Health Care Payment Advice
276/277 Companion Guide

Refers to the ASC X12N 276/277
Technical Report Type 3 Guide
(version 005010X212E2)

Companion Guide Version Number: 1.4

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Preface

This Companion Guide to the *ASC X12N Implementation Guides* adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Blue Cross Blue Shield of Massachusetts. Transmissions based on this companion guide, used in tandem with *the X12N Technical Report Type 3 Guides*, are compliant with both X12 syntax and those guides. This Companion Guide is intended 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 Technical Report Type 3 Guides*.

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1. Introduction

1.1. Overview

The Health Insurance Portability and Accountability Act–Administration Simplification (HIPAA-AS) requires Blue Cross Blue Shield of Massachusetts ("Blue Cross" or "BCBSMA") and all other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

This guide is designed to help those responsible for testing and setting up electronic claim status transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Blue Cross. This guide supplements (but does not contradict) requirements in the ASC X12N 276/277 (version 005010X212E2) implementation. This information should be given to the provider's business area to ensure that claim status responses are interpreted correctly.

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1.2. References

- The ASC X12N 276/277 (version 005010X212E2) Technical Report Type 3 guide for Health Care Claim Status Request and Response has been established as the standard for claim status transactions and is available at www.wpc-edi.com/HIPAA.
- Blue Cross' Provider Portal containing documentation on transactions for providers is located at bluecrossma.com/provider.

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1.3. Technical Requirements

Blue Cross supports the 276/277 ASC X12N version 005010X212E2 for claim status requests and responses. Providers wishing to receive the 277 must support this version. We support both Real Time and Batch transactions.

Real Time 276s have a single ST/SE loop, one information source, one information receiver, one service provider loop, one subscriber loop, one dependent loop (when needed), and one claim loop. For trading partners using the NEHEN portal, the last character of the GS02 element is set to "R" on the 276. Typical turnaround time is under 10 seconds during which the portal connection is held open.

Batch 276s also have a single ST/SE loop, one information source, one information receiver, one service provider loop, one subscriber loop, one dependent loop (when needed), and one claim loop. Batch 276s can take up to 6 hours to process a response. A single 277 is created for each 276 submitted. For trading partners using the NEHEN portal, the last character of the GS02 is set to "B" on the 276.

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2. Testing

2.1. Testing with Blue Cross

We recommend that Trading Partners submit two successful and unique 276 submissions and receive the associated 277 responses in order to obtain our approval to promote to Production. Providers must coordinate with us for testing timeframes and to ensure that the necessary patient and claim test data is available.

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3. Connecting and Communicating

3.1. e-Channels

We provide multiple options for submission of 276 requests.

- Provider Central (our provider portal) – bluecrossma.com/provider.
- New England Healthcare Exchange Network (NEHEN) –nehen.org.
- Change Healthcare - http://www.changehealthcare.com/legacy/our-partners/providers/ or **1-866-817-3813**
- Direct channel for Real Time 276 transactions in accordance with CAQH CORE connectivity rules:
    - Communication Methods Supported:
        - The transport protocol is HTTPS over the Internet
        - The message (payload) protocol can be either SOAP or MIME
        - The content of the request and response is a standard X12N HIPAA transaction.
        - Production URL: https://authsso.bluecrossma.com/s44318/caqh2 SOAP connection
        - Production URL: https://authsso.bluecrossma.com/s44319/caqh2 MIME connection
    - Technical standards and versions for HTTPS/SOAP are:
        - HTTPS Version 1.1
        - SOAP Version 1.2
        - SSL Version 1.2
        - WS-Security Version 1.x
        - Health Care Eligibility and Benefit Inquiry and Response Version 005010X279A1
    - Technical standards and versions for HTTPS/MIME are:
        - HTTPS Version 1.1
        - MIME Version 1.0
        - SSL Version 1.2

    - Health Care Eligibility and Benefit Inquiry and Response Version 005010X279A1 Submissions & Response Pickups use MTOM to handle the file payloads.
- User ID and password for SOAP and CMIME are provided upon completion of enrollment process.

