based on
ASC X12N/005010X212
Health Care Claim Status Request and Response (276/277)

Version 5.1
January 2024

Preface

This companion guide (CG) to the Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare Insurance Company ("UnitedHealthcare"). Transactions based on this companion guide, used in tandem with the TR3, also called 276/277 Health Care Claim Status Request and Response ASC X12N (005010X212), are compliant with both X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the TR3 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 TR3.

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1. INTRODUCTION

This is a companion guide to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Health Care Claim Status Request and Response 276/277 (005010X212). This document provides information to explain the data content used in electronic claim status transactions for AARP Supplemental Plans from UnitedHealthcare Insurance Company ("UnitedHealthcare") and is a supplement to the ASC X12 Technical Report Type 3 ("TR3").

Within this document, the Health Care Claim Status Request and Response ASC X12N 276 and 277 may be detailed with the use of tables. When used, the tables contain a row for each segment for which UnitedHealthcare explains codes and usage specific to transactions for AARP Supplemental Plans, information over and above the information in the TR3. That information can do the following:
1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Provide any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

The following table is an example of the use of a table to explain eligibility and benefit response information specific to AARP Supplemental Plans.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
254	**2100D**	**NM1**	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. Notes or comment about the segment itself will be found here.
257	2100D	NM109	Subscriber Identifier		**11**	This type of row exists to limit the length of the specified data element. For example, no more than 11 characters are used for the insured member's member identification number in NM109.
294	**2100D**	**NM1**	**Subscriber Name**			
303	2100D	EB04	Identification Code Qualifier	**MI**		This type of row calls attention to the element identifier codes used. For example, MI should be used in the 276 request and will be returned in the 277 response to designate the Member Identification Number.

1.1 SCOPE

This document is intended to supplement the ASC X12 Standard for Electronic Data Interchange Technical Report Type 3 Health Care Claim Status Request and Response 276/277 (005010X212), in the electronic exchange of claim status information with UnitedHealthcare for people who have AARP Supplemental Plan coverage. This "companion guide" is not intended to replace, or exceed the data requirements specified in, the TR3.

1.2. OVERVIEW

This companion guide will replace, in total, the previous version of the AARP Medicare Supplemental Insurance Plans from UnitedHealthcare Insurance Company Companion Guide for Health Care Claim Status Request and Response transactions and must be used in conjunction with the TR3 instructions. This companion guide is intended to assist you in implementing and conducting claim status inquiries that meet UnitedHealthcare processing standards by identifying pertinent structural and data-related requirements and recommendations.

Updates to this companion guide will be available at UHCprovider.com, and can be accessed at https://www.UHCprovider.com. On the home page, click the "Menu" at the top left, and select "Resource Library," then "Electronic Data Interchange" in the menu on the left or midway down the page. In the menu on the left select "EDI Companion Guides," and then "276/277: Claim Status Inquiry and Response," and "276/277: AARP Supplemental Plans (005010X212)."

1.3. REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 276/277 Health Care Claim Status Request and Response (005010X212) and to purchase copies of these documents, consult the Washington Publishing Company web site at http://store.x12.org.

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ASC X12 standards are recognized by the United States as the standards for North America. Electronic Data Interchange (EDI) adoption has been proven to reduce the administrative burden on providers.

2. GETTING STARTED

2.1. WORKING WITH UNITEDHEALTHCARE

UnitedHealthcare currently uses Optum Clearinghouse Services ("Optum Clearinghouse") as the exclusive clearinghouse for managing Health Care Claim Status Request and Response (276/277) transaction connections for AARP Supplemental Plans. If your current clearinghouse is not a trading partner with UnitedHealthcare, please contact your clearinghouse vendor regarding their ability to work with Optum Clearinghouse for the 276/277 transactions.

If you have an Optum Clearinghouse account, please contact your Optum Clearinghouse account manager. If you do not have an Optum Clearinghouse account manager and are interested in learning about Optum Clearinghouse services, please visit www.UHCprovider.com/ediconnect for more information.

2.2. TRADING PARTNER REGISTRATION

Optum Clearinghouse currently manages the Health Care Claim Status Request and Response transaction connectivity for AARP Supplemental Plans from UnitedHealthcare. Before exchanging claim status information for members with AARP Supplemental Plans with UnitedHealthcare, you must register with Optum Clearinghouse. For information regarding trading partner registration with Optum Clearinghouse, please visit www.UHCprovider.com/ediconnect for more information.

2.3. CERTIFICATION AND TESTING OVERVIEW

UnitedHealthcare Insurance Company is CORE Phase I and Phase II certified.

For information regarding 276/277 transaction testing for AARP Supplemental Plans, please contact your current clearinghouse vendor or Optum Clearinghouse account manager.

