

EDI Reference Guide

Dental Electronic Services

Revised January 2008

UNITED CONCORDIA
Insuring America's Dental Health

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1 Introduction

The Provider EDI Reference Guide addresses how Providers, or their business associates, conduct Dental Claim, Claim Acknowledgement, Claim Payment Advice, Claim Status and Eligibility HIPAA standard electronic transactions with United Concordia. This guide also applies to the above referenced transactions that are being transmitted to United Concordia by a clearinghouse.

An Electronic Data Interchange (EDI) **Trading Partner** is defined as any United Concordia customer (Provider, Billing Service, Software Vendor, Clearinghouse, Employer Group, Financial Institution, etc.) that transmits to, or receives electronic data from, United Concordia.

United Concordia EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide. United Concordia EDI Operations supports transactions for multiple payers; each transaction chapter lists the supported payers for that transaction.

While United Concordia EDI Operations will accept HIPAA compliant transactions from any covered entity, HIPAA security requirements dictate that proper procedure be established in order to secure access to data. As a result, United Concordia has a process in place to establish an Electronic Trading Partner relationship. That process has two aspects:

- A Trading Partner Agreement must be submitted which establishes the legal relationship and requirements. This is separate from a participating provider agreement.
- Once the agreement is received, the Trading Partner will be sent a logon ID and password combination for use when accessing United Concordia's EDI system for submission or retrieval of transactions. This ID is also used within EDI Interchanges as the ID of the Trading Partner. Maintenance of the ID and password by the Trading Partner is detailed in the security section of this document.

United Concordia will be supporting the following EDI Transactions:

Provider Transactions

270 Transaction	Eligibility/Benefit Inquiry
271 Transaction	Eligibility or Benefit Information (response to 270)
276 Transaction	Claim Status Request
277 Transaction	Claim Status Notification (response to 276)
837 Transaction	Two implementations of this transaction: Dental Professional
835 Transaction	Claim Payment/Advice (Electronic Remittance)
277A Transaction	Claim Acknowledgement (Replaces Submission Summary Report)
997 Transaction	Functional Group Acknowledgement

NOTE: To receive authorization to submit EDI transactions to United Concordia, you must complete the Trading Partner Agreement and Trading Partner EDI Application which can be found on our website at www.unitedconcordia.com. Select the “Dentist” tab, then select the “Electronic Data Interchange” link at the left side of the page, then select the category which best represents your company.

2 General Information

2.1 Contact Information

Information on EDI Transactions can be accessed at www.unitedconcordia.com.

For questions concerning logon IDs, passwords, or file transmissions, please contact Dental Electronic Services.

Address: Dental Electronic Services
P.O. Box 69408
Harrisburg, PA 17110

or

TELEPHONE NUMBER: (800) 633-5430

FAX NUMBER: (717) 260-7131

When contacting Dental Electronic Services have your Trading Partner Number and Logon ID available. These numbers facilitate the handling of your questions.

Dental Electronic Services personnel are available for questions from 8:30 a.m. to 5:00 p.m. ET, Monday through Friday.

Questions regarding the content of the claim information or eligibility information received should be directed to the appropriate Customer Service Department listed below:

For example, if you are questioning the payment amount on a claim or the effective date of coverage for a member, the appropriate Customer Service department should be contacted.

Dental (Commercial Products) (800) 332-0366

Dental (Tricare Dental Programs) (800) 866-8499

2.2 System Operating Hours

United Concordia is available to handle EDI transactions 24 hours a day seven days a week, except during scheduled system maintenance periods.

We strongly suggest that United Concordia EDI Trading Partners transmit any test data during the hours that United Concordia Dental Electronic Services support is available.

2.3 Audit Procedures

Provider offices that send EDI claims must ensure that input documents and medical records are available for every automated claim for audit purposes. United Concordia may require access to the records at any time.

The Provider's automated claim input documents must be kept on file for a period of seven years after date of service for auditing purposes. Microfilm/microfiche copies of Provider documents are acceptable. The Provider, not his billing agent, is held accountable for accurate records.

The audit consists of verifying a sample of automated claim input against medical records. Retention of records may also be checked. Compliance to reporting requirements is sample checked to ensure proper coding technique is employed. Signature on file records may also be verified.

In accordance with the Trading Partner Agreement, United Concordia may request, and the Provider is obligated to provide, access to the records at any time.

2.4 Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", United Concordia can accept characters from the basic and extended character sets with the following exceptions:

<u>Character</u>	<u>Name</u>	<u>Hex value</u>
!	Exclamation point	(21)
>	Greater than	(3E)
^	Caret	(5E)
	Pipe	(7C)
~	Tilde	(7E)

These five characters are used by United Concordia for delimiters on outgoing transactions and control characters for internal processing and therefore would cause problems if encountered in the transaction data. As described in the X12 standards organization's Application Control Structure document (X12.6), a string data element is a sequence of characters from the basic or extended character sets and contains at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. In the actual data stream trailing spaces should be suppressed. The representation for this data element type is AN.

3 Security Features

United Concordia Dental Electronic Services personnel will assign Login IDs and Passwords to Trading Partners. EDI Transactions submitted by unauthorized Trading Partners will not be accepted by our United Concordia EDI Operations system.

Trading Partners should protect password privacy by limiting knowledge of the password to key personnel. Also, the password should be changed if there are personnel changes in the Trading Partner office, or at any time the Trading Partner deems necessary.

3.1 Confidentiality

United Concordia and its Trading Partners will comply with the privacy standards for all EDI transactions as outlined in the United Concordia EDI Trading Partner Agreement.

3.2 Authorized Release of Information

When contacting Dental Electronic Services concerning any EDI transactions, you will be asked to confirm your Trading Partner information.

4 Authorization Process

New Trading Partners wishing to submit EDI Transactions electronically must complete and forward a Trading Partner Agreement and EDI Transaction Application to United Concordia Dental Electronic Services.

Completion of the Trading Partner Agreement indicates compliance with specifications set forth by United Concordia for the submission of EDI Transactions. This form must be completed and signed by an authorized representative of the organization.

Complete and accurate reporting of information on both documents will insure that your authorization forms are processed in a timely manner. If you need assistance in completing these forms, contact Dental Electronic Services.

Upon completion of the authorization process, a Logon ID and Password will be assigned to the Trading Partner. Dental Electronic Services will authorize, in writing via mail, the Trading Partner to submit production EDI Transactions.

Test files may be submitted at the discretion of the Trading Partner.

4.1 Where to Get Enrollment Forms to Request a Trading Partner ID

To receive a Trading Partner ID, you must complete the Trading Partner Agreement and the EDI Transaction Application. You can download these forms from our website, www.unitedconcordia.com. Select the “Dentist” tab, then select the “Electronic Data Interchange” link at the left side of the page, then select the category which best represents your company.

4.2 Receiving 835 Transactions

If you are not currently receiving 835 (Electronic Remittance Advice) transactions and wish to, you will either need to complete a new EDI Transaction Application or fax a request to Dental Electronic Services. Please include your Trading Partner number on the request. When a Trading Partner is approved to receive 835 transactions, those transactions will be sent for all United Concordia products.

4.3 Adding a New Provider to an Existing Trading Partner

Trading Partners currently using electronic claim submission who wish to add a new provider to their Trading Partner Number should instruct the provider to call Dental Electronic Services at (800) 633-5430.

4.4 Deleting Providers from an Existing Trading Partner

Providers wishing to be deleted from an existing Trading Partner should contact Dental Electronic Services at (800) 633-5430.

4.5 Reporting Changes in Status

Trading Partners changing their information must inform Dental Electronic Services by completing a new EDI Transaction Application or by faxing a letter with the changes indicated to (717) 260-7131. Include the Trading Partner Number on the request.

5 Testing Policy

5.1 United Concordia Syntax Testing

All transactions will be taken into United Concordia's translator and edited for X12 syntax. A functional acknowledgement 997 transaction will be returned indicating the results of the test. Note that syntax checking is done for any transaction submitted to United Concordia regardless of test or production status of the submitted file.

Trading Partners may choose to submit test transactions to United Concordia at any time. In order to submit a test file, you must indicate "test" in the ISA segment. Any transactions marked as "production" will be processed against actual production data.

Refer to Chapter 8 Section 8.1.3 for details on testing of business edits in the 837D transaction.

6 Communications

6.1 Asynchronous Dial-Up

Trading Partners submitting via modem dial a toll free telephone number and establish a reliable link with United Concordia.

In order to submit electronically via modem, you will need a computer, modem, and software programmed with the option to submit electronic to United Concordia. Additionally, a dedicated telephone line for your modem is recommended.

Trading Partners should use modems that support the Z modem transfer protocol and incorporate error correction capabilities. Modem baud rates can range up to 56,000.

For transmitting or retrieving transactions, the asynchronous phone numbers are (877) 533-1539 (Toll-free) and (717) 214-7376 (Toll). You must use the Toll number when retrieving the 835 transaction.

After connecting to United Concordia you will be required to enter your EDI User Logon ID.

To reach a command prompt, enter the Logon ID followed by a semicolon(;). You will then be required to enter your password. At that point and you will get to the prompt (PN>). The alpha character in the Logon ID must be entered as lower case.