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3.2. Security

We are dedicated to maintaining the confidentiality of personal health information. We have adopted a mindset to safeguard member information as if it were our own. Associates are required to safeguard member privacy by using reasonable measures during all phases of the information-handling process: from collection and storage, to disclosure and disposal. This policy applies to the personally identifiable health information of all applicants and past or present members. Information may be in the form of data in storage or in transit, on paper or in electronic format.

Due to its sensitivity, the use and disclosure of Personal Health Information (PHI) is restricted, except in circumstances where permitted or required by law or where appropriate authorization for use or disclosure is obtained. Access to PHI is limited to those with a business need to know the information for treatment, payment, or health care operations, or as otherwise permitted or required by law. Associates with a business need to handle PHI must be identified and granted appropriate access in accordance with their department-level policies and procedures.

Blue Cross maintains policies and procedures for the HIPAA compliant transfer of protected health information to external health care partners. These provisions include secure file transfer, encryption, password protection, secure fax, and other measures, as indicated based on the nature of the data being transferred.

NEHEN trading partners transmit transactions using private network frame relay connections, Virtual Private Networks (VPN) or X.509 digital certificates for Web Services connections.

Direct Submitter (CORE) Trading Partners exchange transactions using secure HTTP over the Internet. The HTTPS connection is secured by a certificate. Each request is authenticated by a User ID and Password.

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3.3. System Availability

Blue Cross will be available to process Real Time and Batch transactions 24x6, Monday through Saturday from 1:00 AM ET – 12:59 AM ET. Maintenance may be performed by Blue Plans on the following major holidays:

- New Year's Day (1/1)
- Memorial Day (Last Monday in May)
- Independence Day (7/4)
- Labor Day (1st Monday in September)
- Thanksgiving Day (4th Thursday in November)
- Christmas Day (12/25)

In addition, routine maintenance may be performed on Sundays. Trading partners may receive rejection messages indicating that Blue Cross is unable to respond to their transactions. It is recommended that transactions submitted during these maintenance windows be sent in Batch mode.

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4. Provider Support

If you cannot find the answers to your questions within this Companion Guide, please use the contact information below to reach the appropriate support area.

EDI Support

For technical questions or help related to 276 or 277 transactions, please contact:

Phone: 800-771-4097
Email: EDISupport@bcbsma.com

Provider Central (provider portal)

Provider Central provides information regarding our products, policies and procedures, as well as Companion Guides for various electronic transactions. Please refer to online documentation for the most up-to-date materials.

Website: bluecrossma.com/provider

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5. Blue Cross 276/277 Patient Information

We process 276 requests for Blue Cross members, Federal Employee Program (FEP) members, and Out-of-State Blue Plan (BlueCard) members.

If the member is enrolled with an Out-of-State BCBS Plan (BlueCard), we may coordinate with the member's Home Plan to return a 277 response. 277 responses for these members may vary based on the Home Plan's processing.

5.1. Identification Number Requirements

Blue Cross member IDs begin with a three character alpha or alpha-numeric prefix followed by nine (without suffix) or eleven (with suffix) numeric characters.

Out-of-State Blue Plan member IDs begin with a three character alpha or alpha-numeric prefix followed by four to fourteen alpha-numeric characters.

Federal Employee Program (FEP) member IDs begin with the letter "R" followed by eight numeric characters.

Note: Member IDs should not contain hyphens, spaces, or any special characters.

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5.2. Name Normalization

In accordance with CAQH CORE requirements and under the recommendation of the Massachusetts Administration Simplification Workgroup, Blue Cross normalizes the patient's last name and first name from the submitted 270 request and compares them to a normalized version of the patient information contained in our membership files. When making name comparisons:

- The match will not be case-sensitive
- All special characters within the basic character set are ignored:

"!", """, "&", "'", "(", ")", "*", "+", ",", "-", ".", "/", ":", ";", "?", "=" and space

- All of the following character strings are ignored when they are:
  - At the beginning of the data element and followed by a space, comma, or forward slash
  - At the end of the data element and preceded by a space, comma, or forward slash

JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

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5.3. Patient Relationship

5.3.1. Subscriber Submitted as Dependent

If the patient is a dependent in Blue Cross' membership files, but was submitted in the Subscriber loop on the 276 request (2100D), the patient will be returned in the appropriate

Dependent loop on the 277 response (2100E). We will also return the corrected Subscriber information in the 2100D loop.