3. TESTING WITH THE UNITEDHEALTHCARE

Physicians and Healthcare professionals should contact their current clearinghouse vendor regarding testing of the 276/277 transactions for AARP Supplemental Plans with Optum Clearinghouse.

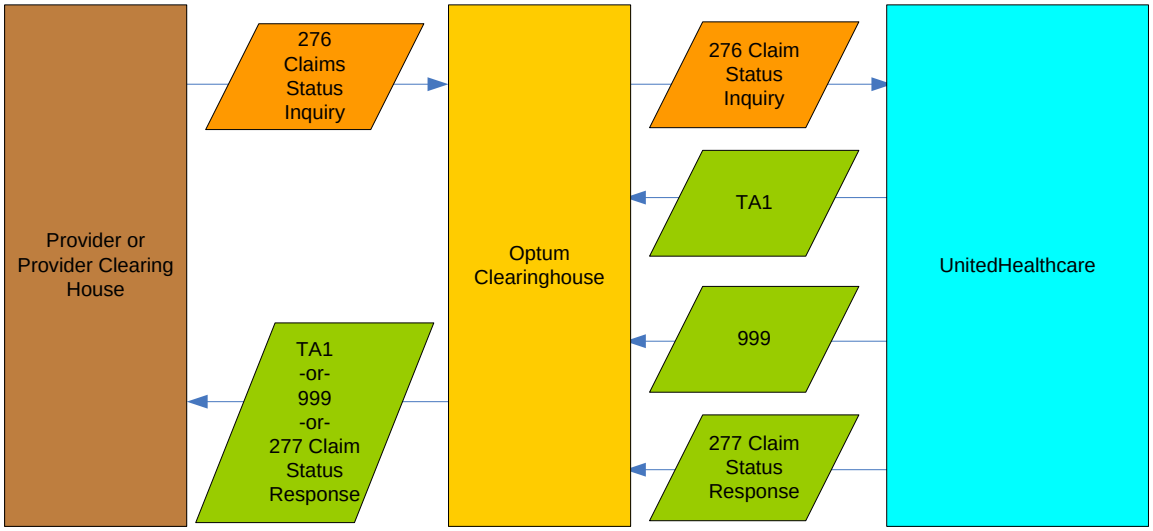
4. CONNECTIVITY WITH UNITED HEALTHCARE / COMMUNICATIONS

4.1. PROCESS FLOWS

Real-time Claim Status Request and Response:

The response to a real-time claim status inquiry transaction will consist of one of the following:

1. First level response – a TA1 will be generated if errors occur within the envelope.
2. Second level response – 276 transactions which fail compliance checks will generate a real-time 999 message back to the sender with an error message indicating the nature of the compliance error.
3. Third level response:
   - Transactions that pass compliance checks, but fail to process (e.g. due to member not being found) will generate real-time 277 response transactions including an STC segment indicating the nature of the error.
   - Transactions which pass compliance checks and do not have errors will return 277 transactions with STC segments indicating the status of the claims.



4.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

Only real-time mode is supported for AARP Supplemental Plans from UnitedHealthcare Insurance Company, payer ID 36273.

4.3 RE-TRANSMISSION PROCEDURE

Please review the instructions within the 277 STC segment for information on what data corrections need to be made to resubmit a successful request and receive the requested information in response.

4.4 COMMUNICATION PROTOCOL SPECIFICATIONS

Physicians and healthcare providers are advised to contact their current clearinghouse vendor to discuss communication protocol specifications. The provider's clearinghouse may work with Optum Clearinghouse to address questions regarding communication protocols.

4.5 PASSWORDS

Physicians and healthcare providers are advised to contact their current clearinghouse vendor to discuss password policies.

Questions about Optum Clearinghouse passwords must be directed to Optum Clearinghouse.

4.6 SYSTEM AVAILABILITY

Optum Clearinghouse provides information regarding downtime for their regularly-scheduled maintenance on the Optum EDI Client Center page at https://www.Optum.com. During these maintenance outages, Optum Clearinghouse will be unavailable for claim status inquiry and response transactions.

Optum Clearinghouse also provides information to their EDI clients regarding UnitedHealthcare system availability when planned outages are scheduled to occur. During UnitedHealthcare system downtime, health care claim status inquiry and response transactions may be impacted or unavailable.

4.7 COSTS TO CONNECT

Healthcare trading partners who use Optum Clearinghouse incur no transaction costs. Healthcare professionals who use other clearinghouses should contact their clearinghouse vendor to discuss costs.

5. CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE

If you have questions related to transactions submitted through a clearinghouse, please contact your clearinghouse vendor.

If you have an Optum Clearinghouse account, please contact your Optum Clearinghouse account manager with questions related to health care claim status inquiry and response transactions.

5.2 EDI TECHNICAL ASSISTANCE

Clearinghouse

- When receiving the 277 from a clearinghouse, please contact the clearinghouse for EDI technical assistance.