The following is a list of valid commands. All of the commands are shown here in upper case. These commands must be entered into the system in lower case (no shift key or shift-lock). The system will always echo the characters back in upper case:

XS	Submit any X12 transaction
XACK	Retrieve any and all X12 functional acknowledgements
XR	Retrieve 835 transactions
X271	Retrieve 271 transactions (response to 270 inquiry)
X277	Retrieve 277 transactions
X277U	Retrieve 277U (unsolicited) transactions
X###	Retrieve other X12 response transactions (future)
CHPASS	Change Password
L	Logoff

NOTE: All of the commands are shown above in upper case. These commands must be entered into the system in lower case (no shift key or shift-lock). The system will always echo the characters back in upper case.

6.1.1 Menu Option

To reach the EDI Operations menu, enter the User Login ID at the Login prompt and you will be directed to the Welcome page (see example). **NOTE: The S, G, A, R, and H commands are not valid for HIPAA-compliant transactions.**

In addition to options listed on the menu screen, you can also enter HIPAA-compliant commands. At “Enter letter or selection”, type XS, XACK, etc.



In addition to options listed on the menu screen, you can also enter HIPAA-compliant commands. At “Enter letter or selection”, type XS, XACK, etc.

6.2 Internet

UCCI offers secured File Transfer Protocol (FTP) through “eDelivery.” “eDelivery” is available for Trading Partners who submit or receive any HIPAA-compliant EDI transactions.

6.2.1 Internet File Transfer Protocol (FTP) through “eDelivery”

United Concordia utilizes the Highmark Secure FTP Server (“eDelivery”) to provide an FTP service over an encrypted data session providing “on-the-wire” privacy during file exchanges. This service offers an Internet accessible environment to provide the ability to exchange files with customers, providers, and business partners using a simple FTP process in an encrypted and private manner. Any state of the art browser can be used to access the Highmark Secure FTP Server. Browsers must support strong encryption (128 bit) and must allow cookies for session tracking purposes. Once the browser capabilities are confirmed, the following are the general guidelines for exchanging files.

1. Launch your web browser. Highmark has tested Internet Explorer 6.x and Netscape 7.x browsers.
2. Connect to the FTP servers at: <https://ftp.highmark.com>
3. The server will prompt for an ID and Password. Use the ID/Password that Highmark has provided you for accessing this service. Enter the ID, tab to password field and enter the password, then hit enter or click on OK.
4. The server will then place you in your individual file space on the FTP server. No one else can see your space and you cannot access the space of others. You will not be able to change out of your space.
5. You will need to change into the directory for the type of file you are putting or getting from the server.
6. By default, the file transfer mode will be binary and this mode is acceptable for all data types. However, you may change between ASCII and Binary file transfer modes by clicking the “Set ASCII”/“Set Binary” toggle button.
7. Send United Concordia a file. The following is an example of the submission of an 837 claim transaction file:
 - a. Click on the “hipaa-in” folder to change into that directory.
 - b. Click on the browse button to select a file from your system to send to United Concordia. This will pop open a file finder box listing the files available on your system.

- c. Select the file you wish to send to United Concordia and Click on OK.
 - d. This will return you to the browser with the file name you selected in the filename window. Now click on the **“Upload File”** button to transfer the file to Highmark. Once completed, the file will appear in your file list.
8. Retrieve a file from United Concordia. The following is an example of retrieval of a 997 Functional Acknowledgement file:
 - a. Click on the “hipaa-out” directory.
 - b. Your browser will list all the files available to you.
 - c. Click on the “997” directory.
 - d. Click on the file you wish to download. Your browser will download the file. If your browser displays the file instead of downloading, click the browser back button and click on the tools next to the file you wish to receive. Select **application/octet-stream**. Your system may then prompt you for a “Save As” file location window. Make the selection appropriate for your system and click on **Save** to download the file.

7 Transmission Envelopes

7.1 General Information

Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as described in the national implementation guides. United Concordia’s expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each transaction chapter.

Note – United Concordia only supports one interchange (ISA/IEA envelope) per incoming transmission (file). A file containing multiple interchanges will be rejected for a mismatch between the ISA Interchange Control Number at the top of the file and the IEA Interchange Control Number at the end of the file.

7.1.1 Delimiters

As detailed in the national implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to United Concordia EDI Operations (inbound transmissions), the following list contains all characters that can be accepted as a delimiter.

Please note: Delimiters used may not be used in any text/notes/narrative data within the transaction

Description	Hex value
StartOfHeading	01
StartofTeXt	02
EndofTeXt	03
EndOfTrans.	04
ENQuiry	05
ACKnowledge	06
BELL	07
VerticalTab	0B

Description	Hex value
FormFeed	0C
CarriageReturn	0D
DeviceControl1	11
DeviceControl2	12
DeviceControl3	13
DeviceControl4	14
NegativeAcK	15
SYNchron.Idle	16
EndTransBlock	17
FileSeparator	1C
GroupSeparator	1D
RecordSeparator	1E
!	21
“	22
%	25
&	26
‘	27
(28
)	29
*	2A
+	2B
,	2C
.	2E
/	2F
:	3A
;	3B
<	3C
=	3D
>	3E
?	3F

Description	Hex value
@	40
[5B
]	5D
* ^	5E
{	7B
}	7D
~	7E

*NOTE: May be used as a Data Element Separator, but will not be accepted as Component Element Separate, Repeating Element Separate or Segment Terminator.

United Concordia will use the following delimiters in all outbound transactions.

Delimiter Type	Character Used	(hex value)
Data element separator	^	(5E)
Component element separator	>	(3E)
Segment terminator	~	(7E)
Repeating element separator		(7C)

7.2 Data Detail and Explanation of Incoming ISA to United Concordia

Segment: **ISA** Interchange Control Header (Incoming)

Note: This fixed record length segment must be used in accordance with the guidelines in the national transaction implementation guides, with the clarifications listed below.

Data Element Summary

Ref Des.	Element Name	Element Note
ISA01	Authorization Information Qualifier	United Concordia can only support code 00 - No Authorization Information present.
ISA02	Authorization Information	This element must be space filled.
ISA03	Security Information Qualifier	United Concordia can only support code 00 - No security Information present.
ISA04	Security Information	This element must be space filled.
ISA05	Interchange ID Qualifier	Use qualifier code value "ZZ" Mutually Defined, to designate a payer-defined ID. United Concordia only supports United Concordia-assigned proprietary IDs for senders.
ISA06	Interchange Sender ID	United Concordia must receive the security logon ID assigned to the trading partner. This field will be validated against the logon supplied. The ID must be left justified and space filled. Alpha character must be in upper case.
ISA07	Interchange ID Qualifier	Use qualifier code value "33". United Concordia only supports the NAIC code to identify the receiver (United Concordia).
ISA08	Interchange Receiver ID	United Concordia must be identified using NAIC code 89070. The code must be left justified and space filled.
ISA14	Acknowledgement Requested	United Concordia does not consider the contents of ISA14. A TA1 segment is returned when the incoming interchange is rejected.
ISA15	Usage Indicator	United Concordia uses the value in this element to determine the test or production nature of all transactions within the interchange. Only syntax editing will be done when this indicator is set to test.

7.3 Data Detail and Explanation of Outgoing ISA from United Concordia

Segment: **ISA** Interchange Control Header (Outgoing)

Note: Listed below are clarifications of United Concordia’s use of the ISA segment for outgoing interchanges.

Data Element Summary

Ref Des.	Element Name	Element Note
ISA01	Authorization Information Qualifier	United Concordia can only support code 00 - No Authorization Information present.
ISA02	Authorization Information	This element must be space filled.
ISA03	Security Information Qualifier	United Concordia can only support code 00 - No security Information present.
ISA04	Security Information	This element must be space filled.
ISA05	Interchange ID Qualifier	United Concordia will send qualifier code value “33” to designate that the NAIC code is used to identify the sender (United Concordia).
ISA06	Interchange Sender ID	United Concordia will be identified by NAIC code 89070. The code will be left justified and space filled.
ISA07	Interchange ID Qualifier	Use qualifier code value “33”. United Concordia only supports the NAIC code to identify the receiver (United Concordia).
ISA08	Interchange Receiver ID	United Concordia must be identified using NAIC code 89070. The code must be left justified and space filled.
ISA14	Acknowledgement Requested	United Concordia always uses a 0 (no Interchange Acknowledgement Requested).
ISA15	Usage Indicator	United Concordia uses the value in this element to determine the test or production nature of all transactions within the interchange. Only syntax editing will be done when this indicator is set to test.

7.4 Outgoing Interchange Acknowledgement TA1 Segment

United Concordia returns a TA1 Interchange Acknowledgement segment when the entire interchange (ISA-IEA) must be rejected. The reason for the rejection is indicated by the code value in the TA105 data element. This fixed length segment is built in accordance with the guidelines in Appendix B of the national transaction Implementation Guides. Each United Concordia TA1 will have an Interchange Control envelope (ISA-IEA). TA1 segments are not returned for interchanges that are received with no interchange-level errors.

7.5 Outgoing Functional Acknowledgement 997 Transaction

United Concordia returns a 997 Functional Acknowledgement for each Functional Group (GS - GE) envelope that is received. If multiple Functional Groups are received in an Interchange (ISA - IEA) envelope, a corresponding number of 997 Functional Acknowledgement transactions will be returned.