5.3.2. Dependent Submitted as Subscriber

If the patient is a subscriber in our membership files, but was submitted in the Dependent loop on the 276 request (2100E), the patient will be returned in the appropriate Subscriber loop on the 277 response (2100D).

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6. Blue Cross 276/277 Claim Status Information

6.1. Blue Cross Match Criteria

We recommend submitting a Claim Status inquiry 1 – 2 weeks after a claim has been submitted for processing and a remittance has not been received.

We evaluate certain data elements from the 276 request to use in finding a matching claim(s).

The following data elements must match the data elements submitted on the claim:

- The **billing provider's NPI** (2100C NM109)
- The **patient's Subscriber ID #** (2100D NM109)
- The **patient's date of birth** (2100D/E DMG02)
- The **patient's gender** (2100D/E DMG03) if submitted on the 276 request
- The **date(s) of service** (2200D/E DTP03)

We perform a "flexible" match by evaluating all matching claims found within the date of service range submitted.

The following data elements will be used as filters (if submitted) to return more specific claim(s):

- **Payer Claim Control Number** (REF01 = "1K")
  If the 276 request includes a Blue Cross ICN and that ICN matches a claim with all the criteria in section 6.1, only that claim will be returned on the 277 response.
- **Patient Control Number** (REF01 = "EJ")
  If the 276 request includes a Patient Account Number and that Patient Account Number matches a claim with all the criteria in section 6.1, only that claim will be returned on the 277 response.
- **Total Claim Charge Amount** (AMT02)
  If the Total Claim Charge Amount on the 276 request matches a claim with all the criteria in section 6.1, only that claim will be returned on the 277 response.

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6.2. 277 Claim Level Information

- We provide information regarding the status of your claim(s). Please see Appendix A for our most common Claim Level STC code values.
- If multiple matching claims are identified, each claim will be returned in a separate 2200D/E segment on the 277 response.
- When a 277 response indicates that a claim is finalized, we recommend referencing either the 835 Health Care Claim Payment/Advice or the Payspan Remittance Advice for more detailed information regarding the adjudication of your claim.

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6.3. 277 Line Level Information

- We provide information regarding the status of each claim line. Please see Appendix B for our most common Line Level STC code values.
- If a matching claim has multiple claim lines, each claim line will be returned in a separate 2220D/E segment on the 277 response.

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6.4. 277 Error Responses

Some scenarios may result in an error 277 response. Please see Appendix C for a list of error responses.

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7. 999 Acknowledgement for Health Care Insurance

276 Claim Status Requests submitted to Blue Cross must be HIPAA compliant.

We will issue a 999 Acknowledgment for Health Care Insurance (005010X231A1) when a 276 request (Batch or Real Time) fails validation of WEDI SNIP Type 1-5 HIPAA edits. We do not return positive acknowledgments for successful 276 requests (the 277 acts as the acknowledgment).

The purpose of the 999 Acknowledgment (Reject) is to identify critical errors within the 276 request based on the ASC X12N 276 (version 005010X212E2) Technical Report Type 3 guide. The submitter should review the 999 to determine what errors occurred.

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8. 276 Data Specifications

Note: All Data must be submitted in UPPER CASE. Leading spaces must be omitted. Trailing spaces must be omitted unless necessary to fulfill a minimum field length.

8.1. Header Data

Segment ID	Element ID	Data Element Name	Blue Cross Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"
	06	Interchange Sender ID	Value assigned by Blue Cross
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	Value assigned by Blue Cross
	14	Acknowledgment Requested	"0" (numeric)
	15	Interchange Usage Indicator	P – Production Requests T – Test Requests
GS		**Functional Group Header**	
	02	Application Sender's Code	Value assigned by Blue Cross
	03	Application Receiver's Code	Value assigned by Blue Cross
	08	Version/Release/ Industry	

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8.2. Loop Specific Data

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2100A	**NM1**	**Payer Name**	

