ELECTRONIC CLAIM STATUS INQUIRIES

Registered MEDI users can inquire about the status of submitted claims through the IEC links in MEDI. This document provides instructions on how to electronically locate, download and interpret the claim status of LTC direct billed claims.

The claim status transactions available in MEDI follow the Washington Publishing Company Implementation Guidelines for Health Insurance Portability and Accountability Act (HIPAA), version 005010X223.

- The Acknowledgment for Health Care Insurance (ASC X12 999) Transaction provides a syntactical and relational analysis of a submitted claim file.
- Claim Status Request (276) transactions can be sent to request the status of an individual claim or a batch of specified claims. HFS provides a Claim Status Response (277) transaction, which will provide the current adjudication status of claims.
- Health Care Claim Payment/Advice (835) is an electronic remittance advice which provides the final claim adjudication status.

Providers may find it helpful to refer to the following websites of the Washington Publishing Company to obtain the applicable implementation guides and code reference information.

In addition, The HFS Medical Provider Handbook, Chapter 300 Companion Guide provides supplemental information related to the electronic processing of the HIPAA 5010 transaction specific to Illinois.

Implementation Acknowledgment for Health Care Insurance (ASC X12 999)

The 999 X12 file provides an acknowledgment that the submitted claim file was received, and whether the file was accepted or rejected. In addition, the 999 X 12 fie provides information regarding whether the submitted file contained errors and what data elements are in error. The HFS Medical Provider Handbook Chapter 300 reference to Edit and Rejections gives an overview of the 999 acknowledgement available in the MEDI IEC Download X12 File link.

The Error Identification (IK3) of the 999 informs the receiver which segment is in error on the submitted file. The segment's positon and loop are given along with a syntax error code that indicates the error. The Implementation Data Element Note (IK4) indicates the relative position of the simple data element in error within a segment. The Data Element Reference Number is provided to locate the data element in the Data Element. The Transaction Set Response Trailer (IK5) gives the Transaction Set Acknowledgement Code indicating if the file has been accepted or rejected based on the syntax editing of the transaction set.

The segment and code definitions are available in the WPC Implementation Acknowledgment for Health Care Insurance (ASC X12 999) Implementation Guide.

NOTE:

If the Header information data element ISA06 or GS02 in the submitted X12 file are incorrect HSF cannot take in your file or produce a 999. The 999 acknowledgment is produces almost immediately. Therefore, if a 999 for a submitted file is not received within a day after the submitted file was uploaded the file was not accepted. The file Header information should be reviewed and corrected before the file is resubmitted. To locate the 999 that

is reporting the results for a specified uploaded 837I file refer to the 999's AK102 field, which reports the GS06 from the uploaded 837 file.

Example of a 999 for a Rejected File

ISA*00* *00* *ZZ*37-
1320188INT *ZZ*123456789DPA001*170207*1337*^*00501*000000002*0*P*:
GS*FA*37-1320188*123456789001*20170207*133700*20001*X*005010X231A1
ST*999*0001*005010X231A1
AK1*HC*28*005010X223A2
AK2*837*0001*005010X223A2
IK3*REF*11*2010*8
IK4*2*127*5*123456789001
IK5*R*5
AK9*R*1*1*0
SE*8*0001
GE*1*20001
IEA*1*000000002

Translation of the IK3 segment

IK3-Error Identification

IK301 Segment ID Code- Code defining the segment ID of the data segment in error (REF in example above).

IK302 Segment Position in Transaction Set- The numerical count of this data segment from the start of the transaction set header (11 in example above).

IK303 Loop Identifier Code- The loop ID number given on the transaction set diagram (Loop 2010 in example above).

IK304 Implementation Segment Syntax Error Code- Code indicating the error found based on the syntax editing of a segment (8 in example above). The error codes and their definitions are listed below:

1: Unrecognized segment ID
2: Unexpected segment
3: Required segment missing
4: Loop occurs over maximum times
5: Segment exceeds maximum use
6: Segment not in defined transaction set
7: Segment not in proper sequence
8: Segment has data element errors
I4: Implementation "Not Used" segment present
I6: Implementation dependent segment missing
I7: Implementation loop occurs under minimum times
I8: Implementation segment below minimum use
I9: Implementation dependent "Not Used" segment present

Translation of the IK4 segment

IK4- Implementation Data Element Note

IK401 Position in Segment- Indicates the relative position of the simple data element in error within a segment (2 in this example).

IK402 Data Element Reference Number- Reference number used to locate the data element in the Data Element Dictionary (127 in this example, which is the Billing Provider Tax Identification Number).

IK403 Implementation Data Element Syntax Error Code- Code indicating the implementation error found after syntax edits of a data element (5 in this example). The error codes and their definitions are listed below:

1: Required data element missing
2: Conditional required data element missing
3: Too many data elements
4: Data element too short
5: Data element too long
6: Invalid character in data element
7: Invalid code value
8: Invalid date
9: Invalid time
10: Exclusion condition violated
12: Too many repetitions
13: Too many components
I10: Implementation "Not Used" data element present
I11: Implementation too few repetitions
I12: Implementation pattern match failure
I13: Implementation dependent "Not Used" data element present
I6: Code value not used in Implementation
I9: Implementation dependent data element missing

IK404 Copy of Bad Data Element-This is a copy of the data element in error (123456789001 in this example).

Translation of the IK5 segment

IK5- Transaction Set Response Trailer

IK501 Transaction Set Acknowledgement Code- Code indicating accepted or rejected condition based on the syntax editing of the transaction set (R in this example). The codes and their definitions are listed below:

A: Accepted
E: Accepted but errors were noted
M: Rejected, Message Authentication Code (MAC) failed
R: Rejected
W: Rejected, assurance failed validity tests
X: Rejected, content after decryption could not be analyzed

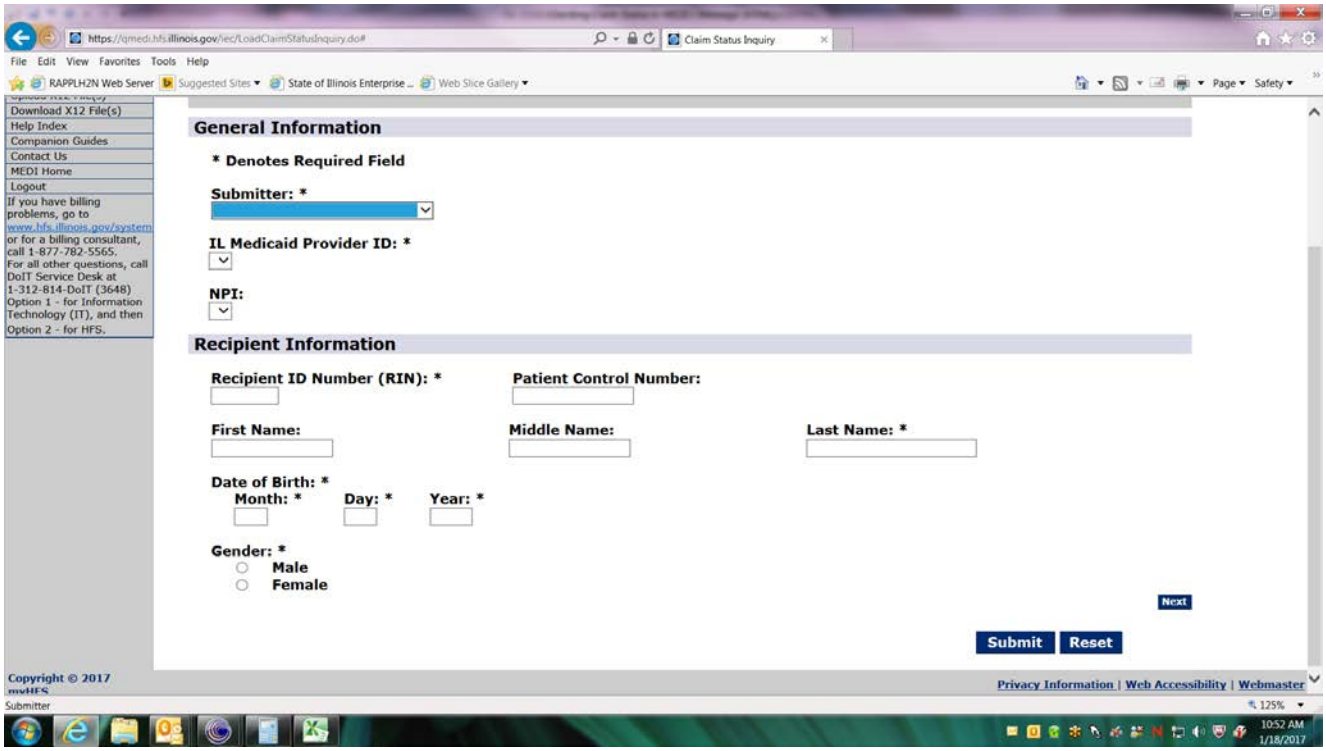
Claim Status Request and Response 276/277