Action on a Functional Group can be: acceptance, partial acceptance, or rejection. A partial acceptance occurs when the Functional Group contains multiple transactions and at least one, but not all, of those transactions is rejected. (Transaction accepted/rejected status is indicated in AK501.) The location and reason for errors are identified in one or more of the following segments:

- AK3 – segment errors
- AK4 – data element errors
- AK5 – transaction errors
- AK9 – functional group errors

Rejection reason codes are contained in Appendix B of each transaction's national Implementation Guides. Rejected transactions or functional groups must be fixed and resubmitted.

997 transactions will have Interchange Control (ISA-IEA) and Functional Group (GS-GE) envelopes. The Version Identifier Code in GS08 of the envelope containing the 997 will be "004010", indicating a generic 4010 997 transaction. Note that this will not match the Implementation Guide identifier that was in the GS08 of the envelope of the original submitted transaction. This difference is because the 997 is generic to the 4010 version and is not unique to each transaction standard.

8 Dental Claim (837D)

The 837D transaction is utilized for dental claims and encounters. The national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage, and requirements. This companion document contains clarifications and payer-specific requirements related to data usage and content when submitting an 837D to United Concordia based on the national 837D implementation guide.

This EDI Reference Guide applies to transactions related to the following United Concordia traditional and managed care products: Preferred Provider Organization (PPO), Point of Service (POS), Indemnity, and Dental Health Maintenance Organization (DHMO).

United Concordia accepts electronic claims for those payers listed below. Those payers are identified by their NAIC codes in the 2010BB destination payer loop of this transaction. United Concordia EDI Operations, identified by United Concordia's NAIC code of 89070, is considered to be the interchange receiver (ISA08) in the ISA Interchange Control Header, and the transaction receiver (NM109) in the 1000B Receiver Name loop of the transaction.

The health care payers and corresponding National Association of Insurance Commissioners (NAIC) codes:

- 89070 - United Concordia
- 54771 - Highmark

8.1 General Information and Guidelines for Submitting an 837D

8.1.1 Data that is Not Used

While the claim information listed below can be (and in some instances must be) contained in a standard claim transaction, United Concordia's processing does not currently use the following information:

1. Submitter EDI Contact and Billing Provider Contact (will use contact information on internal files for initial contact)
2. Receiver and Payer name (will use ID, not name)
3. Pay-To provider that is different than the Billing Provider. The payers' business policy does not recognize or enumerate a "Pay-To" provider separate from a "Billing" provider. Therefore, payments will be made to the Billing Provider, even if a Pay-To Provider is submitted in the claim transaction.
4. Provider addresses (will use data on internal files if provider is identified)
5. Subscriber and Patient Secondary Identification (not needed for processing)

6. Payer Secondary Identification (not needed for processing)
7. Tooth Status Information in the DN2 segment
8. Other Payer Provider identifiers and Other Payer Provider information (not needed because claims are not sent to other payers for COB)

8.1.2 Transaction Size

As required in the national implementation guide, United Concordia can accept up to 5,000 claims per 837D transaction. That is, up to 5,000 “2300” Claim Information loops per ST-SE.

8.1.3 837D Business Edit Testing

To test the 837D business edits associated with United Concordia, you must first contact Dental Electronic Services at 800-633-5430. Dental Electronic Services will provide you the instructions needed to send your test files.

Business edit testing is not required. However, United Concordia highly recommends that an 837D test transaction be sent for all new Trading Partners or when testing new software or software enhancements. We recommend that the 837D test transactions contain between 10-50 claims.

Please see Appendix B for a listing of United Concordia’s business edit responses.

8.2 Data Detail for 837D

The following segment references are clarifications and payer-specific requirements related to data usage and content.

Segment: **GS** Functional Group Header
Loop:
4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02	Application Sender's Code	Sender's United Concordia assigned Trading Partner Number
GS03	Application Receiver's Code	To support United Concordia's routing process, all claims in a functional group must be for the same payer. Submit the NAIC number for the payer identified as the destination payer in loop 2010BB of the 837D transaction. Following is a list of recognized payers and their respective NAIC codes: 89070 - United Concordia

Segment: **REF** Transmission Type Identification
Loop:
4010A1 Page: 57

Data Element Summary

Ref Des.	Element Name	Element Note
REF02	Transmission Type Code	Submit the value specified in the national implementation guide for production mode. Test transmissions are designated by the appropriate code value in the Interchange Control Header segment at ISA15. The submission of a "D" suffix in this REF segment is not necessary to indicate a test transaction, and will not be carried or considered in processing.

Segment: **NM1** Submitter Name
Loop: 1000A
4010A1 Page: 59

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Submitter Identifier	Send Trading Partner Number as assigned by United Concordia's Dental Electronic Services. (i.e., 94XXXX)

Segment: **NM1** Receiver Name
Loop: 1000B
4010A1 Page: 66

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Receiver Primary Identifier	Use 89070 - This 1000B Receiver Name loop identifies the receiver of the transaction, which for United Concordia equates to the interchange receiver identified in the ISA08 element of the Interchange Control Header. The identifier in this element must be United Concordia's NAIC code, 89070, to identify United Concordia EDI Operations as the receiver. United Concordia Dental Electronic Services accepts claims for a number of payers as explained in the introduction to this section of the reference guide. Those payers are identified by the NAIC codes in the 2010BB destination payer loop.

Segment: **PRV** Provider Specialty Information

Loop: 2000A Billing/Pay-To Provider
 2310A Referring Provider
 2310B & 2420A Rendering Provider
 2310D & 2420C Assistant Surgeon

4010A1 Page: 69, 183, 190, 202, 292, 304

Note: The provider class and specialty from internal files will be used for processing, not the submitted taxonomy code.

Segment: **REF** **Provider Secondary Identification**

Loop: 2010AA Billing Provider
 2310A Referring Provider
 2310B & 2420A Rendering Provider
 2310C Service Facility Location
 2310D & 2420 C Assistant Surgeon

4010A1 Page: 80, 185, 192, 197, 204, 294, 306

Note: United Concordia requires a secondary identifier to identify the provider.

Data Element Summary

Ref Des.	Element Name	Element Note
REF01	Reference Identification Qualifier	Send qualifier code 1A - Blue Cross Provider Number 1B - Blue Shield Provider Number G2 - Provider Commercial Number
REF02	Reference Identification	Must contain a valid United Concordia proprietary provider number.

Segment: **NM1** **Subscriber Name**

Loop: 2010BA

4010A1 Page: 102

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Identification Code	This is the Member Identification Number assigned by United Concordia.

Segment: **NM1** Payer Name

Loop: 2010BB

4010A1 Page: 113

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Payer Identifier	Submit the NAIC number for the destination payer. Following is a list of recognized payers and their respective NAIC codes: 89070 - United Concordia 54771 - Highmark

Segment: **NM1** Patient Name

Loop: 2010CA

4010A1 Page: 131

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Patient Primary Identifier	This is the Member Identification Number assigned by United Concordia.

Segment: **CLM** Claim Information

Loop: 2300

4010A1 Page: 144

Data Element Summary

Ref Des.	Element Name	Element Note
CLM05-3	Claim Frequency Type Code	All claims will be adjudicated as original (code value = 1) regardless of the value submitted.

Segment: **PWK Claim Supplemental Information**

Loop: 2300

4010A1 Page: 164

Note1: Attachments associated with a PWK paperwork segment should be sent at the same time the 837D claim transaction is sent. United Concordia's business practice is that additional documentation received more than 5 days after the receipt of your 837D claim transmission may not be considered in adjudication thereby resulting in development or denial of your claim.

Note2: The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established business policies and guidelines. The PWK and attachments should not be used without regard to established requirements because their use will trigger procedures to consider the contents of the supplemental information that may delay the processing of the claim as compared to a like claim without a PWK.

Note3: A Cover Sheet should be used when faxing or mailing supplemental information in support of an electronic claim. **PLEASE INDICATE PATIENT NAME, PATIENT ID NUMBER, PROVIDER NAME AND PROVIDER NUMBER ON BOTH THE COVER SHEET AND THE ATTACHMENT.**

Data Element Summary

Ref Des.	Element Name	Element Note
PWK01	Attachment Report Code	United Concordia may be able to adjudicate your claim more quickly and accurately if you utilize a specific code in PWK01 and not the generic "OZ" - Support Data for Claim.

PWK02	Attachment Transmission Code	United Concordia's business practices and policy only support the following transmission types at this time:
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BM - By mail;

Mail Tricare Dental Plan claims attachments to:

TDP Claims
PO Box 69411
Harrisburg, PA 17106-9411

Mail all other United Concordia claims attachments to:

United Concordia Commercial Claims
PO Box 69421
Harrisburg, PA 17106-9421

FX - By fax; fax to (800) 985-2024.

EL - Electronically Only (Attachment Warehouses)

Segment: **AMT COB Patient Paid Amount**

Loop: 2320

4010A1 Page: 223

Note: This COB Patient Paid Amount AMT segment should not be used. The national standards group has confirmed that an oversight resulted in two places for reporting this amount in the 4010 Implementation Guide, this 2320 AMT and the 2320 CAS. Therefore, this usage of the AMT segment will be removed in the next version of the guide. The amount (previous payer paid to the patient) will be reported to the provider in the previous payer's 835 remittance in a CAS segment, and therefore can and should be reflected in the CAS segment (2320 loop) in an 837D claim to a secondary payer.

