NOVITAS SOLUTIONS

Understanding the 277CA Claims Acknowledgement

For X12N 837 electronic claim files only

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What is the 277CA?

- The 277CA (Claims Acknowledgement) is a report created by Novitas Solutions, Inc. after your claim file has been received electronically and accepted on the 999 report.
- A 277CA will acknowledge all accepted or rejected claims in the file.
- A 277CA for an accepted claim will contain the claim number. Use returned claim numbers for future claim status inquiries.

Why is the 277CA important?

- It is a necessary part of the electronic claim process flow to ensure your claims will be forwarded to the Novitas claim processing system for payment consideration.
- This report provides error details for claims that require corrections.
- Claims with errors may need to be corrected and resubmitted.

Electronic Claim Process Flow:



When is the 277CA available?

- The 277CA is created after your claim file generates the 999. If the 999 rejected, a 277CA will not be generated.
    - See the 999 Training Module for more information on the 999 report.
- Depending on the volume of files being received, it could take up to 25 minutes to receive this report after a file is submitted.
- The 277CA is available for you to retrieve for 60 calendar days only.
- This report is available for test 837 file transmissions. However, NO test claims will be forwarded for processing – the approved/rejected claim information is for test purposes only.

How do I get the 277CA?

- Your vendor may have programmed your software to automatically retrieve the 277CA for you. If you are unsure, you should contact your vendor.

- If you submit your claims through a clearinghouse or billing service, the 277CA would be sent to them. They should be providing you with information on any rejected claims.

- If you are using the PC-ACE software provided by Novitas, refer to the PC-ACE User Guide: Section 9 – Electronic Reports (JH)(JL).

- If you are enrolled to use our Novitasphere Portal, please review the Novitasphere Portal user manual supplement: Claim Submission/ERA using TIBCO (JH)(JL) for steps on downloading your reports.

What does the 277CA look like?

- The report appearance may vary, depending on these things:
  - Whether there were rejected claims.
  - How many batches of claims were sent.
  - Your vendor's programming.

- The 277CA is an electronic transaction file compiled of fields and segments. Knowledge of the technical specifications of the transaction, or vendor interpretation programming, is required to understand the report. Contact your vendor to see if they offer a reader-friendly version of this report.

- The Medicare free billing software, PC-ACE software (JH)(JL), is available to provide an interpreted version.

- Interpretation and report examples are available later in this training module.

Where can I lookup code details?

- Claim Status Codes and Claim Status Category Codes are provided in the STC segments of the 277CA report. These codes identify if the claims were accepted or rejected. The following resources are available for interpreting the Claim Status and Claim Status Category Codes:
  - X12 Claim Status Category Codes
  - X12 Claim Status Codes
- Novitas also offers a 277CA Rejection Code Lookup (JH)(JL) tool. This web page allows you to search for a specific code and obtain the description.

How can I identify claim errors?

- **Look for the STC segments in the file** and locate the Claim Status and Claim Status Category code. i.e. A7:254
- Verify the code's definition using a resource mentioned on the previous page.
- Locate the QTY segment to determine the total rejected claims or total rejected segment quantity.

90 = Acknowledged Quantity	QA = Quantity Approved
AA = Unacknowledged Quantity	QC = Quantity Disapproved

- Locate the Entity Identifier Code in the NM1 segment located just above the STC segment. This will identify which Entity has an error. Examples of the Entity Identifier code are listed below:

AY = Clearinghouse	85 = Billing Provider
41 = Submitter	IL = Subscriber

NOTE: You must review the entire report. There may be rejections on multiple claims.

277CA raw data example

```
ST*277*0001*005010X214
BHT*0085*08*277X2140001*20060205*1635*TH
HL*1**20*1
NM1*AY*2*FIRST CLEARINGHOUSE  ***** 46*CLHR00
TRN*1*200102051635S00001ABCDEF
DTP*050*D8*20060205
DTP*009*D8*20060205
HL*2*1*21*1~NM1*41*2*BEST BILLING SERVICE*****46*S00001
TRN*2*2002020542857
STC*A7:23*20060205*U*1000
QTY*AA*3~AMT*YY*1000.00
HL*3*2*19*0~NM1*85*2*SMITH CLINIC*****FI*123456789
TRN*1*SMITH789
STC*A7:511:85**U*1000.00*****A7:504
QTY*QC*3
AMT*YY*1000.00
SE*22*0001~
```

Interpreting the 277CA, Claim-level rejection

- This is an example of a file that rejected a claim for invalid total charge. View the explanations on the next few pages for help in interpreting this report.

