HIPAA Transaction and Code Set Standards

837 Health Care Claims

For professional, institutional, and dental providers, the 837 provides the capacity to submit electronic health care encounters and claims. Compliance with this electronic transaction includes the use of HIPAA defined, compliant code sets.

835 Health Care Claim Payment/Remit Advice

Utilized by a payer to send electronic remittance advice (ERA) or electronic explanation of payment (EOP) to a requesting provider. Also includes payment of health care claims. However, for 2003, CIGNA HealthCare has elected to implement only the ERA portion of this transaction and will continue to utilize existing banking and related Electronic Fund Transfer processes for payment of health care claims. Providers must request an 835 through their Clearinghouse; it is not automatic.

270/271 Inquiry/Response for Eligibility

Allows determination of subscriber or dependent eligibility as well as the benefit information for the subscriber or dependent. The 270 is the inbound eligibility/benefit inquiry transaction from a provider to a health plan. The 271 is the eligibility/benefit response transaction of this set.

This is an interactive transaction set and responses are "real time."

276/277 Inquiry/Response for Claim Status

Used by providers to request status on a submitted claim (276) and to receive a status response (277). The 276 is utilized by institutional, professional and/or dental providers, and supplemental health care claims processors as defined by the regulations. The 277 response transactions are utilized by payers and other entities that process claims.

This is an interactive transaction set and responses are "real time."

278 Referral Certification, Authorization, Extensions & Appeals

Referral Certification: Used by providers to request certification for a patient to receive health care services. Also provides capacity to appeal a UM decision.

Authorization: Provider receives permission from review entity/UM to refer the patient to a specialist, admit the patient to a facility, or administer medical services or treatment to the patient.

This transaction also covers pre-certification prior to elective hospitalization or treatment, as required, for determination of medical necessity.

This transaction allows the provider to request an extension to a previously approved authorization, pre-certification, or referral.

The 278 is implemented as an interactive transaction.