The amount that the patient paid to the provider is not reported in this segment; rather, that amount is placed in the Patient Paid Amount AMT in the 2300 loop.

Segment: **NM1** Other Payer Name
Loop: 2330B
4010A1 Page: 237

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Other Payer Primary Identifier	<p>Until the National Health Plan ID is established, this NM109 data element will only be used to match to the corresponding information in the 2430 loop.</p> <p>Use a unique number that identifies the other payer in the submitter’s system. As specified in the national implementation guide, if line level adjudication information from this other payer is being submitted in the 2430 Service Line Adjudication Information loop, it is critical that the Other Payer ID number in this 2330B element match exactly the Payer Identifier in the SVD01 element of the 2430 loop.</p> <p>If the submitter’s system does not have a unique identifier for the other payer, a value can be assigned by the submitter that is unique within this transaction.</p>

Segment: **SV3** Service Line
Loop: 2400
4010A1 Page: 262

Data Element Summary

Ref Des.	Element Name	Element Note
SV301-2	Product/Service ID	<p>United Concordia will validate the procedure code reported to ensure that it is an American Dental Association Current Dental Terminology procedure code. Procedure code will be validated to ensure that it is effective for the Date of Service reported.</p>
SV304	Oral Cavity Designation Code	<p>United Concordia business practices and policy do not support the “09 - Other area of Oral Cavity” Code.</p>
SV306	Quantity	<p>United Concordia requires that units of service be reported for anesthesia services. (Units of Service = 15 minutes). For example, 1 hour of anesthesia would be reported as SV306 = 4.</p>

Segment: **TOO** Tooth Information

Loop: 2400

4010A1 Page: 269

Note: United Concordia suggests that multiple iterations of the TOO segment only be used when the SV306 (Quantity) in Loop 2400 is equal to one. This will allow for more accurate reporting of the processed claim on the 835 transaction.

For Example: If reporting a partial denture, multiple tooth numbers may be reported on this service line. However, if multiple crowns or restorations are being reported, they must be reported on separate lines.

Data Element Summary

Ref Des.	Element Name	Element Note
TOO02	Industry Code	United Concordia will validate the tooth number/code reported. Acceptable tooth numbers/codes are: 1 through 32 (Permanent Teeth) A through T (Primary Teeth) 51 through 82 (Supernumerary Permanent Teeth) AS through TS (Supernumerary Primary Teeth)

9 Claim Acknowledgement (277A)

The Claim Acknowledgement transaction is used to return a reply of accepted or not accepted for claims or encounters submitted via the 837D transaction that have passed syntax validation. Acceptance at this level is based on Implementation Guide and United Concordia front-end business edits and will apply to individual claims within an 837D transaction. That is, for a given 837D transaction, this 277A Acknowledgement will indicate which claims were accepted for processing and which claims were not accepted.

The details of United Concordia's acknowledgement transaction are contained in the 277A Claims Acknowledgement Reference Guide document in **Appendix A**.

Generally, claim submitters should expect a 277A Claim Acknowledgement within 24 hours of the time that United Concordia received the 837D claims, subject to processing cutoffs.

Please see Appendix B for a listing of United Concordia's business edit responses.

10 Claim Payment Advice (835)

The 835 is utilized to send an electronic Explanation of Benefits (EOB) remittance advice from a health care payer to a health care provider. Health care providers that may receive the 835 include but are not limited to hospitals, nursing homes, laboratories, physicians, dentists, and allied professional groups.

The national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage and requirements. This supplemental document contains clarifications and payer-specific requirements related to data usage and content when receiving an 835 from United Concordia EDI Operations.

This EDI Reference Guide applies to transactions related to the following United Concordia traditional and managed care products: Preferred Provider Organization (PPO), Point of Service (POS), Indemnity and Dental Health Maintenance Organization (DHMO).

10.1 General Information and Guidelines for 835

While the Claim Payment Advice information listed below may have been submitted in a standard claim transaction, it was not captured and used in processing by the payers listed in the EDI Reference Guide. The payers will utilize data from internal databases.

- Payer name and address
- Payee name and address

10.1.1 Missing Checks

If a payment reflected in the 835 is not received, the **Provider** should contact the payer's customer department for assistance.

Dental (Commercial Products)	(800) 332-0366
Dental (Tricare Dental Programs)	(800) 866-8499

10.1.2 Administrative Checks

Administrative check information will not be reflected in the 835 transaction. Administrative checks are issued from a manual process and are not part of a weekly payment cycle. A letter or some form of documentation usually accompanies the check. An Administrative check does not routinely contain an Explanation of Benefits notice.

10.1.3 Availability

835 transactions are created on a weekly basis to correspond with payers' weekly payment cycles. The 835 transaction files become available for retrieval Monday of each week and remain available through the remainder of the week. If an 835 transaction was expected but not available for retrieval in any given week, contact Dental Electronic Services for assistance at (800) 633-5430.

10.1.4 Highmark Oral Surgery

Claims for oral surgery services that are processed through Highmark Medical-Surgical health care products will be reported in Highmark's 835 transaction.

10.1.5 Unavailable Claim Data

Paper claims and non-HIPAA electronic claim submission modes may not provide all data utilized in the 835. Therefore, some data segments and elements in the 835 Claim Payment Advice may be populated with "dummy data" or not available as a result of the claim submission mode. If a paper claim is received with no procedure code or procedure description, **UNKNO** will be sent back in the SVC01-2 composite data element.

10.1.6 Claim Overpayment Refunds

A check or provider level offset/reduction will be utilized to recoup refunds for overpayment of claims that were not voluntarily returned by the provider after being notified of the refund request. This reduction in total payment (check) will be reported in the PLB segment of the transaction using the WO qualifier code.

10.1.7 Capitation Payments

Capitation payments will not be combined or reported in the weekly 835 Transaction for fee for service claim payments.

10.1.8 Encounter Data on the 835

United Concordia provides encounter data on the 835 transaction.

NOTE: The encounter claim and line charges will reflect the manufactured charges used by United Concordia for encounter processing. The original claim and line level charges, if reported on the incoming encounter, will not be reported back on the 835.

10.1.9 Member Identification Numbers

This is the Member Identification Number assigned by United Concordia.

10.1.10 Data that is Not Used

The following segments will not be utilized in the 835:

- CUR - Foreign Country Information
- REF - Version Identification
- TS3 - Provider Summary Information
- TS2 - Provider Supplemental Summary Information
- QTY - Service Supplemental Quantity

10.2 Data Detail for 835

The following segment references are clarifications and payer-specific requirements related to data usage and content.

Segment: **GS** Functional Group Header

Loop:

4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02	Application Sender's Code	United Concordia will send the NAIC code and transaction related suffix for the following recognized payers: <u>VALUE</u> (PAYER) 89070 (United Concordia)
GS03	Application Receiver's Code	This will be the electronic Trading Partner Number assigned by United Concordia's Dental Electronic Services for transmission of 835 Transactions.
GS06	Group Control Number	United Concordia will send unique control numbers for each functional group.

Segment: **BPR** Financial Information

Loop:

4010A1 Page 45

Data Element Summary

Ref Des.	Element Name	Element Note
BPR01	Transaction Handling Code	The only values that will be passed are H and I.
BPR04	Payment Method Code	CHK will be utilized when payment is made via check. NON will be utilized when the payment amount for the 835 is zero. (Subscriber Paid Claims or Encounters)

Segment: **REF** Receiver Identification

Loop:

4010A1 Page: 57

Data Element Summary

Ref Des.	Element Name	Element Note
REF02	Receiver ID	This will be the electronic Trading Partner Number assigned by United Concordia's Dental Electronic Services for transmission of 835 Transactions.

Segment: **REF** Additional Payer Identification

Loop: 1000A

4010A1 Page: 67

Data Element Summary

Ref Des.	Element Name	Element Note
REF01	Reference Identification Qualifier	The code value "NF" will be utilized to designate the Payer's NAIC code in REF02.
REF02	Additional Payer ID	89070 - United Concordia 54771 - Highmark

Segment: **REF** Payee Additional Identification

Loop: 1000B

4010A1 Page: 77

Data Element Summary

Ref Des.	Element Name	Element Note
REF01	Payee Additional Identification Qualifier	PQ will be utilized for the Payer's assigned provider number.

Segment: **CLP** Claim Payment Information

Loop: 2100

4010A1 Page: 89

Data Element Summary

Ref Des.	Element Name	Element Note
CLP01	Claim Submitter's Identifier	The actual Patient Account value may not be passed from paper claim submissions.

Segment: **PLB** Provider Adjustment

Loop:

4010A1 Page: 165

Data Element Summary

Ref Des.	Element Name	Element Note
PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Provider Adjustment Reason Code	Values noted will be passed when applicable for reducing or increasing the provider's check. WO - will be utilized for recouping claim overpayments - Professional.
PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier	When the Adjustment Reason Code is WO, the reference number will be the Member's ID and or a Customer Service Inquiry Tracking number.

11 Claim Status (276 & 277)

The 276 transaction is used to request the status of a health care claim(s), and the 277 transaction is used to respond with information regarding the specified claim(s). These implementation guides were designed to allow for standardized submission of data content for all users. Entities who can request health care claim status include, but are not limited to, hospitals; nursing homes; laboratories; physicians; dentists; allied professional groups; Preferred Provider Organizations and Billing Services acting on behalf of Health Care Providers.