UnitedHealthcare EDI Issue Reporting

- Report EDI issues online by using the "EDI Transaction Support Form" at https://www.UHCprovider.com. Click "Resource Library," "Electronic Data Interchange," and "EDI Contacts" to access the "EDI Transaction Support Form."

5.3 PROVIDER SERVICES NUMBER

If you have questions regarding the details of a member's AARP Supplemental Plan coverage or claim status information, please call 800-227-7789 to speak with a Provider Services specialist.

5.4. APPLICABLE WEBSITES

- **CAQH CORE** – http://www.caqh.org, provides access to the Council for Affordable Quality Healthcare ("CAQH") Committee on Operating Rules for Information Exchange ("CORE") website
- The provider portal for AARP Supplemental Plans from UnitedHealthcare Insurance Company is accessible at http://aarpprovideronlinetool.uhc.com and provides a robust website with many features for providers. Providers can do the following on the website:
  - Check Claim Status and Member Eligibility
  - View Check and Electronic Deposit details
  - View, Download and print EOB's.
- **Optum Clearinghouse Services** – https:/optum360.com, provides information regarding Optum Clearinghouse services
- **ASCX12** – http://store.x12.org provides access to ASCX12 electronic data interchange products
- **UHCprovider.com -** Updates to this companion guide will be available at UHCprovider.com, and can be accessed at https://www.UHCprovider.com, by clicking "Resource Library" from the drop-down menu, then "Electronic Data Interchange," "EDI Companion Guides," "276/277: Claim Status Inquiry and Response," and "276/277: AARP Supplemental Plans (005010X212)."

6. CONTROL SEGMENTS / ENVELOPES

6.1 ISA-IEA

Transactions transmitted during a session are identified by an interchange header segment (ISA) and by an interchange trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission and provides sender and receiver identification.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled with spaces.

- The first element separator (byte 4) in the ISA segment defines the data element separator to be used through the entire interchange (*).

- ISA-11 defines the repetition separator used throughout the transaction (^).
- The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange (~).
- ISA16 defines the component-element separator to be used throughout the transaction (:).

The table below identifies the ISA field for which UnitedHealthcare requires a specific value to appropriately indicate that the inquiry is for a patient's AARP Supplemental Plans from UnitedHealthcare. The table does not describe all of the fields necessary for a successful transaction. Please refer to the TR3 for that information.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
C.3	**None**	**ISA**	**ISA Interchange Control Header**			
C.5		ISA08	Interchange Receiver ID	**36273 or 362739571**		Electronic Payer ID for AARP Supplemental Plans from UnitedHealthcare -Right pad as needed with spaces to 15 characters.

Please refer to the Technical Report Type 3 ("TR3") for Claim Status Inquiry and Response (276/277) transactions for detailed information regarding the interchange control header (ISA) and interchange control trailer (IEA) segments.

6.2. GS-GE

UnitedHealthcare conforms to the rules for element usage detailed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 ("TR3") for Health Care Claim Status Request and Response (276/277) transactions. Please refer to the TR3 for the appropriate functional group header (GS) and functional group trailer (GE) field values for the claim status inquiry and response transactions.

The table below references only those GS fields for which UnitedHealthcare requires a specific value for inquiries regarding AARP Supplemental Plans, or for which additional guidance is provided regarding what the value should be in the 276 request. The table does not describe all of the fields necessary for a successful transaction. Please refer to the TR3 for that information.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**			
C.7		GS03	Application Receiver's Code	**36273 or 362739571**		Electronic Payer ID Code for AARP Supplemental Plans from UnitedHealthcare
C.8		GS08	Version/ Release/ Industry Identifier Code	**005010X212**		Version of the EDI standard expected for the transaction to be received by UnitedHealthcare.

6.3. ST-SE

UnitedHealthcare conforms to the rules for element usage detailed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 ("TR3") for Health Care Claim Status Request

and Response (276/277) transactions. Please refer to the TR3 for the appropriate transaction set header (ST) and transaction set trailer (SE) field values for the claim status inquiry and response transactions.

6.4 CONTROL SEGMENT HIERARCHY

Real time claim status requests (276 transactions) will contain only one inquiry using the following hierarchy:

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header segment
276 Transaction
SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1. 276 REQUEST

1. Individuals who have coverage under AARP Supplemental Plans from UnitedHealthcare are considered insured members and should be identified in “Subscriber Name,” loop ID 2100D of the claim status inquiry transaction.

2. The member’s last name, date of birth, date type, and 11 digits of the membership ID are required on the 276 health care claim status request.

3. The member’s first name is optional but may facilitate the search and response.

4. If the claim number is submitted in the 276 request, dates of service, if included, will not be used in the search.

5. Providers may submit a range of dates in the 276 inquiry rather than using a claim number; however, if there are more than 50 claims in the insured member’s account within that date range for the provider designated in the inquiry by TIN or NPI, the search will need to be refined. It is recommended that the range of dates submitted in the 276 inquiry be limited to enable a more effective search and response.