ST*277*0001*005010X214~	**ST** –Transaction Set Header **277** – Health Care Information Status Notification **0001** – Transaction Set Control Number **005010X214** - Implementation Convention Reference
BHT*0085*08*277X2140001*20060205*1635*TH~	**BHT** – Beginning of Hierarchical Transaction **0085** - Hierarchical Structure Code - Information Source - Information Receiver - Provider of Service - Patient **08** - Transaction Set Purpose Code (Status) **277X2140001** – Inventory File Number **20060205** – Transaction Set Creation Date **1635** – Transaction Set Creation Time **TH** – Transaction Type Code (Receipt Acknowledgment Advice)

Interpreting the 277CA, Submitter

HL*1**20*1~	**HL** – Information Source Level **1** – Hierarchical ID Number **20** – Hierarchical Level Code (Information Source) **1** – Subordinate Levels exists
NM1*AY*2*FIRST CLEARINGHOUSE***** 46*CLHR00~	**NM1** – Information Source Name **AY** – Entity Identifier Code (Clearinghouse) **FIRST CLEARINGHOUSE** – Information Source Name **46** – ETIN Qualifier **CLHR00** – ETIN
TRN*1*200102051635S00001ABCDEF~	**TRN** – Transmission Receipt Control Identifier **1** - Current Transaction Trace Numbers **200102051635S00001ABCDEF** - Information Source Application Trace Identifier
DTP*050*D8*20060205~	**DTP** – Information Source Receipt Date **050** – Received Qualifier **D8** – Date Expressed as CCYYMMDD **20060205** - Information Source Receipt Date
DTP*009*D8*20060205~	**DTP** – Information Source Process Date **009** – Process Qualifier **D8** – Date Expressed as CCYYMMDD **20060205** - Information Source Process Date

Interpreting the 277CA, Receiver

HL*2*1*21*1~	**HL** – Information Receiver Level **2** – Hierarchical ID Number **21** – Hierarchical Level Code (Information Receiver) **1** – Subordinate Levels exists
NM1*41*2*BEST BILLING SERVICE***** 46*S00001~	**NM1** – Information Receiver Name **41** – Entity Identifier Code (Submitter) **BEST BILLING SERVICE** – Information Source Name **46** – ETIN Qualifier **CLHR00** – S00001
TRN*2*2002020542857~	**TRN** – Information Receiver Application Trace ID **2** - Referenced Transaction Trace Numbers **2002020542857** - Claim Transaction Batch Number
STC*A7:23*20060205*U*1000~	**STC** – Information Receiver Status Info. **A7** - Ack/Rejected for Invalid Information **23** - Returned to Entity. **20060205** - Status Information Effective Date **U** - Reject **1000** - Total Submitted Charges for Unit Work
QTY*AA*3~	**QTY** – Total Rejected Qty **AA** - Unacknowledged Quantity **3** - Total Rejected Quantity
AMT*YY*1000~	**AMT** – Total Rejected Amount **YY** – Returned Qualifier **1000** – Total Rejected Amount

Interpreting the 277CA, Provider

HL*3*2*19*0~	**HL** – Billing Provider of Service Level Segment ID **3** – Hierarchical ID Number **19** – Provider of Service Qualifier **0** – Subordinate Levels does not exist
NM1*85*2*SMITH CLINIC*****FI*123456789	**NM1** – Billing Provider Name Segment ID **85** – Billing Provider Qualifier **2** – Non Person Qualifier **SMITH CLINIC** – Billing Provider Name **FI** - Federal Tax ID Qualifier **123456789** - Federal Tax ID
TRN*1*SMITH789~	**TRN** – Provider of Service Info Trace ID Segment ID **1** – Current Transaction Trace Numbers **SMITH789** - Provider of Service Info Trace ID
STC*A7:511:85**U*1000*****A7:504~	**STC** – Billing Provider Status Information Segment ID **A7** - Ack/Rejected for Invalid Information **511** - Invalid character **85** – Billing Provider Qualifier **U** - Reject **1000** - Total Submitted Charges for Unit Work **A7** - Ack/Rejected for Invalid Information **504** - Entity's Last Name
QTY*QC*3~	**QTY** – Total Rejected Quantity Segment ID **QC** – Quantity Disapproved Qualifier **3** – Total Rejected Quantity
AMT*YY*1000~	**AMT** – Total Rejected Amount Segment ID **YY** – Returned Qualifier **1000** – Total Rejected Amount
SE*22*0001~	**SE** –Transaction Set Trailer **22** – Transaction Segment Count **0001**- Transaction Set Control Number

What's next?

- After your file is accepted at this level, the accepted claims will be sent to the Novitas Solutions, Inc. claims processing system where policy edits will be applied.

- The claims will be paid or denied, based on policy guidelines. "Clean claims" that are Health Insurance Portability and Accountability Act (HIPAA) compliant, submitted electronically, and meet policy criteria will be processed in as early as 14 days.

- To obtain payment information promptly, be sure to retrieve your Electronic Remittance Advice (ERA). If you are not set-up, check with your vendor to see if they offer a program to retrieve the ERA. Providers may enroll for the Novitasphere portal to retrieve the ERA.

Questions?

- If you have any questions on this transaction, contact the EDI Help Desk or your software vendor.

JL EDI Help Desk: 1-877-235-8073, option 2

JH EDI Help Desk: 1-855-252-8782, option 2

Novitasphere Portal Help Desk: 1-855-880-8424