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01	Entity Identifier Code	"PR"
	03	Name Last or Organization Name	"BLUE CROSS BLUE SHIELD OF MASSACHUSETTS"
	08	Identification Code Qualifier	"PI"
	09	Identification Code	"700"
2100C	**NM1**	**Service Provider Name**	
	08	Identification Code Qualifier	"XX"
	09	Identification Code	The NPI of the **Billing Provider** that was submitted on the claim
2000D	**DMG**	**Subscriber Demographic Information**	
	02	Subscriber Birth Date	Required when the patient is the Subscriber
2100D	**NM1**	**Subscriber Name**	
	03	Subscriber Last Name	Required
	04	Subscriber First Name	Required, if known
	08	Identification Code Qualifier	"MI"
	09	Identification Code	Required. This is the patient ID # that submitted with the claim. It must include the alpha or alpha-numeric prefix (e.g. XXH, MTN).
2200D	**REF**	**Payer Claim Control Number**	**Use only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	If used, this is the BCBS Claim # (if known)
2200D	**REF**	**Patient Control Number**	**Use only if the patient is the Subscriber**

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01	Reference Identification Qualifier	"EJ"
	02	Reference Identification	If used, this is the patient's Patient Account # that was submitted on the claim
2200D	**AMT**	**Claim Submitted Charges**	**Use only if the patient is the Subscriber**
	02	Total Claim Charge Amount	Total claim charge amount that was submitted on the claim
2200D	**DTP**	**Claim Service Date**	**Use only if the patient is the Subscriber**
	03	Date Time Period	Claim date(s) of service that was submitted on the claim
2000E	**DMG**	**Dependent Demographic Information**	
	02	Dependent Birth Date	Required when the patient is a dependent
2100E	**NM1**	**Dependent Name**	
	03	Dependent Last Name	Required when the patient is a dependent
	04	Dependent First Name	Required when the patient is a dependent, if known
2200E	**REF**	**Payer Claim Control Number**	
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	If used, this is the Blue Cross Claim # (if known)
2200E	**REF**	**Patient Control Number**	
	01	Reference Identification Qualifier	"EJ"

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	02	Reference Identification	If used, this is the patient's Patient Account # that was submitted on the claim
2200E	**AMT**	**Claim Submitted Charges**	
	02	Total Claim Charge Amount	Total claim charge amount that was submitted on the claim
2200E	**DTP**	**Claim Service Date**	
	03	Date Time Period	Claim date(s) of service that was submitted on the claim

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9. 277 Data Specifications

9.1. Header Data

Segment ID	Element ID	Data Element Name	Blue Cross Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"
	06	Interchange Sender ID	ISA08 value from 276 request
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	ISA06 value from 276 request
	09	Interchange Date	Processed Date in GMT
	10	Interchange Time	Processed Time in GMT
GS		**Functional Group Header**	
	02	Application Sender's Code	GS03 value from 276 request
	03	Application Receiver's Code	GS02 value from 276 request
	04	Date	Processed Date in GMT

	05	Time	Processed Time in GMT
BHT		**Beginning of Hierarchical Transaction**	
	04	Date	Processed Date in GMT
	05	Time	Processed Time in GMT

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9.2. Loop Specific Data

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2100A	**NM1**	**Payer Name**	
	01	Entity Identifier Code	"PR"
	03	Name Last or Organization Name	"BLUE CROSS BLUE SHIELD OF MASSACHUSETTS"
	08	Identification Code Qualifier	"PI"
	09	Identification Code	"700"
2100D	**NM1**	**Subscriber Name**	
	03	Subscriber Last Name	Subscriber's last name from our membership files
	04	Subscriber First Name	Subscriber's first name from our membership files
	05	Subscriber Middle Initial	Subscriber's middle initial from our membership files
	09	Subscriber Primary Identifier	Patient's ID# (including alpha or alpha-numeric prefix) from the 276 request
2200D	**STC**	**Claim Level Status Information**	**Used only if the patient is the Subscriber**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for
	02	Status Information Effective Date	• If the claim is finalized, this is the date the claim finalized. • If the claim is pending or an error is encountered, this is the date the 277 was processed (in GMT).
	04	Total Claim Charge Amount	The total claim charged amount
	05	Claim Payment Amount	The total claim payment amount
	06	Adjudication Finalized Date	If the claim is finalized, this is the date the claim finalized
	08	Remittance Date	If the claim is paid, this is the check/EFT date.
	09	Check Number	If the claim is paid, this is the check/EFT number.
2200D	**REF**	**Payer Claim Control Number**	**Used only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	The Blue Cross claim #
2200D	**REF**	**Patient Control Number**	**Used only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"EJ" is returned if the patient's Patient Account Number was submitted on the 276 request
	02	Reference Identification	This is the submitted patient's Patient Account #
2200D	**DTP**	**Claim Service Date**	**Used only if the patient is the Subscriber**
	03	Claim Service Period	The date(s) of service for the claim