The national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage and requirements. This supplemental document contains clarifications and payer specific requirements related to data usage and content when submitting a 276 to United Concordia EDI Operations or receiving a 277 from United Concordia EDI Operations.

This EDI Reference Guide applies to transactions related to the following United Concordia traditional and managed care products: Preferred Provider Organization (PPO), Point of Service (POS), Indemnity and Dental Health Maintenance Organization (DHMO).

Health care payers, and their corresponding National Association of Insurance Commissioners (NAIC) codes, represented in sections 11.1 and 11.2 of this guide are:

- United Concordia - 89070
- Highmark - 54771

11.1 General Instructions and Guidelines for 276 and 277

The sections below will provide guidelines about the 276 and 277 transaction. These sections provide minimum data requirements for submitting a 276 status request, and what data the payer will respond with on the 277 response transaction.

11.1.1 General Instructions and Guidelines for 276

The general instruction section will provide guidelines in submitting a successful 276 transaction. Detailed in the sections below are minimum data requirements that must be followed in order for the payer to process the 276 request. Also, there is information on dental services, data not used by the payer, specified minimum data requirements and situational data elements, and limitations on submitting multiple requests.

11.1.1.1 General Description

All claim status requests will be processed in a batch mode, and will only include information available on the payers' adjudication system not yet purged. The 276 health care claim request can be used to request a status at a claim level, or for specific service lines.

11.1.1.2 Dental Services

All status requests containing a CDT dental procedure code must be submitted directly to United Concordia Companies, Inc. (UCCI). Any claim status requests for oral surgery services reported with a CPT medical procedure code must be requested to either United Concordia or Highmark according to which payer is responsible for the patient's oral surgery coverage.

11.1.1.3 Data that Is Not Used

While the claim status information listed below can be (and in some cases must be) contained in a standard claim status request transaction, this information may not be captured and used by the payers listed in the EDI Reference Guide:

Payer name - NM1 (2100A) - payer will search for claims using the payer ID, not the payer name.

Payer Contact - PER (2100A) - payer will use contact information on internal files when necessary.

Provider name - NM1 (2100C) - payer will search for claims using the billing provider ID, not provider name.

Subscriber and Patient name - NM1 (2100D/E) - payer will search for claims using the member ID or health insurance claim number, (HIC #), not the Subscriber or Patients name.

Service line information - SVC (2210D/E) - payer will use only the minimum/situational elements described further in this EDI Reference Guide when searching for claims; the payer will not use the service line information reported in the SVC. Note that service line information will be returned in the response transaction if the claim is finalized.

11.1.1.4 Situational Elements and Data Content

United Concordia will sequentially use the following elements and data content to narrow down the search when looking for claims:

Patient Date of Birth	(2000D/E)
Patient First Name (when provided)	(2100D/E)
Medical Record Number (ICN/Claim Number) (when provided)	(2200D/E)

If one of these elements eliminates all potential matches, those claims identified prior to that criteria will be returned.

11.1.1.5 Multiple Requests Per Transaction

Multiple subscribers for one provider and/or multiple dependents for one subscriber can be submitted and a response will be sent for each. Requests for both the subscriber and that subscriber's dependent cannot be included in the same subscriber loop; rather, there must be one subscriber loop for the request concerning the subscriber and a second subscriber loop for the request concerning the dependent.

11.1.2 General Instructions and Guidelines for 277

The general instruction section will provide information regarding a 277 transaction. Detailed in the sections below is the data that will be sent on a 277 response by the payer. This section also addresses claim splits, when to call customer service and the maximum claims returned for one 276 claim status request.

11.1.2.1 General Description of 277

The 277 health care claim response will contain information for both pending and finalized claims, the pending claims will be returned at the claim level, but all finalized claims will be returned with the processed service lines. The 277 response will only return the specified service lines in response to a 276 request for specific service lines.

11.1.2.2 Claim Splits

Claims split during processing will be reported as multiple claims on the 277 Claim Status Response.

11.1.2.3 Customer Service Requests

When it is determined that a request cannot be answered from the information provided, please change your search criteria or contact the customer service area (according to normal procedures).

11.1.2.4 Maximum Claim Responses per Subscriber/Patient/Dependent

If multiple claims are found for one status request, the Payer can only respond with a maximum of 50 claims. If the number of claims found is greater than 50, the last claim on the 277 response will contain a Claim Status Category Code 'D0', Change Search Criteria, and a Claim Status Code of '0', Cannot Provide Further Status Electronically. The requestor should change the data in the 276 request and submit a new request if the claims returned do not answer the initial status request.

11.1.2.5 Claim vs. Line Reporting of Status

All status requests still listed as pending will only receive pending responses at claim level. All pending finalized claims will show no check information but will have line detail information. All status requests that find finalized claims at the claim level will receive a response for all lines. All status requests at a line level will receive responses for only matching lines.

11.2 276/277 Data Detail Instructions

This section will provide the data detail that is required when submitting a 276 transaction. The segments below contain the minimum data requirements that must be followed in order for the payer to process the 276 claim status request transaction. This section also covers what data detail will be sent by the payer on the 277 response transaction.

11.2.1 Data Detail for Claim Status Request (276)

Specific segments and content detail must be included on the 276 health care claim request in order for the payer to process the 276 claims status request. Please look over the data detail in this section before submitting a 276 health care claim request.

Segment: **GS** Functional Group Header

Loop:

4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02	Application Sender's Code	Sender's United Concordia-assigned Trading Partner Number. Must be prefixed with a "B" for Batch (i.e., B94XXXX).
GS03	Application Receiver's Code	To support United Concordia's routing process, all 276 transactions in a functional group should be for the same payer. Submit the NAIC number for the payer identified in loop 2100A of the 276 transaction. Following is a list of recognized payers and their respective NAIC codes: 89070 - United Concordia

Segment: **NM1** Payer Name
Loop: 2100A
4010A1 Page: 54

Data Element Summary

Ref Des.	Element Name	Element Note
NM108	Identification Code Qualifier	The payers' Claim Status routing process requires the use of the National Association of Insurance Commissioners (NAIC) Identification, therefore code value "NI" must be used with the appropriate NAIC identifier in NM109. Enter the payer's NAIC number from the list below.
NM109	Payer Identifier	89070 - United Concordia 54771 - Highmark

Segment: **NM1** Information Receiver Name
Loop: 2100B
4010A1 Page: 62

Data Element Summary

Ref Des.	Element Name	Element Note
NM108	Identification Code Qualifier	The payers' Claim Status process requires the use of the Trading Partner Number as assigned by United Concordia EDI Operations. This must be designated by a code value in this data element of "46", Electronic Transmitter Identification Number.
NM109	Information Receiver Identification Number	Send Trading Partner Number as assigned by United Concordia's EDI Operations. This must be the same number as identified in GS02. (i.e., 94XXXX)

Segment: **NM1** Provider Name
Loop: 2100C
4010A1 Page: 67

Data Element Summary

Ref Des.	Element Name	Element Note
NM108	Identification Code Qualifier	As specified in the national implementation guide, because the payers do assign specific ID numbers to providers, those numbers must be used with a qualifier of "SV", Service Provider Number, in this data element.
NM109	Provider Identifier	Enter your United Concordia assigned Provider Number.

Segment: **NM1** Subscriber Name
Loop: 2100D
4010A1 Page: 74

Data Element Summary

Ref Des.	Element Name	Element Note
NM108	Identification Code Qualifier	Use code value "MI", Member Identification Number.
NM109	Subscriber Identifier	This is the Member Identification Number assigned by United Concordia.

Segment: **REF** Payer Claim ID Number
Loop: 2200D
 2200E
4010A1 Page: 80, 107

Data Element Summary

Ref Des.	Element Name	Element Note
REF02	Payer Claim Identification Number	Enter the Payer's Claim Control Number. Note: When the Payer's Claim ID Number is provided, the Payer will limit its search to an exact match of that ID number.

11.2.2 Data Detail for Claim Status Response (277)

The payer will return specific data content on the 277 health care claim response. The detail data listed in this section will be what is sent back on the 277 response transaction.

Segment: **GS** Functional Group Header

Loop:

4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note				
GS02	Application Sender's Code	United Concordia will send the NAIC code and transaction related suffix for the following recognized payers: <table border="0" style="margin-left: 20px;"> <tr> <td style="text-align: center;"><u>VALUE</u></td> <td style="text-align: center;"><u>(PAYER)</u></td> </tr> <tr> <td style="text-align: center;">89070</td> <td style="text-align: center;">(United Concordia)</td> </tr> </table>	<u>VALUE</u>	<u>(PAYER)</u>	89070	(United Concordia)
<u>VALUE</u>	<u>(PAYER)</u>					
89070	(United Concordia)					

12 Eligibility Request (270) and Response (271)

The 270 / 271 transactions are designed so that inquiry submitters (information receivers) can determine whether an information source has a particular subscriber or dependent on file, and the health care eligibility about the subscriber or dependent.

The national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule is the primary source for definitions, data usage and requirements. This supplemental document contains clarifications and payer specific requirements related to data usage and content when submitting a 270 to United Concordia EDI Operations or receiving a 271 from United Concordia EDI Operations.