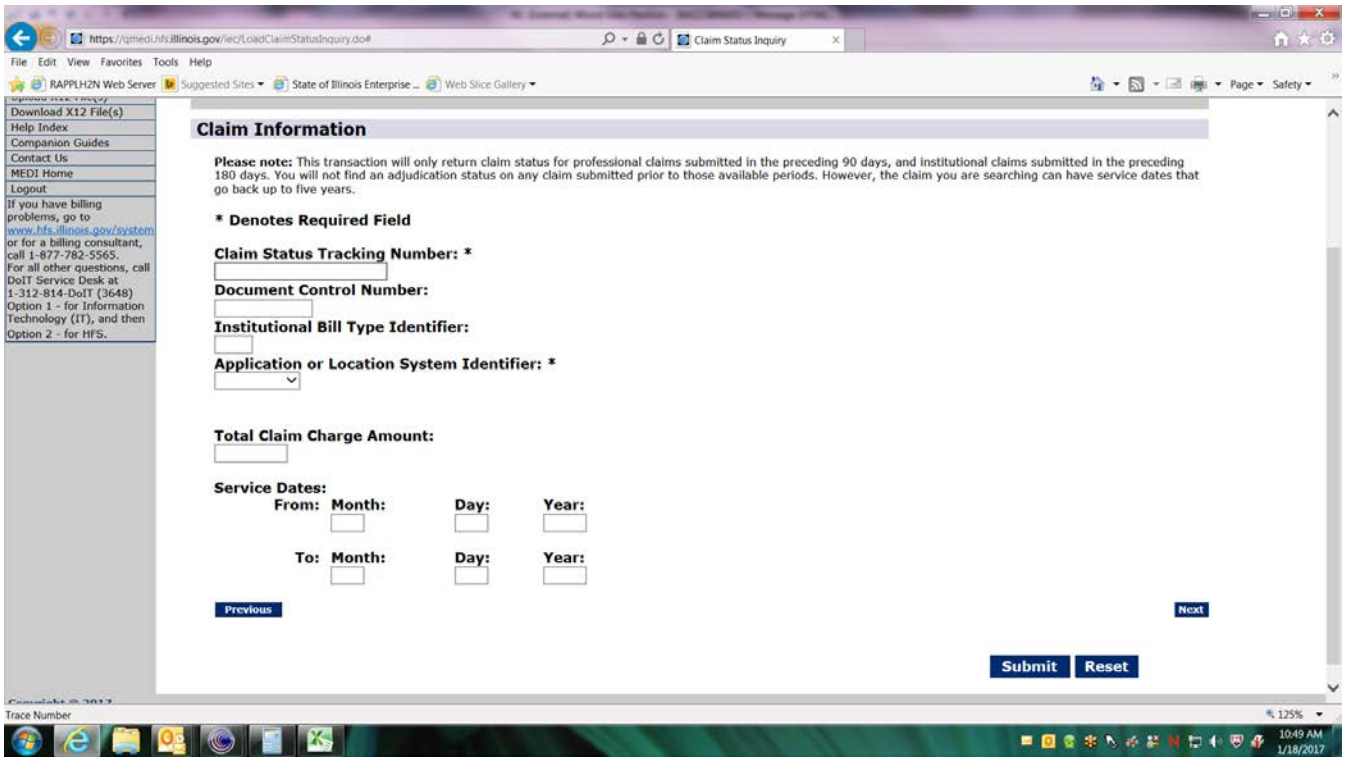
Through the MEDI IEC links, the status of accepted claims can be requested individually or by submitting an X12 batch file. It can take up to three business days for the claims status of an accepted claim to appear in MEDI. However, individual claim status can be viewed in MEDI up to 90 days from the receipt of the claim. After 90 days, the claim status is only available through a batch process which requires a Claim Status Request (276) X12 file to be submitted. In response, HFS will send a Claim Status Response (277) X12 file.

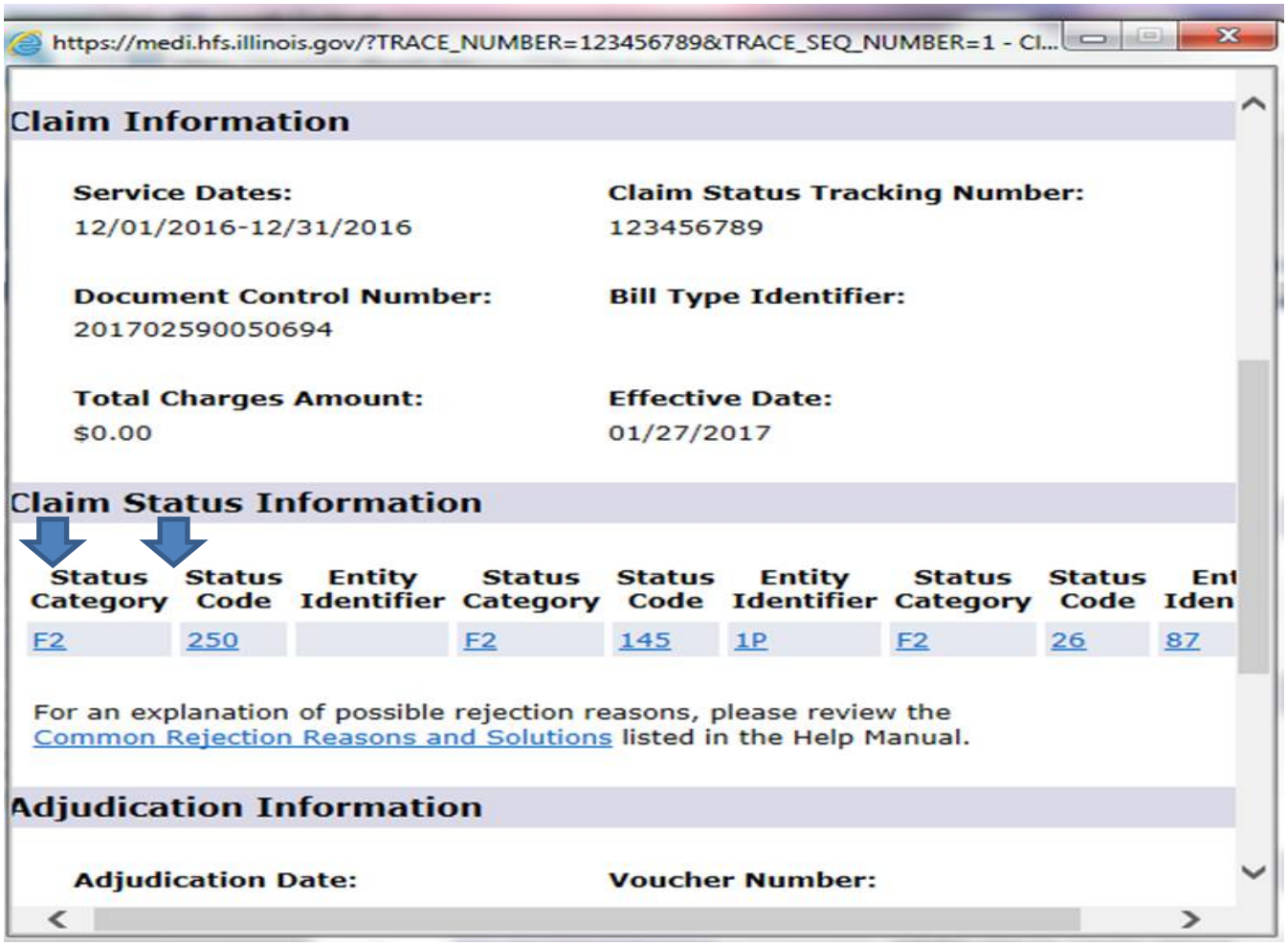
To perform Claim Status inquiries you must be an Administrator on the Medicaid Provider MEDI account or a registered employee.

