OREGON HEALTH AUTHORITY
OREGON HEALTH LEADERSHIP COUNCIL
ADMINISTRATIVE SIMPLIFICATION GROUP

Oregon Companion Guide

For the Implementation of the

ASC X12N/005010X212

HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

(276/277)

(Based on Version 5, Release 1 - August 2006)

And the published errata:

- ***ASC X12N/005010X212E1 (April 2008)***
- ***ASC X12N/005010X212E2 (January 2009)***

AUGUST 2013
VERSION 1.2

Disclaimer
The following Oregon Companion Guide is intended to serve as a companion document to the corresponding *ASC X12N/005010X212 Health Care Claim Status Request and Response.* Throughout the rest of the document, the ASC X12 technical report and attendant errata are referred to as 005010X212

The document further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the *005010X212* in a manner that will make its implementation by users to be out of compliance. Further, this guide is not a replacement for using the Technical Report 3 (TR3): the TR3 is required for the compliant implementation of this transaction. Using this companion guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

Statutory Authority
It is intended that this companion guide will be adopted and its use will be mandated for all HIPAA covered entities (payers, providers, and clearinghouses) conducting business or licensed in the state of Oregon.

Document Changes
The content of this companion guide is subject to change. The version, release and effective date of the document are included in the document, as well as a description of the process for handling future updates or changes.

About the Oregon Health Authority
The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. Although the state is in the planning stages for organizing the new agency, work to change the health care system has already begun. The OHA works with a nine-member, citizen-led board called the Oregon Health Policy Board. Members are appointed by the Governor and confirmed by the Senate. The Health Authority will transform the health care system in Oregon by; improving the lifelong health of Oregonians; Increasing the quality, reliability, and availability of care for all Oregonians; Lowering or containing the cost of care so it is affordable to everyone in the state.
http://www.oregon.gov/OHA/

About the Oregon Health Leadership Council
The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance is more affordable to people and employers in the state. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care.
http://www.orhealthleadershipcouncil.org

About the Administrative Simplification Group
The Administrative Simplification group was first formed in the spring of 2008 by the Oregon Medical Association, Oregon Association of Hospitals & Health Systems and Regence BlueCross BlueShield of Oregon. After the formation of the Oregon Health Leadership Council, the workgroup became one of the four Leadership Council's workgroups.

This group identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals in order to streamline the business side of health care and provide cost-savings to the entire system. Three sub-groups were formed to explore increasing use of web sites for eligibility and claims information, investigate a common credentialing solution, and work toward standardization and automation of key processes.
http://www.orhealthleadershipcouncil.org/administrative-simplification

Contact for Further Information on this Oregon Companion Guide
Oregon Health Authority (OHA)
500 Summer Street, NE, E-20
Salem, OR 97301-1097
Phone: 503-383-6260
Phone: 503-947-2340
Phone: 877-398-9238

All published Oregon Companion Guides may be found at the following location:
http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx

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Oregon Companion Guide Revision History

Ver.	Revision Date	Summary Changes
1.0	May 10, 2012	Complete initial draft of Oregon Companion Guide (276/277)
1.1	June 19, 2012	Clarified implementation requirements section 3.2
1.2	August 31, 2013	Format changes and corrections for consistency across all OCGs Reflect changes in federal regulations from the CORE rules

1 EXCERPT FROM STATEMENT: OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

2 OVERVIEW

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published rules (CMS–0009–F) announcing the adoption of new versions of the federal transaction standards, known as ASC X12/005010 ("Version 5010"). The compliance deadline to implement the 5010 version of the transaction standards, on a nationwide basis, was January 1, 2012.

One of the major transactions included in this version upgrade is the Health Care Claim Status Request and Response (276/277). The standard was originally published in August 2006.

The purpose of generating a 276 is to obtain the current status of the claim within the adjudication process. Status information can be requested at the claim and/or line level.

The payer uses the 277 Health Care Claim Status Response to transmit the current status within the adjudication process to the requester. When the 276 does not uniquely identify the claim within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester

Beginning January 1, 2012, Providers and Health Plans executing the Health Care Claim Status Request and Response (276/277) transactions may only use the 5010 version of the transaction (005010X212).