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
2220D	**SVC**	**Service Line Information**	**Used only if the patient is the Subscriber**
	01-1	Product or Service ID Qualifier	• "AD" if Dental claim • "HC" if Professional claim OR if Institutional claim line was submitted with HCPCS Code "NU" if Institutional claim line was submitted without HCPCS code
	01-2	Procedure Code	• If SVC01-1 is "AD", this is the ADA Code • If SVC01-1 is "HC", this is the HCPCS Code • If SVC01-1 is "NU", this is the Revenue Code
	01-3 01-4 01-5	Procedure Code Modifiers	Up to 3 Procedure Code Modifiers (if used)
	02	Claim Line Charge Amount	The claim line charged amount
	03	Claim Line Payment Amount	The claim line payment amount
	04	Revenue Code	If Institutional claim line was submitted with HCPCS Code, this is the Revenue Code
	07	Units of Service Count	The claim line units of service
2220D	**STC**	**Service Line Status Information**	**Used only if the patient is the Subscriber**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim line
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim line
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim line

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	02	Status Information Effective Date	• If the claim is finalized, this is the date the claim finalized. • If the claim is pending, this is the date the 277 was processed (in GMT)
2220D	**DTP**	**Service Line Date**	**Used only if the patient is the Subscriber**
		Service Line Date	The date(s) of service for the claim line
2100E	**NM1**	**Dependent Name**	**Used only if the patient is a Dependent**
	03	Dependent Last Name	Dependent's last name from our membership files
	04	Dependent First Name	Dependent's first name from our membership files
	05	Dependent Middle Initial	Dependent's middle initial from our membership files
2200E	**STC**	**Claim Level Status Information**	**Used only if the patient is a Dependent**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim
	02	Status Information Effective Date	• If the claim is finalized, this is the date the claim finalized. • If the claim is pending or an error is encountered, this is the date the 277 was processed (in GMT).
	04	Total Claim Charge Amount	The total claim charged amount
	05	Claim Payment Amount	The total claim payment amount

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Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	06	Adjudication Finalized Date	If the claim is finalized, this is the date the claim finalized
	08	Remittance Date	If the claim is paid, this is the check/EFT date.
	09	Check Number	If the claim is paid, this is the check/EFT number.
2200E	**REF**	**Payer Claim Control Number**	**Used only if the patient is a Dependent**
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	The Blue Cross claim #
2200E	**REF**	**Patient Control Number**	**Used only if the patient is a Dependent**
	01	Reference Identification Qualifier	"EJ" is returned if the patient's Patient Account Number was submitted on the 276 request
	02	Reference Identification	This is the submitted patient's Patient Account #
2200E	**DTP**	**Claim Service Date**	**Used only if the patient is a Dependent**
	03	Claim Service Period	The date(s) of service for the claim
2220E	**SVC**	**Service Line Information**	**Used only if the patient is a Dependent**
	01-1	Product or Service ID Qualifier	• "AD" if Dental claim • "HC" if Professional claim OR if Institutional claim line was submitted with HCPCS Code "NU" if Institutional claim line was submitted without HCPCS code

Loop ID	Segment/ Element ID	Data Element Name	Blue Cross Business Rule
	01-2	Procedure Code	• If SVC01-1 is “AD”, this is the ADA Code • If SVC01-1 is “HC”, this is the HCPCS Code • If SVC01-1 is “NU”, this is the Revenue Code
	01-3 01-4 01-5	Procedure Code Modifiers	Up to 3 Procedure Code Modifiers (if used)
	02	Claim Line Charge Amount	The claim line charged amount
	03	Claim Line Payment Amount	The claim line payment amount
	04	Revenue Code	If Institutional claim line was submitted with HCPCS Code, this is the Revenue Code
	07	Units of Service Count	The claim line units of service
2220E	**STC**	**Service Line Status Information**	**Used only if the patient is a Dependent**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim line
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim line
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim line
	02	Status Information Effective Date	• If the claim is finalized, this is the date the claim finalized. • If the claim is pending, this is the date the 277 was processed (in GMT)
2220E	**DTP**	**Service Line Date**	**Used only if the patient is a Dependent**
		Service Line Date	The date(s) of service for the claim line