This EDI Reference Guide applies to transactions related to the following United Concordia traditional and managed care products: Preferred Provider Organization (PPO), Point of Service (POS), Indemnity and Dental Health Maintenance Organization (DHMO).

The health care payer, and its corresponding National Association of Insurance Commissioners (NAIC) code, represented in sections 12.1 and 12.2 of this guide is:

- 89070 - United Concordia
- 54771 - Highmark

12.1 General Instructions and Guidelines for 270 and 271

12.1.1 United Concordia Requirements

In some instances United Concordia's business is supported by only some of the allowed values. In these cases the values allowed are identified in the reference guide along with the action which will be taken if the guide is not followed.

12.1.2 Oral Surgery Inquiries

Oral Surgery inquiries must be submitted to both United Concordia for Dental coverage and Highmark for Medical coverage.

12.1.3 Definition of Active Coverage

“Active” is defined as coverage where the effective date is less than or equal to date of service and the cancel date is null or is greater than or equal to the date of service. 'Inactive' is coverage where the cancel date is less than or equal to the date of service.

12.1.4 Primary Care Provider Verification for DHMO/POS Patients

If the patient has HM - Health Maintenance Organization (HMO) or PS - Point of Service in the EB04 data element, United Concordia will provide Primary Care Provider (PCP) verification as follows:

If the Requesting Provider **IS** the PCP, the 2120C/D, NM109 data element will contain the United Concordia assigned Provider Number. The absence of the 2120C/D loop indicates the requesting provider **IS NOT** the PCP.

12.1.5 Benefit Inquiries

For every EQ01 (even a value 30 - generic question), we will provide the following answers:

- active or inactive for the applicable date(s)
- plan coverage description for active coverage

Note: Benefit Summary information will be provided in the MSG segment.

12.1.6 Allowable Time Frames for Inquiries

United Concordia will respond to requests up to 60 months prior to the current date, and will respond with current coverage if the requested date up to 6 months in the future.

12.1.7 Disclaimer

Enrollment information may change due to cancellations or other changes in coverage. United Concordia acknowledges and understands that the information contained in a 271 response reflects current files. Claims will be processed according to benefit and membership information on our files at the time of processing. Therefore, the information contained within a 271 response does not guarantee reimbursement.

12.1.8 Dates on the Incoming 270

When dates are submitted at both the Subscriber/Dependent level and the Eligibility/Inquiry level, the date at the Eligibility/Inquiry level will take precedence.

12.1.9 Range Dates on the Incoming 270

When a range date is submitted, we will use the first date of the range.

12.1.10 Level of Detail on Outbound 271

We will not provide a response at the service type, procedure code, modifier or diagnosis code level.

12.1.11 Specific Service Code Request

If a non-supported service type code is received, United Concordia will respond with a generic service type code, 35 (Dental Care). The supported service codes are 30 or 35.

12.1.12 Real Time Request

United Concordia is developing the capability to respond to real-time requests; however, they are not currently supported. Transactions received with a real-time designation will not be processed.

12.1.13 Two Connection Modes Supported

United Concordia's EDI interface supports two modes of connection: asynchronous and FTP. When a real-time capability is added, response time expectations for each connection mode will be added in this section.

12.1.14 Data that is Not Used

While the eligibility information listed below can be (and in some instances must be) contained in a standard eligibility transaction, this information will not be captured and used in processing by the payers listed in this EDI Reference Guide:

- Information Receiver Additional Identification - REF (2100B) - payer will use the primary identifier in the NM1.
- Information Receiver Address - N3, N4 (2100B) - payer does not need for processing.
- Information Receiver Contact Information - PER (2100B) - payer will use information on internal files when a contact is necessary.
- Patient Address - N3, N4 (2100C & 2100D) - payer does not need for processing.
- Provider Information - PRV (2100C) - payer does not need for processing.

12.1.15 Multiple Requests Per Transaction

The Eligibility Inquiry process for the payers in this Reference Guide is limited to one Information Source, and Information Receiver per ST / SE transaction. If multiples are sent, only the first occurrence within each loop will be processed.

Multiple subscribers and multiple dependents for a single subscriber can be submitted and a response will be sent for each. Requests for both the subscriber and that subscriber's dependent cannot be included in the same subscriber loop; rather, there must be one subscriber loop for the request concerning the subscriber and a second subscriber loop for the request concerning the dependent.

12.1.16 Date Ranges Submitted on the 270

Dates can be submitted at several levels with the 270 request. Processing will be conducted in the following order:

- If the Eligibility Question (EQ) level has a date, that will be used for processing the request.
- If no date at the EQ level, a patient level date will be used.
- If no date at either the EQ or patient level, the transaction creation date (BHT04) will be used.

12.1.17 Minimum Amount of Data Required for Search

The following four pieces of patient data **ARE REQUIRED** on the incoming 270 transaction:

- Member ID
- Date of Birth
- First Name
- Last Name

The following data is NOT REQUIRED by United Concordia for each 270 transaction. However it could be beneficial in narrowing the search when there is more than one potential match.

- Gender Code
- Patient Relationship Code
- Patient Middle Name

12.2 270/271 Data Detail Instructions

This section will provide the data detail that is required when submitting a 270 transaction. The segments below contain the minimum data requirements that must be followed in order for the payer (Information Source) to process the 270 eligibility request transaction. This section also covers what data detail will be sent by the payer on a 271 response transaction.

12.2.1 Data Detail for Eligibility Request (270)

This section includes specific comments and directions for United Concordia’s implementation of the 270 transaction. Please read them carefully.

Segment: **GS** Functional Group Header

Loop:

4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02	Application Sender’s Code	Submit the sender’s United Concordia-assigned Trading Partner Number, with a prefix of B. This indicates a request for a batch-mode response. (A prefix of “R” will be used when the capability for real-time responses is added). The submitted value must not include leading zeros. (eg. B94XXXX)
GS03	Application Receiver’s Code	Submit the Receiver’s NAIC code value: 89070 - United Concordia

Segment: **BHT** Beginning of Hierarchical Transaction

Loop:

4010A1 Page: 38

Data Element Summary

Ref Des.	Element Name	Element Note
BHT02	Transaction Set Purpose Code	Use value “13”. This is the only value United Concordia will accept in this field.

Segment: **NM1** Information Source Name

Loop: 2100A

4010A1 Page: 44

Data Element Summary

Ref Des.	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value “PR”, Payer. This is the only value United Concordia will accept in this field.
NM108	Identification Code Qualifier	Enter code value “NI”, NAIC Identification. This is the only value United Concordia will accept in this field. Enter NAIC code value:
NM109	Information Source Primary Identifier	89070 - United Concordia 54771 - Highmark These are the only values United Concordia will accept in this field.

Segment: **NM1** Information Receiver Name

Loop: 2100B

4010A1 Page: 50

Data Element Summary

Ref Des.	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value “1P”. This is the only value United Concordia will accept in this field.
NM108	Identification Code Qualifier	Enter code value “SV”. This is the only value United Concordia will accept in this field.
NM109	Information Receiver Identification	Must contain a valid United Concordia proprietary provider number.

Segment: **EQ** Subscriber/Dependent Eligibility or Benefit Inquiry
Information

Loop: 2110C
2110D

4010A1 Page: 90, 132

Data Element Summary

Ref Des.	Element Name	Element Note
		It is United Concordia's business practice to respond to these types of eligibility inquiries:
EQ01	Service Type Code	30 - Health Benefit Plan 35 - Dental Care
		All other submitted codes will be answered as a dental care "35".

Segment: **III** Subscriber/Dependent Eligibility or Benefit Inquiry
Information

Loop: 2110C
2110D

4010A1 Page: 101, 140

Note: United Concordia does not support this level of functionality.

Segment: **REF** Subscriber/Dependent Additional Information

Loop: 2110C
2110D

4010A1 Page: 104, 143

Note: United Concordia does not support this level of functionality.

12.2.2 Data Detail for Eligibility Response (271)

This section includes specific comments and directions for United Concordia’s implementation of the 271 transaction. Please read them carefully.

Segment: **GS** Functional Group Header

Loop:

4010A1 Page: B.8

Data Element Summary

Ref Des.	Element Name	Element Note
GS02	Application Sender’s Code	The sender’s NAIC code and a transaction related suffix will be sent: <u>VALUE</u> <u>(PAYER)</u> 89070 (United Concordia)
GS03	Application Receiver’s Code	United Concordia’s Trading Partner Number assigned to the receiver will be used, with a prefix of B. This indicates a request for a batch-mode response. (A prefix of “R” will be used when the capability for real-time responses is added). (eg. B94XXXX)

Segment: **N3** Subscriber/Dependent Address

Loop: 2100C

2100D

4010A1 Page: 200, 277

Note: United Concordia business practice does not supply Subscriber/Dependent address information for eligibility inquiries.

Segment: **N4** Subscriber/Dependent City, Street, Zip Code

Loop: 2100C

2100D

4010A1 Page: 201, 278

Note: United Concordia business practice does not supply Subscriber/Dependent address information for eligibility inquiries.