6. The total submitted charge for the claim may be submitted with the dates of service; this information may help to further refine the search. Please note the following:

   - The “total submitted charge” refers to the billed amount.
   - The expected benefit payment, which, in many cases is the Medicare co-insurance amount, should not be submitted as the “total submitted charge.”
   - If the “total submitted charge” from the 276 request does not match the total submitted charge on a claim in the database, that claim will not be returned in the response even if the dates of service match.

7. Future dates of service cannot be submitted in the 276 request.

8. Dates of service more than 18 months in the past cannot be submitted in the 276 request.

7.2. 277 RESPONSE

UnitedHealthcare conforms to the rules for element usage detailed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 ("TR3") for Health Care Claim Status Request and Response (276/277) transactions. Please refer to the TR3 for information regarding the 277 claim status response transactions.

8. ACKNOWLEDGEMENTS AND OR REPORTS

8.1. REPORT INVENTORY

None identified at this time.

9. TRADING PARTNER AGREEMENTS

9.1 TRADING PARTNERS

Trading partner agreements define and document the relationship between electronic data interchange trading partners, which, for the purpose of this document, are defined as any party (health care provider, billing service, software vendor, financial institution, etc.) that transmits EDI data directly to, and receives EDI data directly from, UnitedHealthcare.

UnitedHealthcare is not currently establishing direct connections with healthcare providers for the purpose of exchanging electronic data for members who have AARP Supplemental Plans. Rather, UnitedHealthcare exchanges electronic data with providers through Optum Clearinghouse. Therefore, providers and their clearinghouses will not have trading partner agreements with UnitedHealthcare specifically for electronic data exchange for their patients who have AARP Supplemental Plans. However, providers or their clearinghouses may need to establish trading partner agreements with Optum Clearinghouse. For information regarding trading partner registration with Optum Clearinghouse, please visit www.UHCprovider.com/ediconnect for more information.

10. TRANSACTION SPECIFIC INFORMATION

10.1 CLAIM STATUS REQUEST 276 (005010X212)

Please specify payer ID #36273 as the identification code (NM109) for the information source, and provide the following when submitting claim status inquiries for patients with AARP Supplemental Plans from UnitedHealthcare:

- Provider's TIN or NPI
- Member's first name, date of birth, and 11 digits of the member ID. (The patient's membership identification number can be found on the AARP Supplemental Health Plan Insurance ID card issued by UnitedHealthcare.)
- Dates of service. (However, if claim number is submitted, dates will not be used to search.)

10.2 CLAIM STATUS RESPONSE 277 (005010X212)

Claim status responses for patients with AARP Supplemental Plans from UnitedHealthcare conform to the ASC X12 Standards for Electronic Interchange Technical Report Type 3 Health Care Claim Status Request and Response 276/277 (005010X212). Please refer to the TR3 for details about the claim status information returned in the 277 claim status response transactions.

11. APPENDICES

11.1. IMPLEMENTATION CHECKLIST

A basic checklist for establishing claim status inquiry and response transaction capability is as follows:

1. Register and complete any necessary contract with Trading Partner
2. Establish connectivity
3. Send test transactions
4. If testing succeeds, proceed to send production transactions

11.2. BUSINESS and TRANSMISSION SCENARIOS

Various business and transmission scenarios may be found in the ASC X12 Standard for Electronic Data Interchange Technical Report Type 3 Health Care Claim Status Request and Response (276/277). A copy of the Technical Report Type 3 may be obtained from ASC X12 at http://store.x12.org.

11.3. FREQUENTLY ASKED QUESTIONS

1. ***Does this Companion Guide apply to all UnitedHealthcare payers?***
   No. This guide will apply only to business for AARP Supplemental Plans from UnitedHealthcare Insurance Company using Payer ID 36273.

2. ***If a 276 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?***
   No. UnitedHealthcare will always send a response. Even if UnitedHealthcare's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

11.4 CHANGE SUMMARY

Version	*Release Date*	*Changes*
1.0	**December 2011**	Initial External Release – Changes to comply with HIPAA 5010.
2.0	**April 2016**	Contact information updated and unnecessary text removed
2.1	**July 2016**	Replaced references to “AAA segments” with “STC segments” for error situations and follow-up inquiries
3.0	**November 2019**	Updated to address enhancements to 276/277 transaction process for AARP Supplemental Health Plans
3.1	**November 2019**	Updated website reference
4.0	**September 2021**	Updated reference to payer name Added bullet points in section 7.1, Item #6, regarding “total submitted charge”
4.1	**January 2022**	Updated contact information for Optum Clearinghouse
5.1	**January 2024**	Removed repeated word in Section 2.1