The following steps show how to submit an **individual** claim status inquiry:

1. Login to MEDI https://medi.hfs.illinois.gov/
2. Select Internet Electronic Claims (IEC)
3. Select Claim Status Inquiry
4. Fill in only the boxes with a (*) asterisk
5. Select your provider number from the drop down box
6. Enter the RIN, DOB, and Gender for the recipient you are inquiring about
7. Click “Next”
8. Claim Status Tracking Number can be any number for Long Term Care providers but is a required field
9. Select “Institutional” from the “Application or Location System Identifier”
10. Enter the Service Date as a calendar month – Example: 12/01/2016 – 12/31/2016
11. Click “Submit”




Claim Status Inquiry
Download X12 File(s)
Help Index
Companion Guides
Contact Us
MEDI Home
Logout
If you have billing problems, go to www.hfs.illinois.gov/system or for a billing consultant, call 1-877-782-5565. For all other questions, call DoIT Service Desk at 1-312-814-DoIT (3648) Option 1 - for Information Technology (IT), and then Option 2 - for HFS.
Claim Information
Please note: This transaction will only return claim status for professional claims submitted in the preceding 90 days, and institutional claims submitted in the preceding 180 days. You will not find an adjudication status on any claim submitted prior to those available periods. However, the claim you are searching can have service dates that go back up to five years.
* Denotes Required Field
Claim Status Tracking Number: *
Document Control Number:
Institutional Bill Type Identifier:
Application or Location System Identifier: *
Total Claim Charge Amount:
Service Dates:
From: Month: Day: Year:
To: Month: Day: Year:
Previous
Next
Submit
Reset


https://medi.hfs.illinois.gov/?TRACE_NUMBER=123456789&TRACE_SEQ_NUMBER=1 - Cl...
Claim Information
Service Dates:
12/01/2016-12/31/2016
Claim Status Tracking Number:
123456789
Document Control Number:
201702590050694
Bill Type Identifier:
Total Charges Amount:
$0.00
Effective Date:
01/27/2017
Claim Status Information
Status Category
Status Code
Entity Identifier
Status Category
Status Code
Entity Identifier
Status Category
Status Code
Iden
F2
250
F2
145
1P
F2
26
87
For an explanation of possible rejection reasons, please review the Common Rejection Reasons and Solutions listed in the Help Manual.
Adjudication Information
Adjudication Date:
Voucher Number:

You will receive a Claim Status Category Code reflecting where the claim is in the adjudication process. Claim Status Codes may also be displayed, which are industry standard codes that give a high level description of claim errors.

You will receive one of the following status messages:

- A: Acknowledgement
- A1: Acknowledgement/Receipt: Claim has been received. This does not mean the claim has accepted for adjudication.
- A2: Acknowledgement/Acceptance into adjudication system.
- A3: Acknowledgement/Returned as unprocessable. The claim has been rejected and has not been entered into the adjudication system.
- A4: Acknowledgement/Not Found: The claim cannot be found in the adjudication system.
- D0: Data Search Unsuccessful – The payer is unable to return status on the requested claim(s) based on the submitted search criteria.
- P: Pending
- P0: Pending: Adjudication/Details – This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued or only part of the claim has been paid.
- P1: Pending/In Process: The claim is in the adjudication system
- P2: Pending/In Review: The claim is suspended pending review. Claim holds take additional days or weeks to either process for payment or get assigned error codes because they are taken out of the typical adjudication process
- F: Finalized
- F1: Finalized/Payment: The claim has been paid
- F2: Finalized/Denial: The claim has denied.

For detailed information of what these codes are describing and how they relate to the claim please visit the Washington Publishing Company at the following links:

Claim Status Codes:

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/

Claim Status Category Codes:

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/

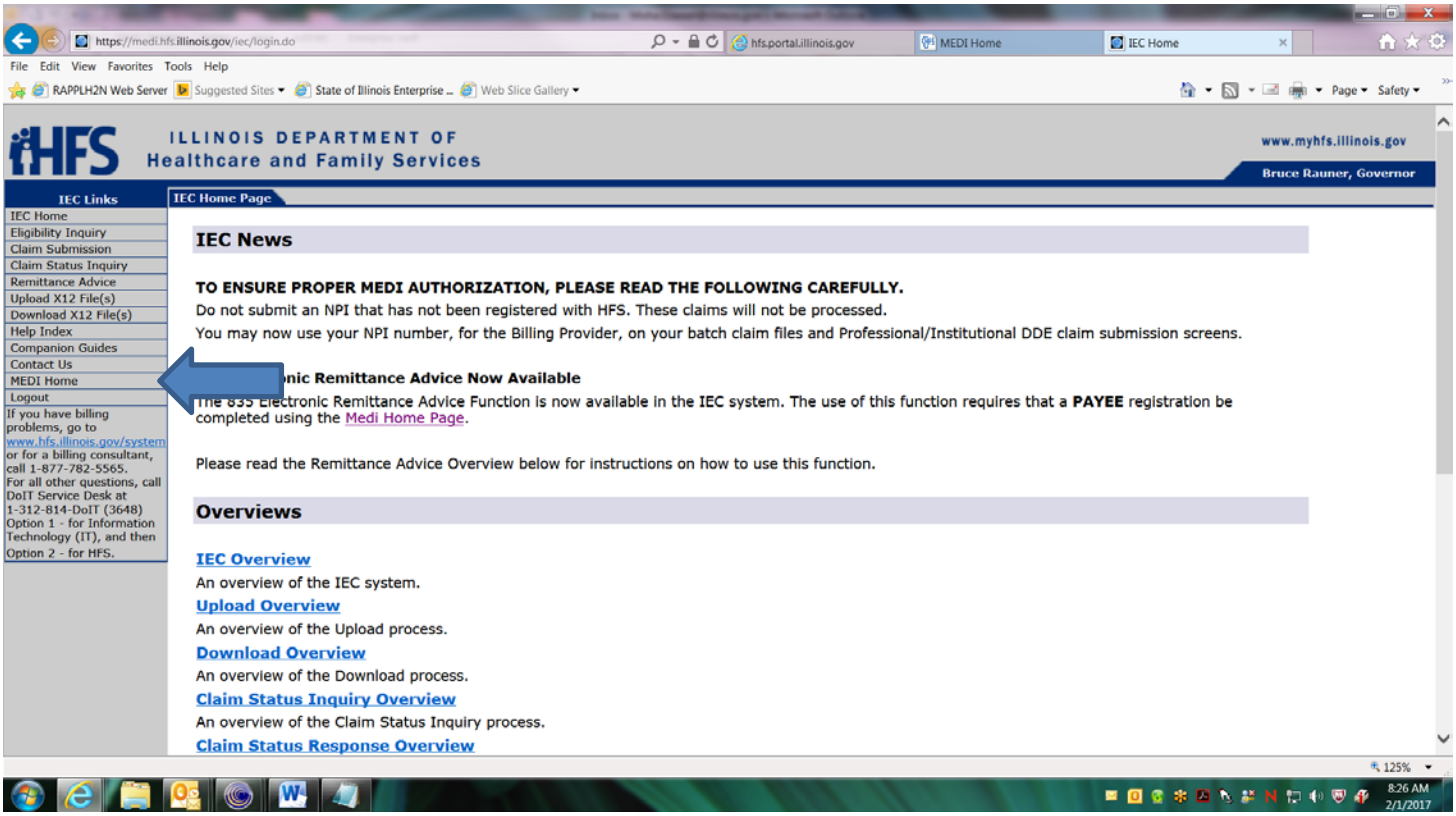
NOTE:

If MEDI claim status inquiry indicates claim has been rejected or denied please refer to the Common Rejection Reasons and Solution listed in the MEDI Help Manual. Also refer to the actual remittance advice (electronic and paper), for rejection reasons.

276 – 277 Batch Request

To request claim status information in a batch file, providers must submit a file of claims for which they are seeking status. The submitted file must be in an X12 format and follow the Washington Publishing Company's 276/277 Health Care Claim Status Request and Response Implementation Guidelines for the Health Insurance Portability and Accountability Act (HIPPA), (version 005010X223). The HFS Medical Provider Handbook Chapter 300 also contains a Health Care Claim Status Request and Response Standard Companion Guide, which provides Illinois specific information related to the 276/277 transaction.