Segment: **EB** Eligibility or Benefit Information
Loop: 2110C
 2110D
4010A1 Page: 219, 296

Data Element Summary

Ref Des.	Element Name	Element Note
EB01	Eligibility or Benefit Information	A returned value of “V” (can not process) indicates the patient is not on our system OR could not be uniquely identified.
EB05	Plan Coverage Description	Group number and Group name will be returned in this field preceded by the transaction Group Number Qualifier (6P) and a space. There will also be a space between the Group Number and Group Name. Example: 6P 252895000 John Doe Industry would be returned for employee group “John Doe Industry” with Group Number 252895000.

Segment: **NM1** Benefit Related Entity Name
Loop: 2120C
 2120D
4010A1 Page: 253, 330

Note: If the Requesting Provider IS the PCP, the 2120C/D, NM109 data element will contain their United Concordia assigned Provider Number. The absence of the 2120C/D loop indicates that the Requesting Provider IS NOT the PCP.

Data Element Summary

Ref Des.	Element Name	Element Note
NM109	Identification Code	This is the United Concordia Assigned Provider Number.

Segment: **MSG** Message Text

Loop: 2110C

2110D

4010A1 Page: 281, 374

Note: When available, Benefit Summary Information will be provided in the MSG segment. If the benefits are too lengthy to summarize within the maximum 2,640 bytes, the following message will be displayed in the MSG segment – “The entire Patient Benefit Summary has not been displayed due to space limitations”. If our systems are unavailable at the time of the inquiry, the following message will be displayed – “Benefit Information is not available at this time”.

NOTE: This Benefit Summary does not take place of a detailed Benefit report.

Data Element Summary

Ref Des.	Element Name	Element Note
MSG01	Free Form Message Text	When available, Benefit Summary Information will be provided.

NOTE: Benefit Summary Information is displayed as follows:

1. The “:” (colon) is used to indicate a non-covered benefit. The words “non-covered” follow the colon.
2. The “;” (semicolon) is used to separate the Benefit Text from the Benefit Allowance Percentage.
3. The “/” (forward slash) is used to separate the Benefit Text Statements within the Benefit Category or the Beginning of a new Benefit Category.

See following page for an example of the MSG segments.

Example of MSG Segments:

MSG*THIS BENEFIT SUMMARY DOES NOT TAKE THE PLACE OF A DETAILED BENEFIT REPORT / CLEANINGS, 1 IN 6 MONTHS, FLUORIDE TO AGE 19, 1 IN 6 MONTHS; 100% OF ALLOWANCE / SEALANTS THROUGH AGE 10 ON PERMANENT FIRST MOLARS AND THROUGH AGE 15 ON PERMANENT SECOND MOLARS, 1 IN 3

MSG* YEARS; 100% OF ALLOWANCE / SPACE MAINTAINERS TO AGE 19 ON PRIMARY AND PERMANENT FIRST MOLARS; 100% OF ALLOWANCE / SUMMARIZATION OF BENEFITS FOR EXAMS AND X-RAY SERVICES IS NOT YET AVAILABLE/ FILLINGS; 100% OF ALLOWANCE / STAINLESS STEEL CROWNS, PREFABRICATED

MSG*RESIN CROWNS, BUILDUPS, CROWN REPAIR; 50% OF ALLOWANCE / SINGLE CROWNS, INLAYS, ONLAYS, 1 IN 5 YEARS; 50% OF ALLOWANCE / SURGICAL AND NON SURGICAL PERIODONTIC SERVICES; 50% OF ALLOWANCE / ORTHODONTIC SERVICES: NOT COVERED / DENTAL ORAL SURGERY SERVICES; 100% O

MSG*F ALLOWANCE / MEDICAL ORAL SURGERY SERVICES; 100% OF ALLOWANCE / DENTURE ADJUSTMENTS, DENTURE REPAIRS, RELINING, REBASING, AND BUILDUPS; 50% OF ALLOWANCE / FIXED AND REMOVABLE PROSTHETICS; 50% OF ALLOWANCE / PALLIATIVE TREATMENT, SIMPLE EXTRACTIONS, ENDODONTICS

MSG*; 100% OF ALLOWANCE / SUMMARIZATION OF PAYMENT INFORMATION IS NOT YET AVAILABLE FOR DHMO CONTRACTS, REFER TO COPAYMENT SCHEDULES/ ANESTHESIA SERVICES; 100% OF ALLOWANCE / CONSULTATIONS; 100% OF ALLOWANCE / SURGERY SERVICES: NOT COVERED / ASSISTANT SURGERY SER

MSG*VICES: NOT COVERED /

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APPENDIX A

277A

Claim Acknowledgement

**(004010H01) IMPLEMENTATION GUIDE HEALTH CARE
INFORMATION STATUS NOTIFICATION**

Dental Electronic Services

Revised March 2004

UNITED CONCORDIA
America's Premier Dental Insurer

1 Purpose and Business Overview

1.1 Document Purpose

The purpose of this implementation guide is to provide data requirements and content for receivers of United Concordia's version of the 277 - Claim Acknowledgement Transaction (ANSI ASC X12.317). This implementation guide focuses on use of the 277 as an acknowledgement to receipt of claim submission(s). This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables and specifying values applicable for the business focus of the 277 claim submission acknowledgement.

Throughout this implementation guide the reference to "claim(s)" means individual claims or encounters or groupings of claims or encounters.

Entities receiving this application of the 277 include, but are not limited to, hospitals, nursing homes, laboratories, physicians, dentists, allied health professional groups, and supplemental (i.e., other than primary payer) health care claims adjudication processors.

Other business partners affiliated with the 277 include billing services; consulting services; vendors of systems; software and EDI translators; EDI network intermediaries such as health care clearinghouses, value-added networks and telecommunication services.

1.2 Version and Release

This United Concordia implementation guide is based on the October 1997 ASC X12 standard referred to as Version 4, Release 1, Sub-release 0 (004010). This is the first United Concordia guide for this business function of the 277 Transaction set. For purposes of this business use, United Concordia will identify the Version of this Transaction in the GS08 data element as '004010H01'.

1.3 Business Use

This implementation guide only addresses the business use of the 277 Claim Acknowledgement. The purpose of this transaction is to provide a system (application) level acknowledgement of electronic claims or encounters. This implementation guide is to be used specifically as an application acknowledgement response to the ASC X12N 837 Dental claim/encounter submission transactions.

1.3.1 Claim System Acknowledgement

The first level of acknowledgement by United Concordia for the ASC X12 837 transactions will be the ASC X12 Functional Acknowledgement (997) transaction. The 997 transaction is designed to notify the submitter of the receiver's ability or inability to process the entire 837 transaction based on ASC X12 syntax and structure rules.

The second level of acknowledgement by United Concordia for the ASC X12 837 transaction will be the 277 Claim Acknowledgement. This is a system (application) acknowledgement of the business validity and acceptability of the claims. The level of editing in pre-adjudication programs will vary from system to system. Although the level of editing may vary, this transaction provides a standard method of reporting acknowledgements for claims. The application acknowledgement identifies claims that are transferred to another entity, accepted for adjudication, as well as those that are not accepted. The 277 transaction is the only notification of pre-adjudication claim status. Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system and therefore are never reported in the ASC X12 Health Care Claim Payment/Advice (835) transaction. Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to claims processing guidelines. Final adjudication of claims is reported in the ASC X12 Health Care Claim Payment/Advice (835) transaction.

2 Data Overview

This section introduces the structure of the 277 Claim Acknowledgement and describes the positioning of the business data within the structure. Familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure is recommended. Refer to Appendix A of any national transaction set implementation guide named in the HIPAA Administrative Simplification Electronic Transaction rule for information on ASC X12 nomenclature, structure, etc.

2.1 Overall Data Architecture

The implementation view provided at the beginning of Section 3 displays only the segments and their designated health care names described in this implementation guide. The intent of the implementation view is to clarify the purpose and use of the segments.

The 277 Transaction set is divided into two levels, or tables. Table 1 (Heading) contains transaction control information, which includes the ST and BHT segments. The ST segment identifies the start of a transaction's business purpose. The BHT segment identifies the hierarchical structure used. Table 2 (Detail) contains the detail information for the business function of the transaction. See Section 2.3 - Claim Status Theory for specific information on the status reporting detail.

2.2 Data 'Usage' Definitions

Within the Transaction detail, 'Usage' for the various Loops, Segments and Elements will be defined as follows:

Required - This item must be used to be compliant with this implementation guide.

Sit. (Situational) - The use of this item varies, depending on data content and business context. The defining rule is generally documented in syntax or usage notes attached to the item. *The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used.

Not Used - This item should not be used when complying with this implementation guide.

- **NOTE:** If no rule appears in the notes, the item should be sent if the data is available to the sender.

Loop Usage: Loop usage within ASC X12 transactions can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop. If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop. If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

2.3 Claim Status Theory

The level of information potentially available for a Claim Status Response may vary drastically from Payer to Payer. The primary vehicle for the claim status information in the 277 transaction is the STC segment.

The STC segment contains three iterations of the Health Care Claim Status composite (C043) within elements STC01, STC10 and STC11. The standardized codes used in the composite acknowledge the acceptance of the claim or specify the reason(s) for rejection. The composite elements use industry codes from external Code Source 507, Health Care Claim Status Category Code, and Source 508, Health Care Claim Status Code. The primary distribution source for these codes is the Washington Publishing Company World Wide Web site (www.wpc-edi.com).

