CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2165	**Date: February 25, 2011**
	Change Request 7245

SUBJECT: Update for Pub. 100-04, Medicare Claims Processing Manual, Chapter 31

I. SUMMARY OF CHANGES: This Change Request (CR) applies updates to the Internet Only Manual for Pub. 100-04, Medicare Claims Processing Manual, Chapter 31 - ANSI X12N Formats Other Than Claims or Remittance.

EFFECTIVE DATE: *March 25, 2011
IMPLEMENTATION DATE: March 25, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	31/ 20 - ANSI X12N 276/277 Claims Status Request/Response Transaction Standard
R	31/ 20.1 - Transmission Requirements
R	31/ 20.1.3 - Interactive/Online (Non-DDE)
R	31/ 20.2 - Summary of the 276/277 Process for Carriers, DMERCs and Intermediaries
R	31/ 20.3 - Flat Files
R	31/ 20.4 - Translation Requirements

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2165	Date: February 25, 2011	Change Request: 7245

SUBJECT: Update for Pub. 100-04, Medicare Claims Processing Manual, Chapter 31

This Change Request (CR) applies updates to the Internet Only Manual for Pub.100-04, Medicare Claims Processing Manual, Chapter 31 - ANSI X12N Formats Other Than Claims or Remittance.

Effective Date: **March 25, 2011**

Implementation Date: March 25, 2011

I. GENERAL INFORMATION

A. Background: This CR applies updates to the Internet Only Manual for Pub.100-04, Medicare Claims Processing Manual, Chapter 31 - ANSI X12N Formats Other Than Claims or Remittance.

B. Policy: This CR provides direction to the following stakeholders:

1. The Durable Medical Equipment (DME) Common Electronic Data Interchange (CEDI) contractor,
2. The following Part A and Part B (A/B) Medicare Administrative Contractors (MACs) and their subcontractors as appropriate:
    a. Jurisdiction 1 – Palmetto Government Benefits Administrator,
    b. Jurisdiction 3 – Noridian Administrative Services,
    c. Jurisdiction 4 – TrailBlazer Health Enterprise,
    d. Jurisdiction 5 – Wisconsin Physicians Services,
    e. Jurisdiction 9 – First Coast Service Options (FCSO),
    f. Jurisdiction 10 – Cahaba Government Benefit Administrators,
    g. Jurisdiction 11 – Palmetto Government Benefits Administrator,
    h. Jurisdiction 12 – Highmark Medicare Services,
    i. Jurisdiction 13 – National Government Services,
    j. Jurisdiction 14 – National Heritage Insurance Corp, and
    k. Alternate Front End Carriers and Fiscal Intermediaries

Estimates for this CR should include a breakdown as part of the Level of Effort (LOE) response, utilizing the following table to be included in the "Estimate-Specific Comments" portion of the LOE template, to follow the Investment Lifecycle Phases.

Investment Lifecycle Phase	Total Hours	Total Cost
*Pre-Implementation/CR Review		
Design & Engineering Phase		
Development Phase		
Testing Phase		
Implementation Phase		

* **NOTE**: The Pre-Implementation/CR Review costs will not be funded under the unique funding situation for the 5010/D.0 project, but instead out of the MAC's allotted hours for Pre-Implementation/CR Review.

C. Business Assumptions:

(1) CMS expects that external testing will start in January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011.

(2) CMS expects that during the transition period January 2011-March, 2011 contractors shall be ready to receive/send transactions in version 4010A1as well as test in version 5010. From April 2011 to December 2011, contractors shall be ready to receive/send transactions in version 4010A1as well as test and receive/send all transactions in version 5010 or the appropriate errata versions.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7245.1	Contractors shall implement all changes associated with the update to Chapter 31 of Pub 100-04, Medicare Claims Processing Manual.	X	X	X	X	X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Michael Cabral Michael.Cabral@cms.hhs.gov (410) 786-6168

Post-Implementation Contact(s): Michael Cabral Michael.Cabral@cms.hhs.gov (410) 786-6168

Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs*****:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 31 - ANSI X12N Formats Other than Claims or Remittance

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(Rev.2165, 02-25-11)

