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Best Practice Recommendation for

Creating and Receiving the Health Care Claim Acknowledgement

For use with ANSI ASC X12N 277CA (005010X214)
Health Care Claim Acknowledgement
Acknowledgement Guide

Version 2.2

Version	
Issue Date	**Explanation**
12-14-11	Initial Release
03-31-15	Second Release
04-23-15	Wordsmithing Release
03-13-17	• Applicability section – it is a best practice for a health plan to produce 277CA • Returned Information section – no expectation that 277CA will be returned for split claims

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Best Practice Recommendation (BPR)

Creating and Receiving the Health Care Claim Acknowledgement

Topic: Health Plan response to receipt of 837 Claim(s)

Goals:

1) Eliminate the need for providers to submit duplicate claims, or make phone calls, as a means of assuring that the health plan received a specific claim(s) with an 837 transaction.
2) Timely availability of health plan claim number,
   - expedites the submission and processing of paper supporting documentation (if/as required by the health plan), and
   - makes it easier for a provider, and saves time for providers and health plans, when inquiring on a specific claim that was previously submitted in an 837 transaction

Summary: This document outlines the minimum standard set of information that a health plan will return to a provider to acknowledge receipt of a batch of 837 claim transaction(s). The provider can use the returned information for

- timely submission of paper supporting documentation
- further inquiry about a claim(s) using the health plan's web site directly or using the HIPAA 276-277 transaction set

Applicability: Though the 277CA is not yet a HIPAA-mandated transaction, the best practice recommendation is for all health plans to implement the transactions as outlined in this document.

Transaction Compliance with the TR3

This BPR Document is intended to accompany the TR3 for the ASC X12N Health Care Claim Acknowledgement (277CA) transaction. A complete version of the TR3 can be purchased at http//www.wpc-edi.com.

One of the objectives of this BPR document is to recommend practices for how the 277CA transaction should be used to accomplish specific business objectives related to the processing and reporting of claim receipt information. This document assumes that:

1. The reader is familiar with the HIPAA transaction and the related TR3 and has experience implementing the transaction.
2. The creation and exchange of the 277CA transaction by the health plan and provider organization will comply with all requirements laid out in the TR3.

Considerations and Constraints

The 277CA - Claim Acknowledgement transaction is designed to accompany the 999 - Acknowledgment transaction. Whereas the 999 - Acknowledgement confirms receipt of a transaction (in this case the 837), the 277CA provides more specific information about the claims that were contained in the 837, e.g. the unique identifier assigned by the health plan to their claims (i.e. per the TR3 - the payor claim control number)**.**

However, if a claim is rejected due to X12 syntax/format errors and is not accepted into the health plan's system, then the claim may not be included in the 277CA

This BPR outlines the minimum set of information that will be provided for each claim that is contained in the 277CA. However, it is important to recognize that, depending upon the health plan's processing system, every claim submitted in an 837 may not appear on the 277CA.

Using the following situation as an example:

> There are 100 claims in an ST-SE loop on an 837 transaction and one of those claims is rejected because of "compliance" errors.

Health plans may handle this situation in 1 of 3 ways:

1. All 100 claims from the ST-SE will be rejected, reported on the 999[*1] and no 277CA will be sent for that ST-SE loop
2. The one rejected claim will be reported on the 999[*1] and not accounted for on the 277CA, i.e. only 99 claims will appear on the 277CA
3. The one rejected claim will be reported on the 999[*1] and accounted for on the 277CA, i.e. 100 claims will appear on the 277CA

[*1] - In the case of a rejected claim, the provider may need to utilize the 999 transaction for full understanding of the error and it's placement within the file submitted

This BPR does not recognize any one of the above three scenarios as being better or worse than the others. However, provider preference is that scenario 3 be followed by health plans so that providers can use one transaction to follow-up on all of their claims, thus resulting in greater efficiency.

Providers should talk with their health plan to determine which reporting approach the health plan intends to use.

Intended Scope

This BPR will only address those claims that appear on the 277CA. If a health plan rejects a claim and reports that rejection on the 277CA, the reporting of that rejection should comply with the best practices that are recommended within this document.

If a health plan rejects a claim and only reports that rejection on the 999, the practices for reporting that rejection are outside the scope of this document.