2.1 Purpose of the Oregon Companion Guide

The purpose of the Oregon Companion Guide is to clarify, supplement, and further define specific data content requirements to be used in conjunction with the 005010X212 (276/277) Technical Report Type 3 (TR3) created for the electronic transaction standard, mandated by the HIPAA regulations. Its purpose is to provide a common standard that can be easily and consistently applied by all Health Plans and Health Care Providers (refer definitions in Section 2.3) and yet, would continue to be fully compliant with federal regulations.

The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document to refer to the OCG being created at the request of the Oregon Health Authority.

2.2 Key Abbreviations

The following abbreviations are used extensively throughout this document

276/277	The 005010X212 Health Care Claim Status Request And Response transaction.
005010X212	Reference for the Health Care Claim Status Request and Response: ASC X12N/005010X212 (August 2006)

TR3	Technical Report Type 3 – formerly known as the Implementation Guide (IG)
OCG	Oregon Companion Guide – this guide

2.3 Applicability

Effective January 1, 2014, all Health Plans licensed or doing business in Oregon and Health Care Providers providing services for a fee or as an encounter in Oregon, must exchange health care claim status inquiry and response information electronically using

– 276/277 transaction as defined in the 5010 version
– the requirements of the OCG
– implement fully operational transactions within the timelines that will be required under proposed Oregon Statutes (see Section 2.3.1). The only exceptions to the statutory requirements are as follows:

- The requirements do not apply to the exchange of electronic claims status inquiry and response transactions with:
  - Medicare
  - Federally Administered programs
  - Workers' Compensation programs
  - Property and Casualty insurance plans

The following definitions apply to the HIPAA covered entities that will establish trading relationships using this OCG and are consistent with the definitions in the CFR 160 and 164.

2.3.1 OREGON SENATE BILL 94

The Oregon Companion Guides are authorized by OHA and DCBS regulations established under Oregon's Senate Bill 94. The next paragraph is quoted from the Oregon Legislative Senate measure summary. The complete text of the bill is available at the following location:
http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0094.intro.pdf
WHAT THE MEASURE DOES: Authorizes the Department of Consumer and Business Services (DCBS) to adopt uniform standards for health care financial and administrative transactions, including uniform standards for: (a) eligibility inquiry and response; (b) claim submission; (c) payment remittance advice; (d) claims payment or electronic funds transfer; (e) claims status inquiry and response; (f) claims attachments; (g) prior authorization; (h) provider credentialing; or, (i) other health care financial and administrative transactions identified by a stakeholder workgroup. Requires that uniform standards to apply to: (a) health insurers; (b) prepaid managed care health services organizations; (c) third party administrators; (d) self-insurance plans; (e) health care clearinghouses; and, (f) other persons that process health care financial and administrative transactions. Requires the Oregon Health Authority (OHA) to convene a stakeholder workgroup to recommend standards. Requires work group to consider applicable national standards when developing recommendations. Requires DCBS and OHA to confer and reconcile any differences between their respective requirements for health care financial and administrative transactions. Makes the Department of Human Services (DHS) subject to uniform standards. Declares emergency, effective on passage.

2.4 Covered Entities – Definitions

The following definitions apply to HIPAA covered entities that will establish trading relationships using this OCG and are consistent with the definitions in the Code of Federal Regulations (CFR) 160 and 164.

2.4.1 HEALTH PLAN

Health Plan *is defined as follows:*

Note: *This definition reproduced from Subtitle D—Privacy, Section 13400. Definitions, that appear in the Conference Report on page H1345 of Congressional Record—House, February 12, 2009.*

An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).
(1) Health plan includes the following, singly or in combination:

- A group health plan
- A health insurance issuer
- An HMO
- Part A or Part B of the Medicare program under title XVIII of the Act.
- The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.
- An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).
- An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.
- An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- The health care program for active military personnel under title 10 of the United States Code.
- The veterans' health care program under 38 U.S.C. chapter 17.
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.
- An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.
- The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- A high-risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).
- "Health Plan" includes an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974(ERISA)(29 U.S.C. 1002(1)), including

insured and self-insured plans, to the extent that the plan provides medical care, as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42U.S.C. 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan. *45 CFR 160 Subpart A 160.103*

(2) Health plan excludes:

- Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and
- A government-funded program (other than one listed in section 1 of this definition):
  (A) Whose principal purpose is other than providing, or paying the cost of, health care; OR
  (B) Whose principal activity is
    a. The direct provision of health care to persons; or
    b. The making of grants to fund the direct provision of health care to persons.