20 - ANSI X12N 276/277 Claims Status Request/Response Transaction Standard

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

These instructions apply to *Medicare Administrative Contractors (MACs),* intermediaries, carriers, durable medical equipment *Medicare Administrative Contractors (DMEMACs), the Common Electronic Data Interchange (CEDI) contractor for DMEMACs,* and their shared systems on Medicare requirements for their implementation of the current HIPAA compliant version of the *Accredited Standards Committee* (ASC) X12N 276/277 health care claim status request and response format as established in *either* the 004010X093*, 04010X093A1, or 005010X212, Technical Report Type 3 (TR3) also known as an ASC X12 or ASC X12N* Implementation Guide (IG). In order to implement the HIPAA administrative simplification provisions, the 276/277 has been named under part 162 of title 45 of the Code of Federal Regulations as the electronic data interchange (EDI) standard for Health Care Claim Status Request/Response. All other EDI formats for health care claims status request and response become obsolete October 16, 2003. *The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the Federal Register on January 16th, 2009, adopts updated versions of the electronic transactions for Health Care Claim Status Request and Response (276/277). Furthermore, the Final Rule conveys inclusion of errata to the transaction standard. CMS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction*

The *ASC X12 version 005010* version of the implementation guide for the 276/277 standard may be found at the following Website: *http://Store.X12.org* . The 276/277 is a "paired" transaction (the 276 is an in-bound claim status request and the 277 is an outbound claims status response).

20.1 - Transmission Requirements

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

MACS, carriers, DMEMACs, the CEDI contractor, and intermediaries (hereafter called contractors) may continue to operate automated response unit (ARU) capability for providers to request and receive claim status information. ARUs are not considered EDI and are not affected by the HIPAA requirements. Nor do they impact response time requirements for the standard transactions implemented under HIPAA.

20.1.3 - Interactive/Online (Non-DDE)

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

Contractors are not required to accept a 276 query or respond with a 277 in an interactive, online mode if they do not already do so. If contractors do support the 276/277 in an interactive online mode, it must be offered in addition to batch 276/277. If they currently support the interactive/online (non-DDE) functionality, using the *previously developed (e.g. version 003070) or later HIPAA named standard(s) of 276/277 (versions 004010, 004010A1)* or any other direct claim status query and response EDI (non-DDE) format, they have the option to either:

- Terminate that support effective October 2003; or
- If *the contractor(s) have elected* to continue that service beyond the end of September 2003, they must accept version 276 inquiries and respond in the 277 format in an interactive online mode. Contractors

may not continue to operate any other format or version for interactive, online (non-DDE) requests/responses for claim status information. Response time for issuance of data in the 277 format in response to receipt of a valid 276 must be as fast or faster as the interactive, online response time for claim status information prior to the contractor's implementation of version 4010. *Furthermore the contractor(s) must upgrade this operation from any previously adopted HIPAA claim status format to the currently adopted standard (inclusive of any ASC X12 Errata) by the Secretary of Health and Human Services.*

20.2 - Summary of the 276/277 Process for *Medicare Administrative Contractors (MACs) for Part A, Part B and DMEMACs, including Common Electronic Data Interchange (CEDI) previously termed Carriers, DMERCs and Intermediaries.*

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

A. The contractor's translator must perform interchange control and syntax edits on the submitted 276 data at the ANSI *ASC X12* standard level, generate a TA1 (or equivalent local reject report) in batch (or interactive mode if supported) if an interchange control error was detected, and generate an *appropriate Functional Group Acknowledgement (e.g. for version 004010, or 004101A1 the 997, or for claim status transaction(s) version(s) 00510 and beyond inclusive of any adopted errata the 999 Implementation Acknowledgement For Health Care Insurance 999)* in batch (or interactive mode if supported) if a syntax error is detected. In the absence of any interchange control or syntax error, a *Functional Group Acknowledgement/Implementation Acknowledgement (997/999)* is issued in the batch mode only, to confirm receipt of a 276 received via batch. Due to the quick response time for interactive, online transactions, a *Functional Group Acknowledgement/Implementation Acknowledgement (*997*/999)* is not issued to confirm receipt of a valid transaction; the 277 response itself signifies receipt of a valid 276. See §20.4 for additional translation requirements. Translation does not apply to DDE screens.

A TA1 (or local reject report) and *Functional Group Acknowledgement/Implementation Acknowledgement (*997*/999)* issued for a 276 submitted in a batch must be issued within 1 business day of receipt of the 276. A TA1 or *Functional Group Acknowledgement (*997*/999)* for a 276 submitted in an interactive, online mode must be issued as quickly as the 277 would have been issued had the 276 been valid.