1. Create and name a batch file formatted in X12 for submitted claims following the guidelines set forth in the references above.
2. Login to MEDI https://medi.hfs.illinois.gov/
3. Click on Internet Electronic Claims
4. Click on Upload X12 File(s)
5. Select your provider/entity from the dropdown box
6. Browse and find the X12 File you created and select it
7. Click on "Add File"
8. Put a check in the box to the left of the file in the bottom box
9. Click "Upload Files"
10. A response to the batch inquiry response usually occurs within 24 hours
11. When complete the 277 response will be available in the Download X12 tab in MEDI



Sample 276 Request (X12) – 1 Recipient

ISA*00* *00* *ZZ*123456789DPA001*ZZ*37-1320188INT *170222*0847*^*00501*154200555*1*P*>
GS*HR*4KJL3QQLK23N*37-1320188*20170222*0847*154200555*X*005010X212
ST*276*154200555*005010X212
BHT*0010*13*154200555*20170222*0847
HL*1**20*1
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188
HL*2*1*21*1
NM1*41*2*XYZ CLEARINGHOUSE*****46*4KJL3QQLK23N
HL*3*2*19*1
NM1*1P*2*ACME LTC*****XX*1234567890
HL*4*3*22*0
NM1*IL*1*JONES*CLARENCE****MI*999999999
TRN*1*154200555_L71784XX001XB
REF*EJ*L71784XX001XB
REF*BLT*131
REF*LU*INST
AMT*T3*168906.65
DTP*472*RD8*20161201-20161231
HL*5*3*22*0
SE*18*154200555
GE*1*154200555
IEA*1*154200555

Notations:

TRN02: Interchange Control Number and Patient Control # used to submit the claim. This number must match exactly how it was submitted on the claim/batch.

AMT02: Total amount billed on the submitted claim.

Sample 277 Response (X12) – 1 Recipient

ISA*00* *00* *ZZ*37-1320188INT
*ZZ*123456789DPA001*170222*2040*^*00501*000019631*0*P*:
GS*HN*37-1320188*4KJL3QQLK23N*20170222*203330*154200555*X*005010X212
ST*277*0001*005010X212
BHT*0010*08*156906288*20170222*203207*DG
HL*1**20*1
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188
HL*2*1*21*1
NM1*41*2*XYZ CLEARINGHOUSE*****46*4KJL3QQLK23N
HL*3*2*19*1
NM1*1P*2*ACME LTC*****XX*1234567890
HL*4*3*22*0
NM1*IL*1*JONES*CLARENCE****MI*999999999
TRN*2*154200555_L71784XX001XB
STC*P1:38*20170101**16906.65*3744.11
REF*1K*201621090009519
REF*BLT*111
REF*EJ*435071XX001X
DTP*472*RD8*20161201-20161231
HL*5*3*22*0
SE*18*0001
GE*1*196310001
IEA*1*000019631

Notations:

TRN02: Interchange Control Number and Patient Control Number used to send the 276 Claim Status Request will be returned. If the numbers entered on the 276 did not match the number entered on the claim or batch status results may vary or result in D0.

Status breakdown:

STC01: Industry Code (P1) and Status Code (38)
STC02: Date Claim was Placed in Status Category
STC04: Original Submitted Charges
STC05: Adjudicated Amount
REF01: Reference Identification Qualifier

REF02: HFS Payer Internal Claim Control Number (DCN) – This number can be referenced back to the proprietary paper remittance advice.

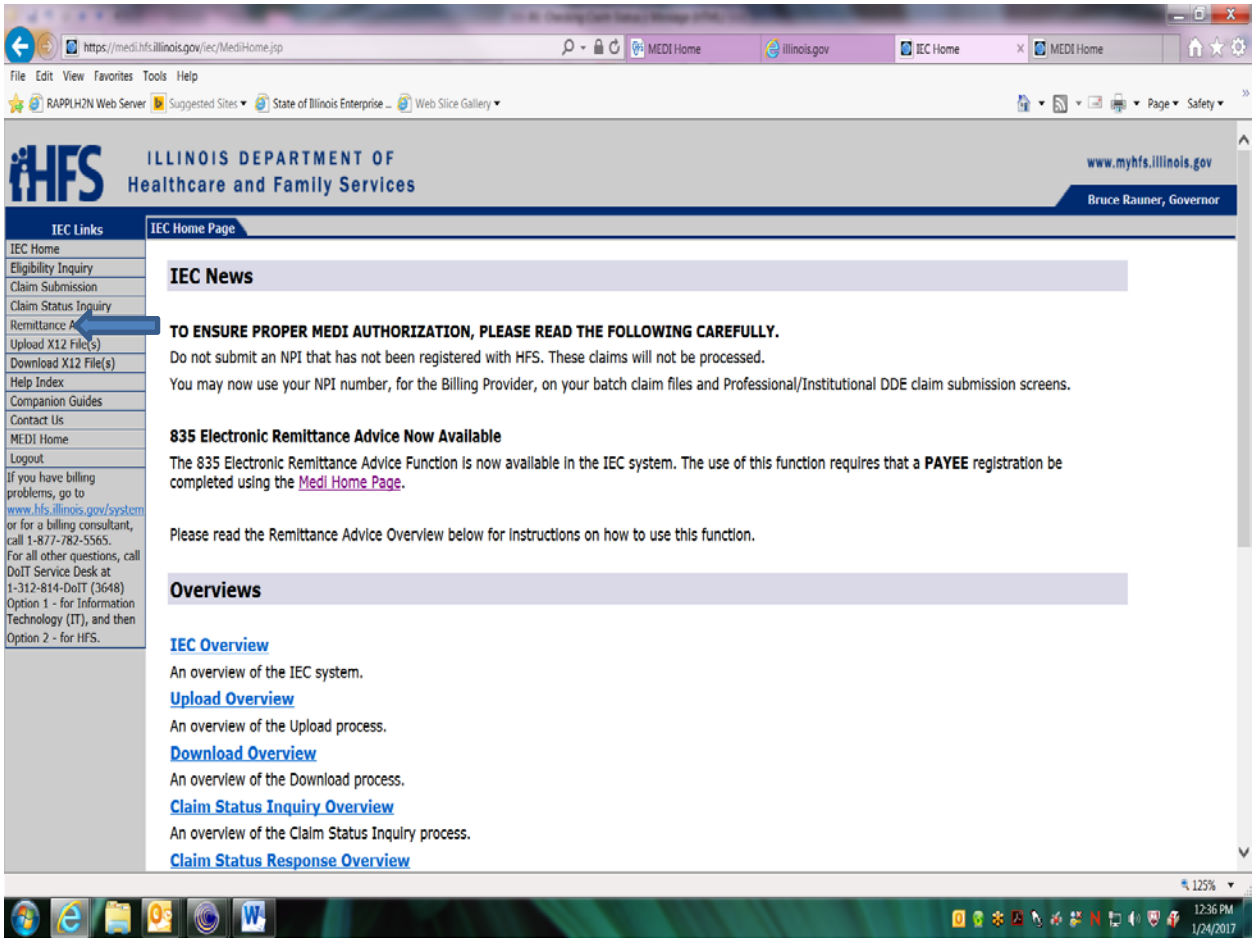
835 ERA Download

Payees registered in MEDI can download 835 Electronic Remittance Advices for their registered LTC providers. The 835 ERA's are in HIPPA compliant X12 format and follow the guidelines set forth by the Washington Publishing Company's 835 Health Care Claim Payment/Remittance Advice Implementation Guidelines for the Health Insurance Portability and Accountability Act (HIPPA) version 005010X223.