Health Plans may also be referred by the industry colloquial - **payers.**

2.4.2 HEALTH CARE PROVIDER

Health Care Provider *is defined as follows:*
A person or organization that provides health care or medical care services within Oregon for a fee and is eligible for reimbursement for these services. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a Health Plan, health carrier, or individual for providing health care services. This definition includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Health Care Providers may also be referred by the industry colloquial - **providers.**

2.4.3 CLEARINGHOUSE

Clearinghouse *is defined as follows:*
Entity contracted by Health Plans and Health Care Providers to create, send, receive, process, manage, or administrate standard electronic transactions are also subject to comply with the OCG. This would include entities that process the Health Care Claim Status Request and Response (276/277) and other HIPAA standard X.12 transactions as or on behalf of a HIPAA covered entity.

2.4.4 TRADING PARTNER

The term Trading Partner is used in the most general sense of its meaning, in EDI terms, within this document. It essentially means any entity that exchanges EDI transactions with another entity, addressed by the scope of the OCG. The entity could be a direct submitter (such as a **Health Plan** or **Health Care Provider**) or an entity that provides EDI and billing agents (such as a **Clearinghouse**).

As described in the beginning of this section, this OCG applies to all claims status inquiries and responses submitted electronically on or after October, 2012 (depending on actions of the Oregon legislature) that use the transaction standard and corresponding *005010X212 (276/277).* The Code of Federal Regulations , title 45, part 162, subpart L specifies that the standard for dental, professional, and institutional Health Care Claim Status Request and Response is this transaction standard.

2.5 Usage of Oregon Companion Guide – Consistency of Application

The 276/277 Health Care Claims Status transactions have the capacity for general as well as very specific requests and very detailed responses. This document provides the agreed upon 'foundation' for a request/response. This document does not prevent trading partners from agreeing to make more specific/detailed requests and receiving more detailed responses. However, the trading partners must all have at least the basic inquiry/response requirements provided in this document.

This OCG contains the maximum required set of data values to be submitted or received by Health Care Providers and Health Plans when executing an electronic claims status inquiry (276) and response transaction (277). This OCG specifies how it will be used in order to accomplish the goal of consistent, efficient, and error free execution of the transactions, among trading partners conducting business in the state of Oregon. The maximum requirements may be extended as per the conditions identified as follows:

1. No trading partner may unilaterally or collectively require any other trading partner(s) to conform to standards that are not included in this OCG.

2. Once adopted through Oregon State mandates, no additions or modifications may be made to this OCG by Health Plans or Health Care Providers through their own companion guides or by establishing other requirements.

3. All transactions must fully comply with the current version of the HIPAA 276/277 transaction TR3 (current version - 005010X212- published in April 2008 and updated through errata published in June 2010) in force at the time of executing the transactions.

2.6 Updating the Oregon Companion Guide

This OCG will be reviewed and updated periodically to conform to prevailing rules and standards that change and evolve over time. The current set of rules and guidelines are described in the TR3 for the 276/277 transaction and two follow up errata that are incorporated in this version of the OCG.

2.6.1 Future Updates to Oregon Companion Guide--Process

Once approved and published, the OCGs are operationally regulated and executed by the OHA. OHA may request a review, changes, or updates to operational OCGs based on industry and related developments. The OHA is the owner of these OCGs and any updates/changes to published guides must be conducted with their approval and involvement.

In order to incorporate relevant changes or updates to the OCGs, the workgroup will retain its membership and organizational structure even after the first versions of the OCGs are completed.

The workgroup will schedule to meet once every quarter, at the minimum, to review industry news during the quarter, and make any recommendations to the Administration Simplification Executive Committee that may result in a change to the guide or operational aspects of executing transactions.

