# Claim Status Basics

## What is a Health Care Transaction?

A health care transaction is an exchange of information between two parties to carry out financial or administrative activities. When electronic transactions are used effectively in health care, they:

- Increase efficiencies in operations
- Improve the quality and accuracy of information
- Reduce the overall costs to the health care system

Widespread use of Healthcare Insurance Portability and Accountability Act of 1996 (**HIPAA) adopted transactions**—where everyone uses the same language, format, and code sets—can lead to substantial savings across the health care industry. To realize these benefits, however, all organizations need to be using the same adopted standards for their transactions.

## Claim Status

A health care **claim status inquiry and response transaction** is a communication between a provider and a payer about a health care claim.

A claim status transaction is used for:

- An inquiry from a provider to a health plan about the status of a health care claim
- A response from the health plan to a provider about the status of a claim

## Adopted Standard

As part of **Administrative Simplification**, HHS adopted a standard for claim status that has two parts:

- The 276 transaction for provider inquiries about claim status
- The 277 transaction for health plan responses about claim status

This standard applies to all **HIPAA-covered entities**—health plans, clearinghouses, and providers.

## Operating Rules

All HIPAA-covered entities are required to adopt business rules, also known as **operating rules** for claim status transactions, as of January 1, 2013.

The operating rules provide guidance for the way certain transactions must be used. For example, health plans must give providers real-time online access to claim status information or respond to a request in a certain amount of time.

View the operating rules on the Council for Affordable Quality Healthcare **CAQH CORE Claim Status**.