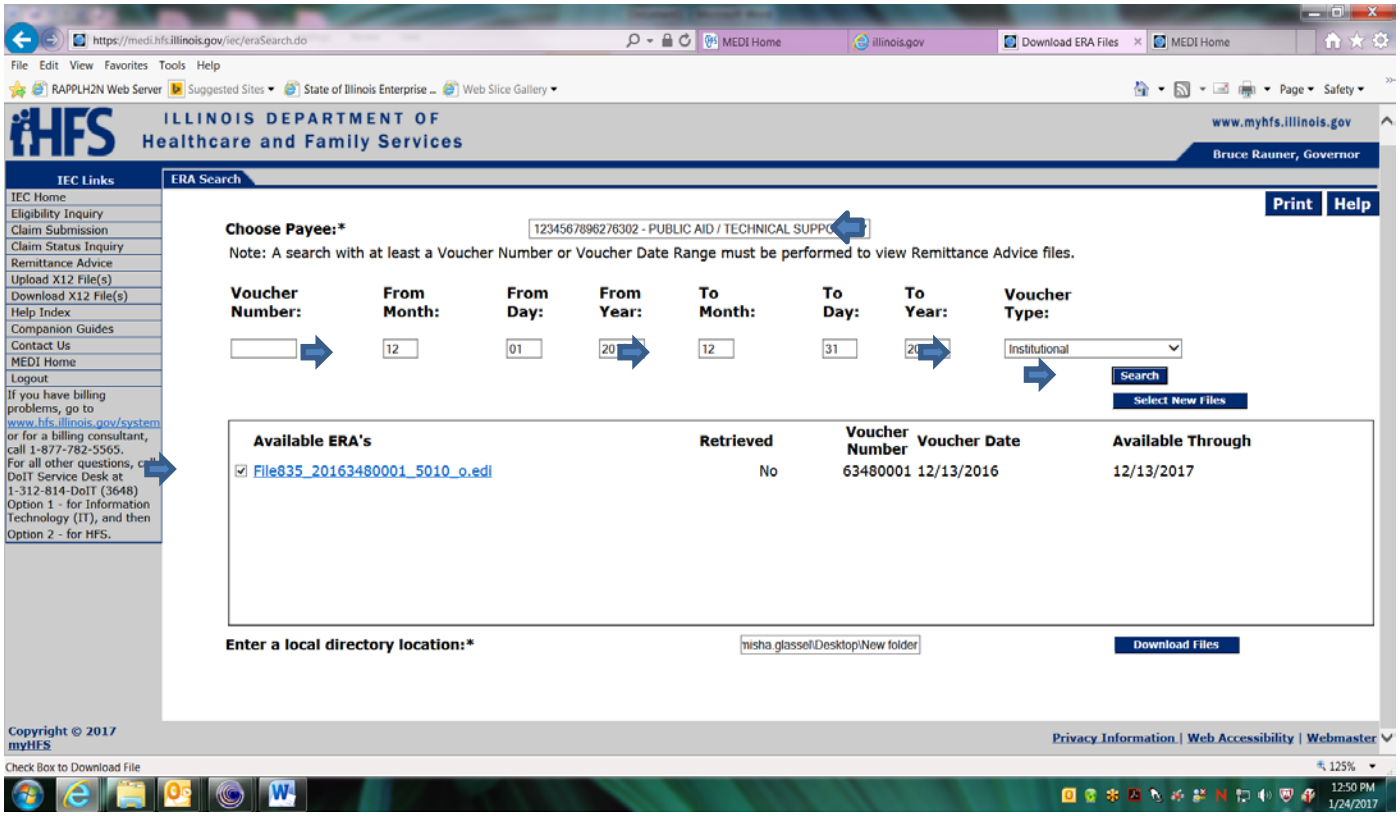
The HFS Medical Provider Handbook, Chapter 300 also contains a Health Care Claim Payment/Advice Standard Companion Guide which provides Illinois specific information related to the 835 transaction https://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx

To view and download available 835 ERA's follow the instructions below:

1. Login to MEDI https://medi.hfs.illinois.gov/
2. Click on Internet Electronic Claims (IEC)
3. Click on Remittance Advice



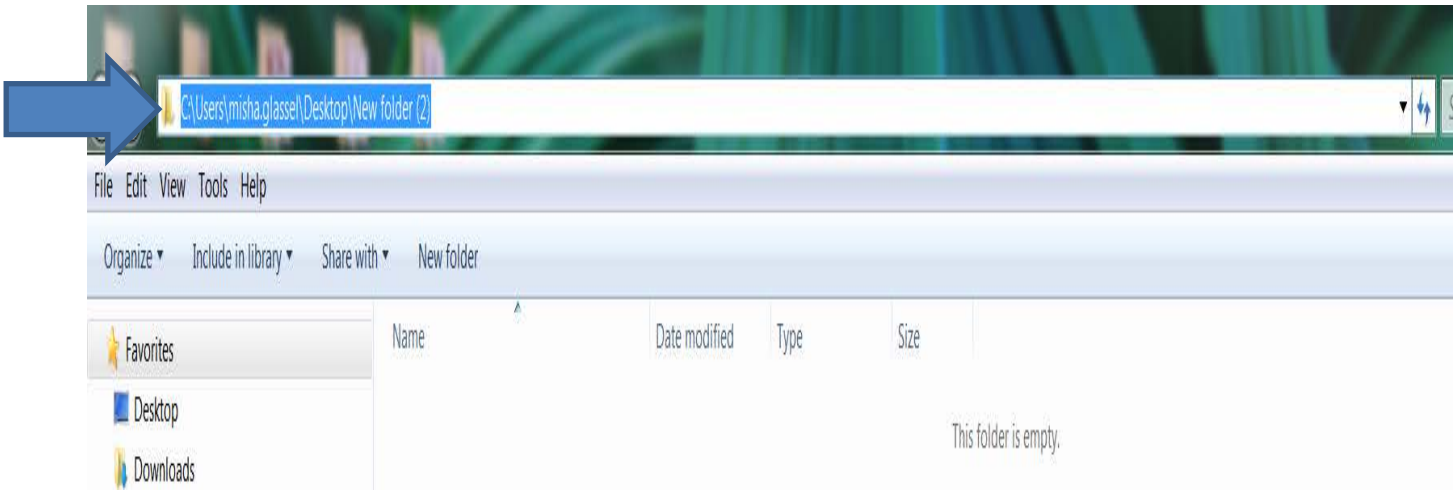
4. Select your provider/payee from the drop down box
5. Enter a date range (**From** and **To** fields are required)
6. Select "Institutional" from the Voucher Type drop down box
7. Click "Search"
8. Check the box next to the "Available ERA's"



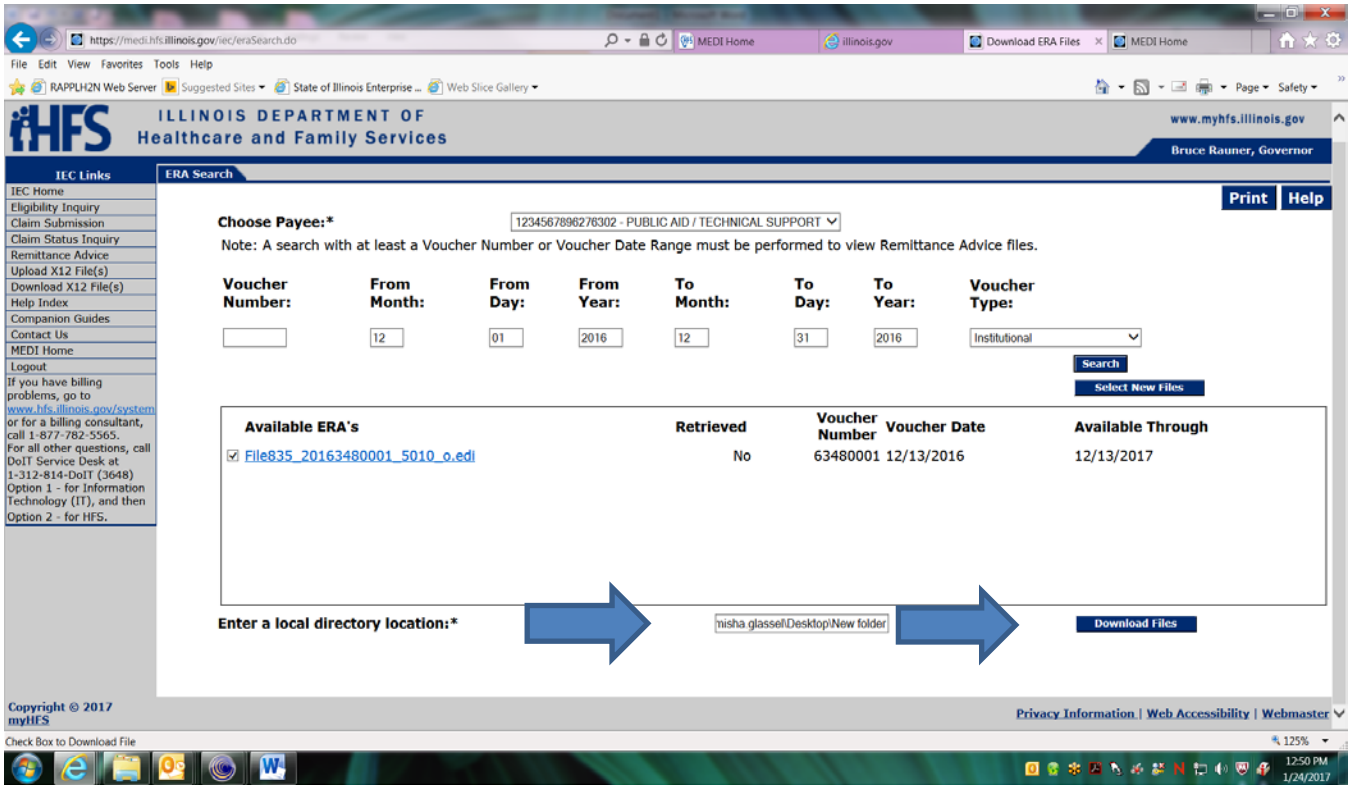
9. Create a folder on your desktop or directory of your choice to download your file to

