
Provider eSolutions Companion Guide Series

276/277 Claim Status Inquiry

Companion Guide

For Clearinghouses and Providers Connecting
Directly or Indirectly to Aetna

**Refers to the X12N Implementation Guide
004010X093A1: 276/277 Health Care Claim
Status Request & Response**

Companion Guide Version Number: 1.1

June 2007



Preface

The **Provider eSolutions Companion Guide Series** clarifies and specifies the data format and content being requested when data is transmitted electronically to Aetna. For HIPAA-mandated provider transactions, the Companion Guides are based on the X12N Implementation Guides adopted under HIPAA.



Provider eSolutions Companion Guide Series

This is the 276/277 Claim Status Inquiry Companion Guide from the Provider eServices Companion Guide Series. It follows the WEDI/CAQH “best practices” template for describing a payer’s implementation of a HIPAA-mandated transaction.

The Aetna Service Options for Health Care ProfessionalsSM Companion Guide Series is designed to include all of the information needed by Aetna’s trading partners¹ to process HIPAA transactions with Aetna. Much of that information, such as Aetna-specific business rules and limitations, applies to any covered entity wishing to process transactions with Aetna, whether connected directly or indirectly. Other information, such as communication protocol specifications and control segments / envelopes, applies only to directly-connected trading partners.

Providers and clearinghouses connected indirectly to Aetna through a third party clearinghouse should contact that party for their companion guide documentation.

Information	Directly-Connected Trading Partners	Indirectly-Connected Providers and Clearinghouses
Connectivity options, communication protocol specifications, interchange control envelope, implementation plans	Vendor Account Manager will provide specific documentation	These entities should ask the clearinghouse with whom they are directly connected for that clearinghouse’s documentation
For each provider transaction, functional group envelope, implementation plans	Provider eSolutions Business Requirement Series - [Transaction] General Instructions	These entities should ask the clearinghouse with whom they are directly connected for that clearinghouse’s documentation
For each HIPAA-mandated provider transaction, clarification of Aetna’s usage of the HIPAA implementation guide for that transaction	Provider eSolutions Companion Guide Series - [Transaction] Companion Guide	Provider eSolutions Companion Guide Series - [Transaction] Companion Guide In addition, these entities should ask the clearinghouse with whom they are directly connected for that clearinghouse’s documentation
For each non-HIPAA provider transaction (e.g., roster, referral or precert ² inquiry, unsolicited claim status), either a listing of Aetna’s usage of the transaction set or clarification of Aetna’s usage of the named implementation guide for that transaction	Provider eSolutions Companion Guide Series - [Transaction] Companion Guide	These entities should ask the clearinghouse with whom they are directly connected for that clearinghouse’s documentation

¹ The term "trading partner" is used exclusively in this document to express the meaning ascribed to it by the Health Insurance Portability and Accountability Act. Physicians are independent contractors. Use herein of the HIPAA-defined term "trading partner" does not imply an agency relationship with Aetna.

² The term "precert" here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.



Overview of Aetna's 276/277 Claim Status Inquiry

Aetna 276/277 Claim Status Inquiry Companion Guide (this document) applies only to HIPAA-mandated inquiries about claim(s) for a specific patient:

<ul style="list-style-type: none">• 276/277 Claim Status Inquiry	<ul style="list-style-type: none">• Supports inquiries on claim status for a single provider, a single member, and a date of service or range of dates• A real-time response is sent within 20 seconds of receipt of request
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In addition, Aetna supports the following non-mandated uses of the 276 and/or 277 transactions:

<ul style="list-style-type: none">• 276/277 Claim Status Report	<ul style="list-style-type: none">• Supports report of claim status for a single provider, date of service or range of dates, and multiple members• A real-time acknowledgment of the request is sent within 20 seconds of receipt of request; an asynchronous (batch-type) response is sent within 12 hours of receipt of request
<ul style="list-style-type: none">• 277 Unsolicited Claim Status Response	<ul style="list-style-type: none">• Returns acknowledgment, error status or other updates for each submitted claim• A batch response is sent by the end of the business day following receipt of claim; subsequent responses may be sent when there is a significant change in claim status
<ul style="list-style-type: none">• 277 Financial Status Request	<ul style="list-style-type: none">• Supports inquiries on financial details of a claim once a 276 claim status inquiry request has been submitted and a 277 claim status inquiry response has been returned for that claim• A real-time response (835 Financial Status Response or 824 Financial Status Error Response) is sent within 20 seconds of receipt of request

Disclaimer

The Provider understands that receipt or use of this information does not guarantee payment of any health care claim by Aetna and such information is subject to change, even retroactively, at any time.

Claim Status Inquiry

The following elements capture all the information needed to locate claims in Aetna's files:

- Member ID (depending on plan, employee SSN, customer member ID, member HMO ID, or employee badge number)
- Patient Name
- Patient Date of Birth
- Patient Gender
- Subscriber Last Name if the Patient is a Dependent
- Provider ID
- Statement From and Through Date, alone or with the Aetna Claim Number, to narrow the search

For each claim it locates, Aetna will return a response with the following information:

- Aetna Claim Number
- Total Charged Amount
- Statement From and Through Date
- Status Message
- Amount Paid to the Provider
- Claim Adjudication Date
- Payment Method Code
- Check Issue/EFT Effective Date
- Check Number/EFT Trace Number
- Line Level Detail



Aetna's Usage of the 004010X093A1: 276/277 Health Care Claim Status Request & Response Implementation Guide

This section describes Aetna's usage of loops, segments, data elements and code values when the information in the **004010X093A1: 276/277 Health Care Claim Status Request & Response Implementation Guide** requires clarification. The tables contain a row for each item where Aetna has something additional to convey. The intention is 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 Guide*. The *Companion Guide* may, for example:

- Indicate a desired number of repeats of loops, or segments
- Specify a sub-set of the IG's internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Provide other information tied directly to a loop, segment, composite or simple data element pertinent to electronic transactions with Aetna, such as whether or not data that can be required at the payer's discretion is in fact required by Aetna to process the transaction, or whether Aetna has implemented or plans to implement specific edits

LEGEND:

SHADED rows represent "segments" in the X12N implementation guide

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

"Loop - specific" comments should be indicated in the first segment of the loop.

Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

Transaction	See Details Beginning on Page...
276 Health Care Claim Status Request	8
277 Health Care Claim Status Response	11



Change Control Log

6-1-04 - Corrected description on page 4 of non-HIPAA provider transactions; added wording on page 5 to clarify Aetna's uses of the 276 and 277 transaction sets; added disclaimer; corrected BHT03 reference

July 2005: Corrected BHT03 reference; added payer ID value of 953402799 to 2100A:NM109

September 2005: Added REF (Group Number) 2200D to page 10; updated implementation guide page number references.

October 2005: Changes in support of acceptance of National Provider Identifier (NPI).

September 2006: Removed the 2100B/2100C NM1 verbiage. Aetna now supports acceptance of National Provider Identifiers (NPI) per the 004010X093A1 276/277 Implementation Guide effective November 2006. Also updated implementation guide page number references and BHT03 reference.

06/05/2007 - removed PER segment from 277 2100A loop. Also updated provider verbiage on page 5 to be non-specific regarding ID.

Aetna's Use of the 276 Health Care Claim Status Request

Page #	Loop ID	Reference	Name	Codes	Length	Comments/Notes
50	Header	BHT03	Reference Identification			Data element not used in HIPAA IG but required by Aetna when sender of the transaction is a clearinghouse. This element is used between the clearinghouse and Aetna to convey the type of interface between the provider and the clearinghouse. Instructions to clearinghouses on how to populate this data element can be obtained from your vendor account manager. The data in this element should not originate from the provider. Data element should not be used when sender of the transaction is a provider.
55	2100A	NM103	Information Source Last or Organization Name			<i>AETNA is the correct organizational name</i>
56	2100A	NM109	Identification Code			<i>953402799 is the correct identification code</i>
57	2100A	PER	Payer Contact Information			Segment is situational in HIPAA IG but will not be used by Aetna
63	2100B	NM107	Information Receiver Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
68	2100C	NM106, NM107	Provider Name Prefix, Provider Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna



Aetna's Use of the 276 Health Care Claim Status Request

Page #	Loop ID	Reference	Name	Codes	Length	Comments/Notes
75	2100D	NM106, NM107	Subscriber Name Prefix, Subscriber Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
81	2200D	REF	Institutional Bill Type Identification			Segment is situational in HIPAA IG but will not be used by Aetna
83	2200D	REF	Medical Record Identification			Segment is situational in HIPAA IG but will not be used by Aetna
85	2200D	REF	Group Number			Segment is situational in HIPAA IG but will not be used by Aetna
91	2210D	SVC	Service Line Information			Segment is situational in HIPAA IG but will not be used by Aetna
94	2210D	REF	Service Line Item Identification			Segment is situational in HIPAA IG but will not be used by Aetna
96	2210D	DTP	Service Line Date			Segment is situational in HIPAA IG but will not be used by Aetna
102	2100E	NM106, NM107	Patient Name Prefix, Patient Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
108	2200E	REF	Institutional Bill Type Identification			Segment is situational in HIPAA IG but will not be used by Aetna
110	2200E	REF	Medical Record Identification			Segment is situational in HIPAA IG but will not be used by Aetna
116	2210E	SVC	Service Line Information			Segment is situational in HIPAA IG but will not be used by Aetna
120	2210E	REF	Service Line Item Identification			Segment is situational in HIPAA IG but will not be used by Aetna
121	2210E	DTP	Service Line Date			Segment is situational in HIPAA IG but will not be used by Aetna



Aetna's Use of the 277 Health Care Claim Status Response

Page #	Loop ID	Reference	Name	Codes	Length	Comments/Notes
135	2100A	NM103	Information Source Last or Organization Name			<i>Aetna to return value of "AETNA" (quotes will not be returned)</i>
136	2100A	NM109	Identification Code			<i>Aetna to return value of "953402799" (quotes will not be returned)</i>
143	2100B	NM106, NM107	Information Receiver Name Prefix, Information Receiver Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
148	2100C	NM106, NM107	Provider Name Prefix, Provider Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
155	2100D	NM106, NM107	Subscriber Name Prefix, Subscriber Name Suffix			Data element(s) situational in HIPAA IG but will not be used by Aetna
155	2100D	NM108	Identification Code Qualifier	ZZ		Code value(s) listed here are defined in HIPAA IG for this data element, but will not be used by Aetna
174	2200D	REF	Medical Record Identification			Segment is situational in HIPAA IG but will not be used by Aetna
200	2100E	NM106, NM107, NM108, NM109	Patient Name Prefix, Patient Name Suffix, Identification Code Qualifier, Patient Primary Identifier			Data element(s) situational in HIPAA IG but will not be used by Aetna
219	2200E	REF	Medical Record Identification			Segment is situational in HIPAA IG but will not be used by Aetna