If a contractor supported interactive, online access to claim status information for providers prior to implementation of the HIPAA compliant version of the 276/277, the HIPAA compliant version of the 277, TA1, *or Functional Group Acknowledgement (997/999)* response time must be as fast or faster than the pre-*HIPAA* version response time for this information. Each contractor must include its anticipated response times for the modes of 276/277 supported in their trading partner agreement *and or Medicare Companion Guide(s)*. The error report should be made available as quickly as the 277 response would have been (had it been error free) whether the response is the TA1, *Functional Group Acknowledgement (*997*/999)* or the shared system generated error report.

Under HIPAA adopted versions prior to Version ASC X12 005010 and any adopted errata, the contractor's translator maps the inbound 276 data that have passed the interchange control and syntax edits to the 276 flat file, and forwards the data in the flat file format to the shared system within 1 business day of receipt of a valid 276. *With the implementation of version 005010, inclusive of any adopted Errata moving forward, the contractor's translator shall edit the incoming claim status transaction (276) as documented by the CMS 276/277Edits spreadsheet (as updated per quarterly release) from the CMS Website:*

http://www.cms.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp#TopOfPage

B. The shared system *shall continue to processes claim status transactions in versions prior to 005010 to* include edits to verify that the submitted 276 data complies with IG and Medicare requirements. If edits are failed, the shared system must generate an edit report following the model established for IG and Medicare program edit reporting for the HIPAA compliant version of the ANSI X12N 837 implementation. The edit report must include any reason(s) for the rejection in a concise but explicit manner that can be understood by provider staff as well as contractor staff. Contractors will forward the edit messages to submitters for correction of the edit condition. The shared system must generate these edit reports within 1 business day.

The IG edits must be performed as defined in the IG segment and data element notes, data element attributes, conditions of use, and overall guiding principles for use of the standards as contained in the introduction section and addenda to the IG. The Medicare program edits must be performed as required by current Medicare program instructions.

C. The A/B MAC or for DME, the CEDI contractor, shall process inbound claim status transactions in ASC X12 version(s) 5010 (inclusive of any ASC X12 Errata) and beyond to include the edits defined in the CMS 276/277Edits spreadsheet as translator applicable in order to pass to the Part A or Part B Common Edits and Enhancement Module (CEM) software a CMS defined flat file format (inclusive of Control Record(s) hereafter referred to as CTRD).

For Part A and Part B, the CEM software shall perform all edits not marked as Translator on the CMS 276/277Edits spreadsheet for inbound claim status transactions in order to pass the fully edited inbound claim status transaction on to the appropriate Part A or Part B shared system for appropriate claim status request processing in the shared system.

For DME, the CEDI contractor shall also process inbound claim status transactions in ASC X12 version(s) 5010 (inclusive of any ASC X12 Errata) and beyond to also include edits defined in the CMS 276/277Edits spreadsheet other than translator applicable in order to pass the fully edited inbound claim status transaction on to the DME shared system for appropriate claim status request processing in the shared system.

D. *For claim status request and response transactions formatted in ASC X12 version(s) prior to version 005010 the* shared system either:

• Stores any 276 data elements required for preparation of a compliant 277 response that are either not retained in the Medicare core system, or exceed the size limits for that type of data in the Medicare core system in a temporary file; or

• Uses an alternate method if less costly for that individual shared system but still compliant with the 277 IG requirements to complete a compliant 277 in response to that 276.

These requirements are *implemented* without changing the core system or using a repository to store additional information. However, if the carrier analysis shows it would be more efficient to do either one, the carrier may do so.

E. For claim status request and response transactions formatted in ASC X12 version(s) 005010 and beyond the shared system:

• Updates the Control Record database with the CTRD record for the activities being processed (e.g. interchange – ISA segment to IEA) and appropriate content of the Control Record . Stores any 276 data

elements required for preparation of a compliant 277 response that are either not retained in the Medicare core system, or exceed the size limits for that type of data in the Medicare core system in a temporary file

• Completes the application request/inquiry according to the components that outbound claim status response requires, as well as, generates and populates the outbound Control Record for the outbound claim status response. These processes shall comply with the Technical Report Type 3 (TR3) for the ASC X12 transaction and the CMS defined Control Record definition (inclusive of any quarterly release updates). The shared system shall also perform data scrubbing of outbound data prior to the data exiting the Enterprise Data Center (EDC) and being transferred to the Local Data Center (LDC) as deemed appropriate by CMS and the MACs. The initial instructions for the outbound data scrubbing were contained in Transmittal 702, Change Request 6946. This edit process shall be implemented beginning with the October 2010 release for DME and in the January 2011 release for Part A and Part B shared systems. The processes shall be modified through subsequent releases, as directed via future Change Requests, add to the editing process of the reference file mechanism designed for each shared system to perform the data scrubbing conversion process.