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10.Appendices

10.1. Appendix A – Claim Level STC Responses

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
P0	0		Claim is pending in Blue Cross' processing system; no further action is necessary
P3	0		Claim is pending in Blue Cross' processing system; no further action is necessary
P3	297		Claim is pending in Blue Cross' processing system, awaiting medical records
F1	0		Claim is approved to pay pending the next Blue Cross payment cycle
F1	1		Claim has completed processing and was paid
F2	1		Claim has completed processing and was denied; please see the claim remittance advice for additional information
F2	27	IL	Claim has completed processing and was denied because services were rendered after the member's coverage had ended
F2	33		Claim has completed processing and was denied because the Subscriber ID is not on file
F2	54		Claim has completed processing and was denied because it is a duplicate of another claim
F2	90	QC	Claim has completed processing and was denied because services were rendered before the member's coverage had begun
F2	93	QC	Claim has completed processing and was denied because the member has not selected a Primary Care Physician
F2	95		Claim has completed processing and was denied because requested information was

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
			not received; please see the claim remittance advice for additional information
F2	97	IN	Claim has completed processing and was denied because the member does not have active coverage
F2	107		Claim has completed processing and was denied because the services are not covered; please see the claim remittance advice for additional information
F2	116		Claim has completed processing and was denied because the claim was submitted to the incorrect payer; please see the claim remittance advice for additional information
F2	171		Claim has completed processing and was denied because the member may have other coverage
F2	242		Claim has completed processing and was denied because additional information is required; please see the claim remittance advice for additional information
F2	327		Claim has completed processing and was denied because additional information is required; please see the claim remittance advice for additional information
F4	1		Claim has completed processing, but no payment was made; please see the claim remittance advice for additional information

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10.2. Appendix B – Line Level STC Responses

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
P0	0		Claim is pending in our processing system; no further action is necessary
P3	0		Claim is pending in Blue Cross' processing system; no further action is necessary
P3	297		Claim is pending in Blue Cross' processing system, awaiting medical records
F1	0		Claim is approved to pay pending the next Blue Cross' payment cycle
F1	1		Claim has completed processing; claim line was paid; see the claim remittance advice for additional information
F1	3		Claim is approved to pay pending the next Blue Cross payment cycle
F2	0		Claim is awaiting the next Blue Cross adjudication cycle; no payment is forthcoming for this claim line
F2	1		Claim has completed processing; no payment was made for this claim line; please see the claim remittance advice for additional information
F2	16	1P	Claim line was denied because information is needed from the provider; please see the claim remittance advice for additional information
F2	16	IL	Claim line was denied because information is needed from the member; please see the claim remittance advice for additional information
F2	27	IL	Claim line was denied because services were rendered after the member's coverage had ended
F2	252	1P	Claim line was denied because services were rendered without a referral

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
F2	54		Claim line was denied because it is a duplicate of another claim line
F2	84		Claim line was denied because services were not authorized
F2	90	QC	Claim line was denied because services were rendered before the member's coverage had begun
F2	93	QC	Claim line was denied because the member has not selected a Primary Care Provider
F2	95		Claim line was denied because requested information was not received; please see the claim remittance advice for additional information
F2	96	1P	Claim line was denied because the provider was not contracted to perform these services
F2	97	IN	Claim line was denied because the member does not have active coverage
F2	107		Claim line was denied because the services are not covered; please see the claim remittance advice for additional information
F2	130	1P	Claim line was denied because the necessary provider information was not submitted; please see the claim remittance advise for additional information
F2	143	1P	Claim line was denied because the necessary provider information was not submitted; please see the claim remittance advise for additional information
F2	182	MR	Claim line was denied because Medicare previously paid for these services
F2	240		Claim line was denied because the submitted tooth number and/or surface may be incorrect
F2	241		Claim line was denied because the submitted tooth number may be incorrect