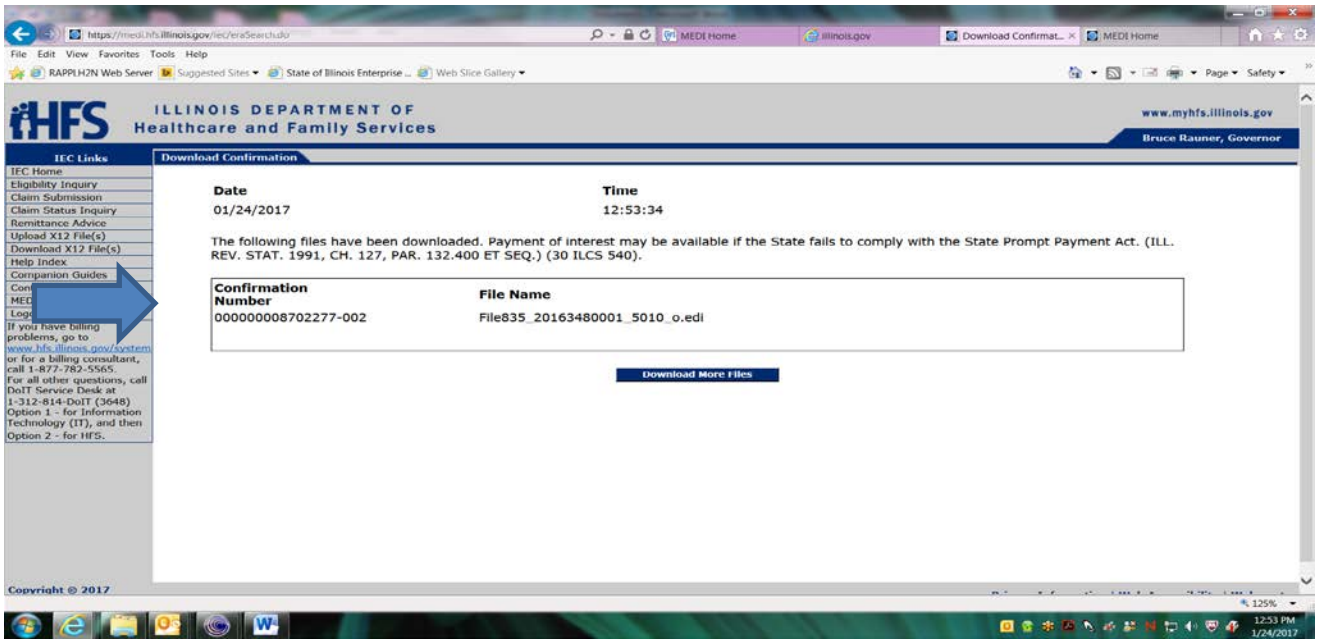
10. Open the newly created file

11. Click on the yellow folder located in the upper left hand corner of the newly created desktop folder and copy the **directory file path**

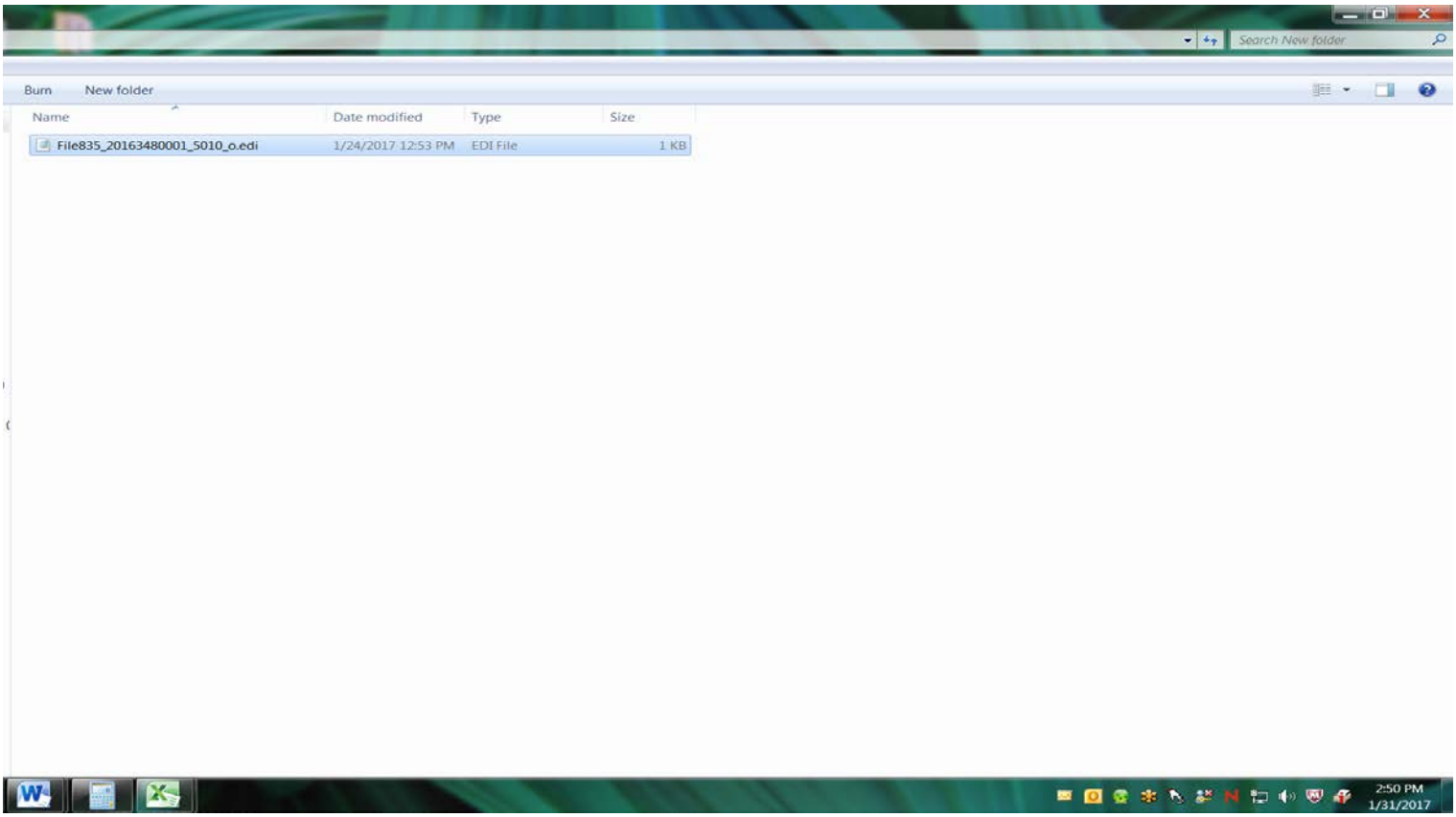


12. Paste the directory path into the “Enter a local directory location” field
13. Click Download Files and make note of the download confirmation number