The EDI Workgroup co-Chairs will retain the option of not calling the meeting if there are no newsworthy or pressing items that need discussion. Interest in scheduling a quarterly meeting may also be confirmed by polling the group sometime before the meeting.

When issues or changes come to light that must be addressed by the workgroup, the team will collectively make appropriate recommendations to the Executive Committee, for their approval, with a new schedule and resource requests necessary to complete the work or resolve the issue(s) or incorporate valid changes to the OCG(s).

The specific process for updating OCG documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide will be available from the OHA's - Oregon Office of Health Information Technology. Their website is as follows:
http://www.oregon.gov/oha/OHPB/pages/health-reform/admin/index.aspx

2.7 Addressing Code Set Issues in the Oregon Companion Guide

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the *005010X212*).
- External Code Sets (referenced by *005010X212* defined and maintained by external bodies) including:

1. Non-Medical External Code Sets (such as Health Care Claim Status, Health Care Claim Status Category codes, Remark Codes, Zip Codes etc). These values must be valid on the date the transaction is created. In the case of a reversal, the codes used must be valid based on the original transaction date.

2. Medical and Dental External Code Sets (such as ICD-9, ICD-10, HCPCS; CDT). These values are effective based upon service date.

Complete list of External Code Sources is included in Appendix A of the TR3 for this transaction.

3 TRANSACTION REQUIREMENTS

3.1 Oregon Requirements for Transaction Implementation

This OCG requires all covered entities to be fully compliant with the CORE phase II rules and the standards described in the 005010X212 TR3, by the required date of January 1, 2014. The OCG adds no additional requirements to the federal standards.

3.1.1 CORE PHASE II RULES

All 276/277 transactions must conform to the following set of rules included in phase II:

250: Claim Status Rule

4.1 Claim Status Connectivity Requirements
4.2 * Claim Status Real Time Acknowledgement Requirements
4.3 * Claim Status Batch Acknowledgement Requirements
4.4 Claim Status Real Time Response Time Requirements
4.5 Claim Status Batch Response Time Requirements
4.6 Claim Status System Availability
4.7 Claim Status Companion Guide

*** Note:**

Section 162.1403 of the CFR adopts the CAQH CORE Phase II operating rules but provides the following exception - "Excluding where the CAQH CORE rules reference and pertain to acknowledgements and CORE certification".

270: Connectivity Rule

4.1 Basic Conformance Requirements for Key Stakeholders
4.2 CORE-compliant Envelope Specifications using Message Enveloping Standards
4.3 General Specifications Applicable to Both Envelope Methods
4.4 Envelope Metadata Fields, Descriptions, Intended Use and Syntax/Value-Sets

Link to complete set of CAQH CORE phase II rules

– Rule requirements are found in section 4 within the corresponding rules section
http://www.caqh.org/pdf/CLEAN5010/PIIv5010Complete.pdf

Link to Federal Register – Interim Final Rule

– Register / Vol. 76, No. 131 / Friday, July 8, 2011
http://www.gpo.gov/fdsys/pkg/FR-2011-07-08/html/2011-16834.htm

3.1.2 X.12 005010X212 TR3

A thorough review and understanding of various sections of the TR3 will allow for a successful implementation. These include:

a. the sections on business purpose and implementation
b. the TR3 notes applicable to specific loops and/or segments
c. the notes applicable to specific data elements
d. the usage of REQUIRED, SITUATIONAL and NOT USED for data elements, segments and loops

3.1.3 TR3 Business Information

This section of the TR3 provides information regarding the purpose as well as implementation principles. Within these sections are details of requirements, which may not be obvious by reviewing only the technical sections of the report.

3.1.4 TR3 Notes

TR3 notes are designed to provide clear implementation detail regarding usage such as but not limited to:

- The number of times a loop or segment may or may not be repeated in a given situation.
- Dependencies when the loop or segment may be required based on data provided in another loop or segment.
- When data may be required based on the type of trading partner or intermediary.

3.1.5 Loops, Segments and Data Elements

This OCG does not reference the required and situational Loops, Segments and Data Elements contained in the 005010X212. The specific instructions associated with the transaction included in the TR3 are fully applicable to the covered entities without modification or qualification.