F. *For claim status request and response transactions formatted in ASC X12 version(s) prior to version 005010 the* shared system searches the claims processing database for the information requested in the 276 and creates a flat file response that is returned to the contractor. (The shared systems maintainers in consultation with their users must develop minimum match criteria for the 276.)

G. The contractor translates the flat file data into the HIPAA compliant version of the 277 format and forwards the 277 to the provider.

20.3 - Flat Files

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

For claim status request and response transactions formatted in ASC X12 version(s) prior to version 005010 the CMS developed flat files that maintainers and contractors may use. The files are available in two formats - a single file containing both 276 and 277 data elements and separate files for each. *These files are available on the following CMS Web page: http://www.cms.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp#TopOfPage*

Maintainers and their users should select which format they will use. The flat files provide for a one to one correlation between the core system data elements and the 276/277 data elements, and functions as a cross check to assure that necessary 276 data is submitted to the shared system and required 277 data can be extracted from the shared system.

Contractors must be able to accept a 276 transaction that complies with the HIPAA compliant version of the IG at the front-end and translate that data into the established flat file format for use by the shared system. Contractors must also be able to accept a flat file formatted feed from their shared system and create a compliant outbound 277.

For claim status request and response transactions formatted in ASC X12 version(s) 005010 and beyond inclusive of any adopted Errata by ASC X12, the CMS developed flat files that maintainers and contractors may use. *These files are available on the following CMS Web page:*

http://www.cms.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp#TopOfPage

20.4 - Translation Requirements

(Rev.2165, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

For claim status request and response transactions formatted in ASC X12 version(s) prior to version 005010, the translation software contractors previously obtained for implementation of HIPAA compliant version of the ANSI X12N 837 and 835 transactions must also be capable of translation of 276 and 277 data. A contractor translator is required to validate that the 276 and 277 meet the ANSI X12N interchange control and syntax requirements contained in the HIPAA compliant version of the 276/277. Implementation guide and Medicare program edits are shared system, rather than translator, responsibility.

Contractors must accept the basic character set on an inbound ANSI X12N 276, plus lower case and the @ sign which are part of the extended character set. Refer to Appendix A, page A2 of the implementation guide for a description of the basic character set. The carrier translator may reject an interchange that contains any other characters submitted from the extended character set.

Contractor translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) in order that the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure that could cause software failure when mapping to the ANSI X12N-based flat file. Contractors are not required to accept multiple functional groups (GS/GE) within one interchange.

A contractor's overall translation process must also:

- Convert lower case to upper case;
- Pass all spaces (default values) to the 276 flat file for fields that are not present on the inbound ANSI X12N 276. Do not generate a record on the 276 flat file if the corresponding segment is not present on the inbound ANSI X12N 276;
- Map "Not Used" data elements based upon that segment's definition, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the ANSI X12N-based flat file; and
- Accept multiple interchange envelopes within a single transmission.

All decimal data elements are defined as "R." A contractor's translator must write these data elements to the X12-based flat file at their maximum field size, which will be initialized to spaces. Use the COBOL picture found under the IG data element name of the flat file to limit the size of the amounts. These positions are right justified and zero-filled. The translator is to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the 276 flat file data element will be used as a placeholder to report an error code if an "R" defined data element exceeds the limitation that the Medicare core system is able to process.

The error code values are:

"X" = value exceeds maximum amount based on the COBOL picture,

"Y" = value exceeds maximum decimal places based on the COBOL picture, and

"b" blank will represent no error.

For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. The translator must map this amount to the X12-based flat file using the COBOL picture of S9(7)V99. The flat file amount will be 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0." The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

For claim status request and response transactions formatted in ASC X12 version(s) 005010 and beyond inclusive of any adopted Errata by ASC X12, Contractors and shared system maintainers shall exchange claim status transactions using the Extended Character Set. except when a CMS and the contractors have deemed to be data scrubbed under the initial instructions for the outbound data scrubbing as contained in Transmittal 702, Change Request 6946 and the modifications through subsequent releases, as directed via future Change Request. Detailed information about the Extended Character Set can be obtain in Appendix B of any ASC X12 Technical Report type 3 (TR3).