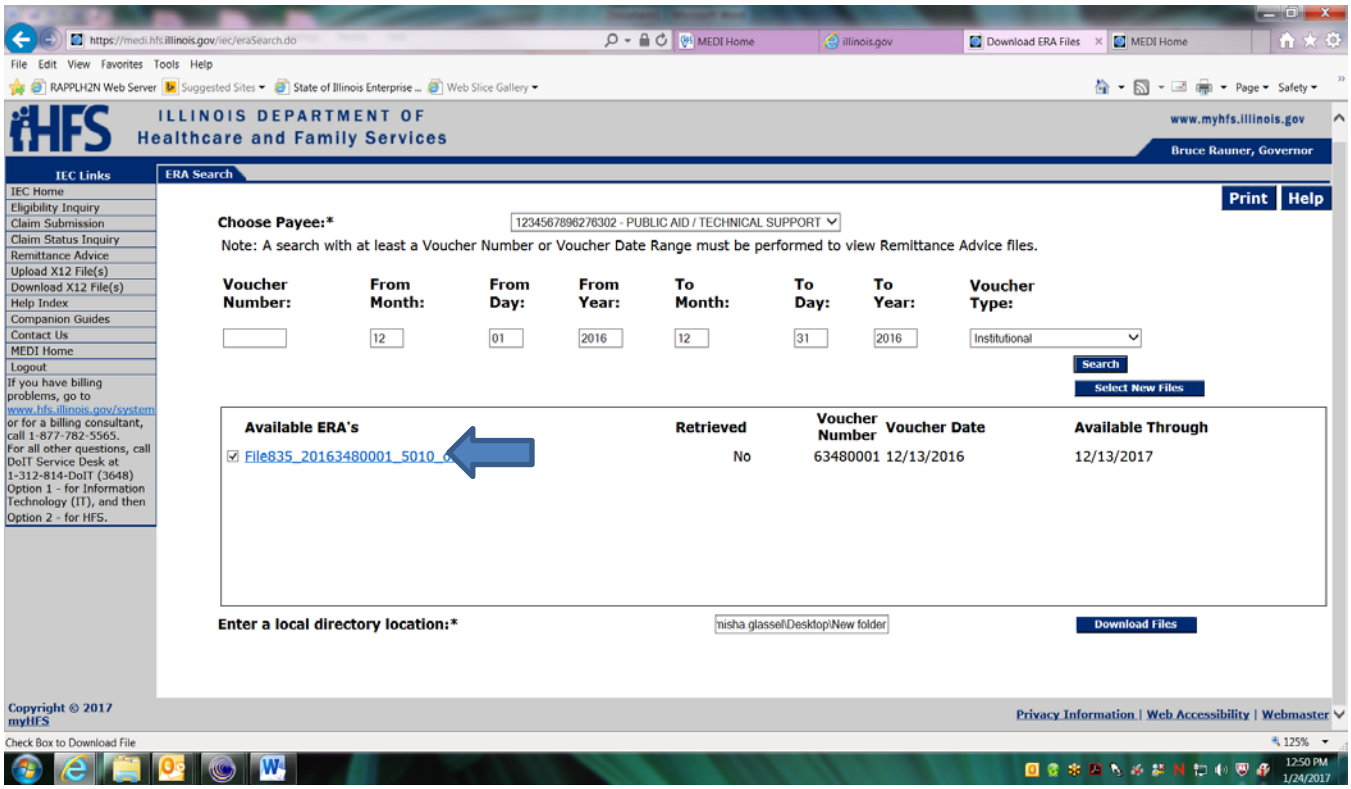




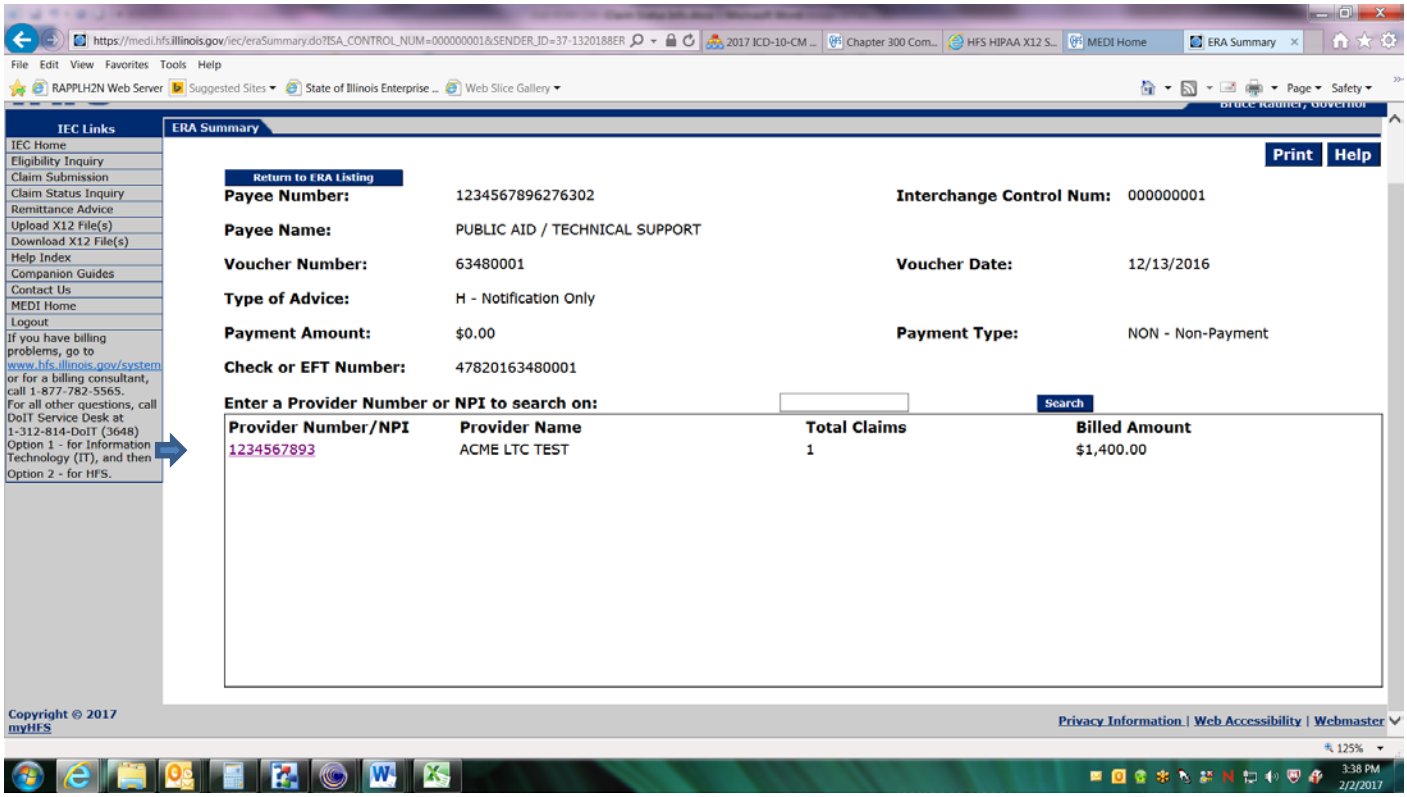
14. Open the folder on the desktop or other local directory
15. If prompted, select the option to open the file '**From a list of available programs'**
16. Open the file using a software program capable of reading and/or formatting X12 data (information that is uploaded in MEDI is formatted as X12 and will be downloadable formatted in X12)