3.2 Implementation Schedule

This OCG for the 276/277 transaction, based on the Oregon Health Authority direction, requires covered entities to conform as per the following schedule:

January 1, 2014	All trading partners must use the 276/277 transactions and conform to this OCG. **All Claims Status inquiries and responses must be exchanged electronically using the 276/277 transactions and/or a comparable on-line application (if available), by this date**.

4 APPENDIX A – SUMMARY OF PHASE I & II CORE OPERATING RULES

Operating rules can be generally defined as the content that must be returned in a response, and may include, but is not limited to, methods of communication, response times, and system availability times. Specifically they are defined in ACA (HR 3590) as follows.

(9) Operating Rules.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.

At the time Version 1.1 of this guide was developed, the CORE (*Committee on Operating Rules for Information Exchange* of the Council for Affordable Quality Healthcare) rules were associated with the 4010 version of the implementation guide and were being redeveloped for the 5010 version of this transaction. It was agreed that the workgroup would work with the eligibility and benefit content requirements laid out in the 5010 version of the TR3 and continue to monitor the development of additional content relevant to the 5010 TR3. The workgroup also agreed to monitor the industry direction for requiring operating rules as set forth in the Patient Protection Act (PPACA). The development of 'Best Practices' related to the 5010 version would be adopted when identified as important to the Oregon stakeholders.

In July, 2011, an Interim Final Rule was published by the Federal Government (Federal Register July 8, 2011 Rules and Regulations p. 40461 Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions) proposing the adoption of Operating Rules developed by CAQH –CORE to be used in the clarification of and use of the 276/277 transaction. The following was published as part of the IFR in describing the place of the proposed operating rules as they related to the HIPAA transactions (including 276/277).

- They are business rules and guidelines;
- They are necessary for the electronic exchange of information;
- They are not defined by a standard;
- They do not conflict with the existing HIPAA standards;
- They are consensus based;
- They are consistent with the HIPAA and Health Information Technology (HIT) standards adopted by the Secretary; and
- Together with standards they
  - ❖ Encourage the use of electronic transactions by reducing ambiguities currently permitted by the standard,
  - ❖ Result in better-defined inquiries and responses that add value to provider practice management and health plan operations.

The operating rules adopted, which affect this transaction, include (at a high level):

- Claims Status Rule
- Connectivity Protocols for Real Time as well as Batch transmissions rules

(See Table 1 for detail applicability of rules below)

4.1 Applicability to the 276/277 OCG

The following table identifies the operating rules that are applicable per this Oregon Companion Guide.

Table 1 - CORE Phase I & II – Applicability to 276/277 OCG

Rule	Applicability*	Description
150	*Excluded*	Batch Acknowledgement Rule v.1.1.0 (*please note that though excluded as a named rule, this rule may be applicable via one of the adopted rules.*)
151	*Excluded*	Real Time Acknowledgement Rule v.1.1.0
152	*Not Applicable*	Companion Guide Rule v.1.1.0
153	*Not Applicable*	Connectivity Rule v.1.1.0
154	*Not Applicable*	270/271 Data Content Rule v.1.1.0
155	*Not Applicable*	Batch Response Time Rule v.1.1.0
156	*Not Applicable*	Real Time Response Time Rule v.1.1.0
157	*Not Applicable*	System Availability Rule v.1.1.0
250	276/277	Claim Status Rule
258	*Not Applicable*	Normalizing Patient Last Name Rule
259	*Not Applicable*	AAA Error Code Reporting Rule
260	*Not Applicable*	Data Content Rule
270	276/277	Connectivity Rule

* *Applicability to the 276/277 OCG*

The requirements for compliance with the new Federal Law does decrease the level of detail provided in this version of the OCG.

The date of compliance with the CORE Operating Rules as specified by the Federal Government is January 1, 2013.

Note:
Section 162.1403 of the CFR adopts the CAQH CORE Phase II operating rules but provides the following exception - "Excluding where the CAQH CORE rules reference and pertain to acknowledgements and CORE certification".

5 APPENDIX B : REFERENCES AND BIBLIOGRAPHY

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