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Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
F2	245		Claim line was denied because the submitted dental quadrant may be incorrect
F2	286		Claim line was denied because the Medicare EOB was not submitted
F2	297		Claim line was denied because necessary information was not received; please see the claim remittance advice for additional information
F2	324		Claim line was denied because necessary information was not received; please see the claim remittance advice for additional information
F2	327		Claim line was denied because necessary periodontal treatment information is required; please see the claim remittance advice for additional information
F2	454		Claim line was denied because of the submitted procedure code
F2	475		Claim line was denied because the submitted procedure code is not valid for the patient's age
F2	488		Claim line was denied because of the submitted diagnosis code
F4	1		Claim has completed processing; no payment was made for this claim line; please see the claim remittance advice for additional information
F4	3		Claim is awaiting the next Blue Cross adjudication cycle; no payment is forthcoming for this claim line

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10.3. Appendix C – Claim Level Error Responses

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
A4	35		Claim not found; Blue Cross was not able to find any claims matching the criteria described in Section 6.1
E0	33		The submitted Subscriber ID was not found in our membership files and Blue Cross was not able to find any claims matching the criteria described in Section 6.1
E0	97	IN	The submitted patient was not found in our membership files and Blue Cross was not able to find any claims matching the criteria described in Section 6.1
E0	187		The submitted date of service is unable to be processed; either the range is greater than 1 year or the date of service is older than 3 years
E2	689		Information Holder is not responding; resubmit at a later time

10.4. Appendix D – Sample 276 Request

```
ISA*00* *00* *ZZ*NEHEN999 *ZZ*NEHEN004
*110825*1825*{*00501*117150267*0*T*^~
GS*HR*NEHEN999*NEHEN004*20110825*1825333*117150267*X*005010X212~
ST*276*0001*005010X212~
BHT*0010*13*276-201108251323*20110825*1825312~
HL*1**20*1~
NM1*PR*2*BLUE CROSS BLUE SHIELD OF MASSACHUSETTS*****PI*700~
HL*2*1*21*1~
NM1*41*2*PROVIDER NAME*****46*999999999~
HL*3*2*19*1~
NM1*1P*2*PROVIDER NAME*****XX*9999999999~
HL*4*3*22*0~
DMG*D8*19010101*F~
NM1*IL*1*LAST*FIRST****MI*XXH999999999~
TRN*1*TRACE NUMBER~
AMT*T3*100~
DTP*472*RD8*20110721-20110721~
SE*15*0001~
GE*1*117150267~
IEA*1*117150267~
```

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10.5. Appendix E – Sample 276 Response

```
ISA*00* *00* *ZZ*NEHEN004 *ZZ*NEHEN999
*110825*1825*^*00501*117150267*0*T*:~
GS*HN*NEHEN004*NEHEN999*20110825*1825356*117150267*X*005010X212~
ST*277*0001*005010X212~
BHT*0010*08*276-201108251323*20110825*1825356*DG~
HL*1**20*1~
NM1*PR*2*BLUE CROSS BLUE SHIELD OF MASSACHUSETTS*****PI*700~
HL*2*1*21*1~
NM1*41*2*PROVIDER NAME*****46*999999999~
HL*3*2*19*1~
NM1*1P*2*PROVIDER NAME*****XX*9999999999~
HL*4*3*22*1~
NM1*IL*1*LAST*FIRST****MI*XXH999999999~
HL*5*4*23~
NM1*QC*1*LAST*FIRST~
TRN*2*TRACE NUMBER~
STC*F1:0*20110825**1400*0~
REF*1K*99999999999999~
DTP*472*D8*20110721~
SVC*HC:99999*1400*696.18****1~
STC*F1:3*20110825~
DTP*472*D8*20110721~
SE*20*0001~
GE*1*117150267~
IEA*1*117150267~
```

10.6. Revision History

Revision Number	Date	Section	Notes
1.1	4/10/2014	9.2	Add STC-08, 09 to Loop 2200D/E
		3.1	Revised Direct Channel
1.2	5/22/2017		Reviewed with no content changes necessary. Updated document template.
1.3	5/15/2018	5.1	Updated prefix content
	5/15/2018	8.2	Updated prefix content
	5/15/2018	3.1	Revised e-Channels

1.4	5/6/2024	10.3	Updated Claim Status Code and Description for Claim Status Category Code E2

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