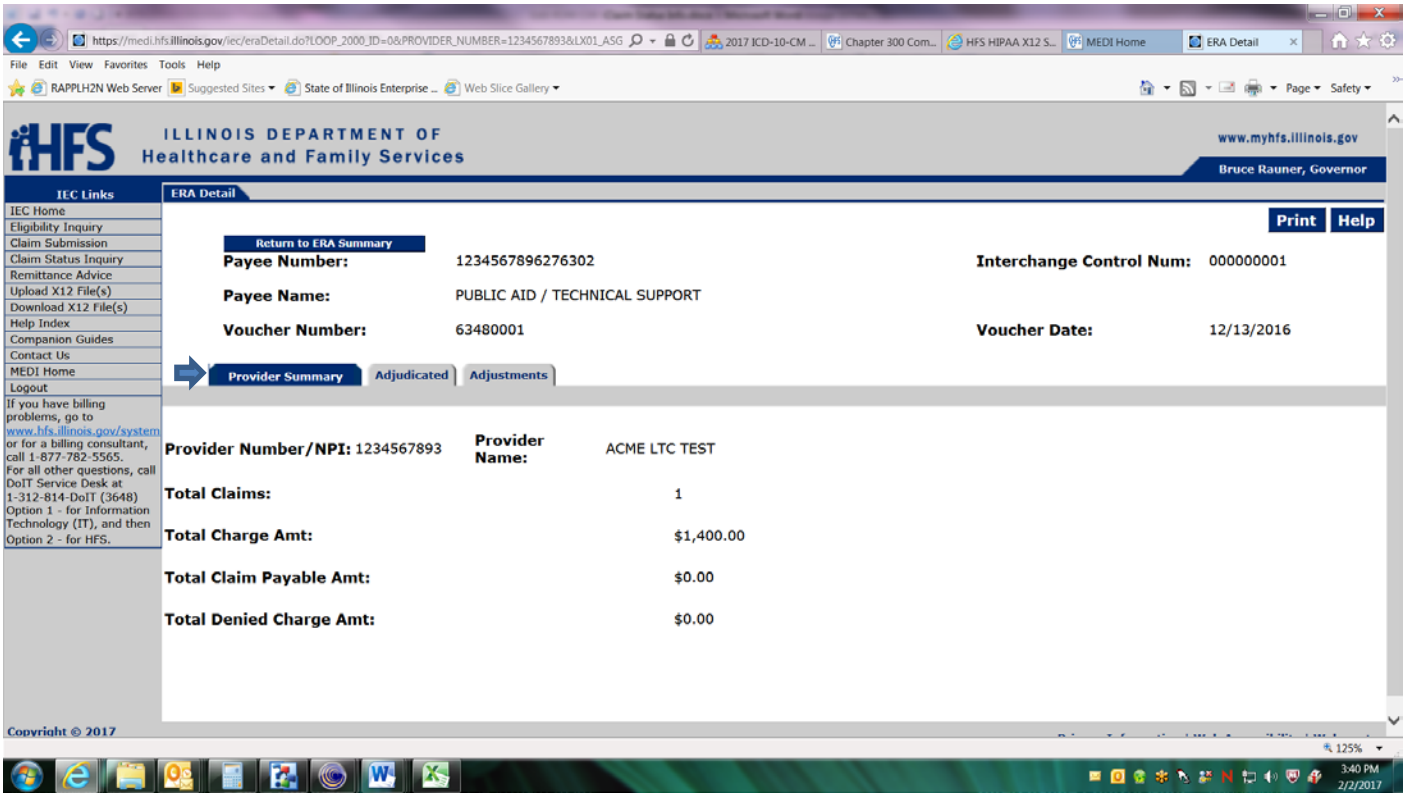
17. Adjudication information can be viewed electronically in MEDI as well as X12 file format by clicking on the highlighted file



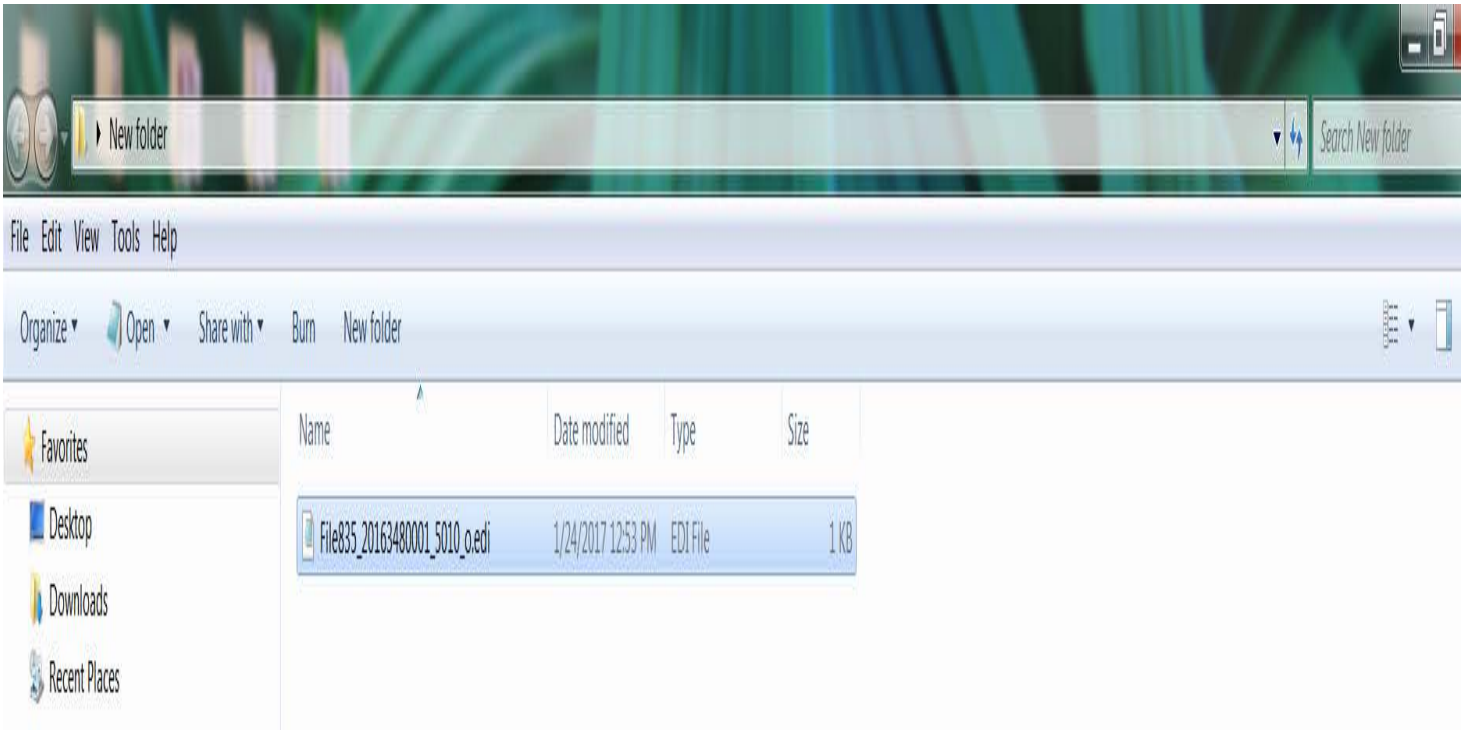
18. On the next page click on Provider Number/NPI



19. The next page contains a Provider Summary, Adjudication information, and Adjustment information



20. If you chose to download your file to a folder open the file with a program capable of reading and/or formatting X12 such as WordPad or NotePad (Sample 835 X12 Below)



The Medicaid Provider Handbook Chapter 300 Companion Guide section on the 835 Health Care Claim Payment /Advice provides Illinois specific guidance related to the 835 remittance advice. Please also visit the following links for 835 Electronic Remittance Advice Adjustment Reasons and Remark Codes at the Washington Publishing Company Website:

Claim Adjustment Reasons:

http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Remittance Advice Remark Codes:

http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

NOTE:

HFS proprietary remittance advices will continue to be produces and mailed within a few business days from the date the claim is adjudicated. The paper remittances will also continue to display the HFS proprietary error codes that may more specifically define the reason for error.

Sample 835

ISA*00* *00* *ZZ*37-1320188ERA
*ZZ*123456789DPA009*161213*1831*^*00501*000000001*0*P*:
GS*HP*37-1320188*6276302*20161213*18311917*1*X*005010X221A1
ST*835*0001
BPR*H*0*C*NON**********20161213
TRN*1*47820163480001*1371320188
DTM*405*20161213
N1*PR*ILLINOIS MEDICAID
N3*201 SOUTH GRAND AVENUE EAST
N4*SPRINGFIELD*IL*627630001
PER*CX*HFS billing helpdesk*TE*1-877-782-5565
PER*BL*HFS technical helpdesk*TE*1-800-366-8768
N1*PE*PUBLIC AID / TECHNICAL SUPPORT*FI*123456789
N3*201 S GRAND AVE E 3RD FLOOR
N4*SPRINGFIELD*IL*62763
REF*PQ*1234567896276302
LX*1
TS3*1234567893*66*20161231*1*1400
CLP*TEST1*1*1400*0**MC*201628490005369*66*3
CAS*CO*A1*1400
NM1*QC*1*LTCEIGHT*BEN****MR*127412328
NM1*82*2*ACME LTC TEST*****XX*1234567893
DTM*232*20161001
DTM*233*20161007
SE*22*0001
GE*1*1
IEA*1*000000001