Within Scope of this Document:

Claim status acknowledgement information will be reported for all claims that appear on the 277CA, i.e. those that are accepted and those that are rejected.

For those claims that are reported on the 277CA as accepted, the 277CA should provide sufficient information to answer the following questions:

- Did you receive my claim?
- What claim number was assigned to my claim by the health plans?
- What initial acknowldgement status was assigned to my claim?

For those claims that are reported on the 277CA as rejected, the 277CA should provide sufficient information to determine why the claim(s) was initially rejected.

Outside Scope of this Document:

In situations where a rejected claim(s) appears on the 999 Acknowledgement transaction, that claim(s) may or may not appear on the 277CA transaction. Handling of rejected claims that do not appear on the 277CA is outside the scope of this BPR. Information about the health plan policy/practice in this regard will be available from the health plan.

For claims that do appear on the 277CA, detail information explaining how the claim was adjudicated or why certain amounts were/were not paid WILL NOT be provided on the 277CA transaction. Answers to those types of questions will be contained in the Remittance Advice (835) transaction. While detailed financial information will only be provided in the Remittance Advice (835) transaction, the Health Care Claim Status Codes on the 277CA will provide general information about whether the claim was accepted or rejected. Claims that are reported as accepted on the 277CA, should be adjudicatied by the health plan and wll appear on the 835. Claims that are reported as rejected on the 277CA, should not be adjudicated and will not appear on the 835.

Best Practices for Provider Organizations

The provider should submit a compliant 837 claim transaction which would include the patient's control number. The patient control number is assigned by the provider for each claim so that, when a 277CA or 835 is returned by the health plan, the provider can identify the appropriate patient-claim(s) that are referenced in those transactions. The patient control number should be unique within the provider's system.

Upon receipt of a 277CA, providers will update the respective patient accounts with the claim numbers assigned by the health plan. The health plan assigned claim number will be used when making further inquiries about the claim and/or supplying additional information.

Best Practices for Health Plans

Performance

The provider organization will send the 837-Claims transaction and the health plans will reply with a 999 - Acknowledgement transaction and a 277 Claims Acknowledgement transaction.

Time Period

Health plans will respond with the 277CA transaction as soon as possible and not later than 1 business day after receiving the 837 transaction. Providers should recognize that the 1 business day time period is in addition to any processing/wait time by clearinghouses or intermediary organizations between the provider and the health plan, i.e. which may extend the response time.

Returned Information

Within the time period, the information returned on the combination of the 999 and the 277CA will include an appropriate acknowledgement of every claim submitted on the 837 transaction, whether that claim is to be adjudicated by the receiving health plan or forwarded for adjudication to another health plan.

If the submitted claim is split at some point in the claim process, after the 277CA associated with the submitted 837 was returned, there is no expectation that an additional 277CA will be returned

As outlined in the 277CA TR3, the health plan will return relevant information contained in the 837 as well as claim information created by the health plan, including totals for accepted and rejected claims.

For 837-submitted claims that are reported on a 277CA, heath plan claim numbers will only be returned for those claims that a health plan adjudicates within their claims processing system.

For example, if a claim(s) is repriced and forwarded to another health plan for adjudication, no claim number will be returned on the 277CA from the "repricing" organization.

Data Content Best Practices

1. The provider's 'Patient Control Number' that was submitted on the 837 must be included in the 277CA transaction from the health plan in order for the transaction to be valid.

2. Health plans will use the most specific code combination that represents the accurate status of that claim in their system – to the extent that their system is able to determine. As a simple example, if the claim is received by the health plan but is not brought into their system for adjudication, then an A1-19 (Entity acknowledges receipt of claim/encounter) will be used. Otherwise an A2-20 (Accepted for processing) will be used.

3. The appropriate coding should be used so that all relevant issues are explained.

4. The Entity Code will be returned when it is required by the Status Code.

5. A listing of Claims Accepted and Rejected, along with totals, will be reported by each Information Receiver and Billing Provider.

   a. Information Receiver (Loop 2200B) Totals:
      - Accepted: Quantity Amount Billed
      - Rejected: Quantity Amount Billed

   b. Billing Provider of Service (Loop 2200C) Totals:
      - Accepted: Quantity Amount Billed
      - Rejected: Quantity Amount Billed

   See pages 44-74 of 277CA TR3 for formatting requirements.