Within the STC segment, composite element STC01 is required; STC10 and STC11 are situational and used to provide additional claim status when needed. The composite element consists of three sub-elements.

The first element in the composite is the Health Care Claim Status Category Code, Code Source 507. The category code indicates the level of processing achieved by the claim. This element is Required for use when the composite is used. For the business purpose of this implementation guide, the following 3 acknowledgement codes are supported:

A0 – Acknowledgement/Forwarded (The claim/encounter has been forwarded to another entity.)

A2 – Acknowledgement/Acceptance (The claim/encounter has been accepted into the adjudication system.)

A3 – Acknowledgement/Returned (The claim/encounter has been rejected and has not been entered into the adjudication system.)

The second element is the Health Care Claim Status Code, Code Source 508. This element provides more detailed information about the rationale for the claim or line item being in the category identified in the first element. This element is Required for use when the composite is used. Examples of status messages include "entity acknowledges receipt of

claim/encounter," "missing/invalid data prevents payer from processing claim," and "business application currently not available."

The third element in the composite is the Entity Identifier Code. The code in this element identifies the entity referred to in the second element (Status Code). The code list identifies an organizational entity, a physical location, property, or an individual. This element is Situational for use when the composite is used. A list of appropriate Entity Identifier Code values is within the STC segment in Section 3.

3 Transaction Set

277A - Claim Acknowledgement

Functional Group ID=HN

Heading:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
A7	005	GS	Functional Group Header	R	1	
A8	010	ST	Transaction Set Header	R	1	
A10	020	BHT	Beginning of Hierarchical Transaction	R	1	
LOOP ID - 1000						1
A11	040	NM1	Submitter Name	R	1	

Detail:

Page No.	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat
LOOP ID - 2000A						>1
A12	010	HL	Information Source Hierarchical Level	R	1	
LOOP ID - 2100						1
A13	050	NM1	Information Source Name	R	1	
LOOP ID - 2000B						1
A14	010	HL	Information Receiver Hierarchical Level	R	1	
LOOP ID - 2100						1
A15	050	NM1	Information Receiver Name	R	1	
LOOP ID - 2000C						>1
A16	010	HL	Provider Hierarchical Level	R	1	
LOOP ID - 2100						1
A17	050	NM1	Billing Provider Name	R	1	
LOOP ID - 2000D						>1
A17	010	HL	Subscriber Hierarchical Level	R	1	
A19	040	DMG	Demographic Information	S	1	
LOOP ID - 2100D						1
A20	050	NM1	Subscriber Name	R	1	
LOOP ID - 2200D						>1
A21	090	TRN	Claim Identification	S	1	
A22	100	STC	Status Information	R	>1	
A24	120	DTP	Date or Time or Period	R	2	
LOOP ID - 2220D						>1
A26	180	SVC	Service Information	S	1	
A28	190	STC	Status Information	R	>1	
A29	200	REF	Service Identification	R	1	
A30	210	DTP	Date or Time or Period	R	1	
LOOP ID - 2000E						>1
A32	010	HL	Dependent Hierarchical Level	S	1	
A33	040	DMG	Demographic Information	R	1	
LOOP ID - 2100E						1

A34	050	NM1	Dependent Name	R	1				
						LOOP ID - 2200E	>1		
A35	090	TRN	Claim Identification	R	1				
A36	100	STC	Status Information	R	>1				
A38	120	DTP	Date or Time or Period	R	2				
						LOOP ID - 2220E	>1		
A40	180	SVC	Service Information	S	1				
A42	190	STC	Status Information	R	>1				
A44	200	REF	Service Identification	R	1				
A45	210	DTP	Date or Time or Period	R	1				
A45	270	SE	Transaction Set Trailer	R	1				
A47	280	GE	Functional Group Trailer	R	1				

Segment: **GS** Functional Group Header
Position: 005
Loop:
Level: Heading
Usage: Required
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information

Syntax Notes:

- Semantic Notes:**
- 1 GS04 is the group date.
 - 2 GS05 is the group time.
 - 3 The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

Notes: **Example: GS*HN*89070*999999*20020826*1101*22755*X*004010H01~**

Data Element Summary

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	
Required	GS01	479	Functional Identifier Code	M ID 2/2
			Code identifying a group of application related transaction sets	
			HN	Health Care Claim Status Notification (277)
Required	GS02	142	Application Sender's Code	M AN 2/15
			Code identifying party sending transmission; codes agreed to by trading partners	
			89070	
Required	GS03	124	Application Receiver's Code	M AN 2/15
			Code identifying party receiving transmission; codes agreed to by trading partners	
			This will always be the United Concordia assigned Trading Partner ID for the entity receiving this transaction.	
Required	GS04	373	Date	M DT 8/8
			Date expressed as CCYYMMDD	
Required	GS05	337	Time	M TM 4/8
			Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	
Required	GS06	28	Group Control Number	M N0 1/9
			Assigned number originated and maintained by the sender	
Required	GS07	455	Responsible Agency Code	M ID 1/2
			Code used in conjunction with Data Element 480 to identify the issuer of the standard	
			X	Accredited Standards Committee X12
Required	GS08	480	Version / Release / Industry Identifier Code	M AN 1/12
			Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	
			'004010H01'	

Segment: **ST** Transaction Set Header
Position: 010
Loop:
Level: Heading
Usage: Required
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes: 1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
Notes: **Example: ST*277*0001~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	ST01	143	Transaction Set Identifier Code Code uniquely identifying a Transaction Set <i>277 Health Care Claim Status Notification</i>	M ID 3/3
Required	ST02	329	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Numbers in ST02 and SE02 will be identical. This unique number also aids in error resolution research. Submitter could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS to GE) and interchange (ISA to IEA), but can be repeated in other groups and interchanges.	M AN 4/9

Segment: **BHT** Beginning of Hierarchical Transaction
Position: 020
Loop:
Level: Heading
Usage: Required
Max Use: 1
Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Syntax Notes:
Semantic Notes:

- 1 BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
- 2 BHT04 is the date the transaction was created within the business application system.
- 3 BHT05 is the time the transaction was created within the business application system.

Notes: **BHT*0010*06*20020118**TH~**

Data Element Summary

	<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Attributes</u>
Required	BHT01	1005	Hierarchical Structure Code Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set <i>0010 Information Source, Information Receiver, Provider of Service, Subscriber, Dependent</i>	M ID 4/4
Required	BHT02	353	Transaction Set Purpose Code Code identifying purpose of transaction set <i>06 Confirmation</i>	M ID 2/2
Not Used	BHT03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
Required	BHT04	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	BHT05	337	Time Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	O TM 4/8
Required	BHT06	640	Transaction Type Code Code specifying the type of transaction <i>TH Receipt Acknowledgment Advice</i>	O ID 2/2

Segment: **NM1** Submitter Name
Position: 040
Loop: 1000 Required
Level: Heading
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: **Example: NM1*41*2*UNITED CONCORDIA*****NI*89070~**

Data Element Summary

Ref.	Data	Element	Name	Attributes
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual 41 <i>Submitter</i> <i>Entity transmitting transaction set</i>	M ID 2/3
Required	NM102	1065	Entity Type Qualifier Code qualifying the type of entity 2 <i>Non-Person Entity</i>	M ID 1/1
Required	NM103	1035	Sender Name Individual last name or organizational name "United Concordia"	O AN 1/35
Not Used	NM104	1036	Name First Individual first name	O AN 1/25
Not Used	NM105	1037	Name Middle Individual middle name or initial	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Not Used	NM107	1039	Name Suffix Suffix to individual name	O AN 1/10
Required	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) When identifying a health plan, code NI is required. When identifying any other entity code ZZ is required. NI <i>National Association of Insurance Commissioners (NAIC) Identification</i> "NI" will be used when ISA07 equals "ZZ".	X ID 1/2
Required	NM109	67	Identification Code Code identifying a party or other code "89070"	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **HL** Information Source Hierarchical Level
Position: 010
Loop: 2000A Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:
Semantic Notes:

Notes: There will only be one Information Source (Payer) per 277. All claims within a specific 277 will have been submitted to a single payer.
Example: HL*1**20*1~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure HL01 will begin with the value "1" and increment by one each time an HL is used in the transaction. Only numeric values will be sent in HL01.	M AN 1/12
Not Used	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	O AN 1/12
Required	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure 20 Information Source Identifies the payer, maintainer, or source of the information	M ID 1/2
Required	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	O ID 1/1

Segment: **NM1** Information Source Name
Position: 050
Loop: 2100 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: This will always be identifying the Payer. This information matches the information supplied in the 2010BB loop of the original 837 claim.
Example: NM1*PR*2*UNITED CONCORDIA*****NI*89070~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual <i>PR Payer</i>	M ID 2/3
Required	NM102	1065	Entity Type Qualifier Code qualifying the type of entity <i>2 Non-Person Entity</i>	M ID 1/1
Required	NM103	1035	Name Last or Organization Name Individual last name or organizational name This identifies the Payer providing the confirmation of acceptance or rejection of the claim for adjudication.	O AN 1/35
Not Used	NM104	1036	Name First Individual first name	O AN 1/25
Not Used	NM105	1037	Name Middle Individual middle name or initial	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Not Used	NM107	1039	Name Suffix Suffix to individual name	O AN 1/10
Required	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) <i>NI National Association of Insurance Commissioners (NAIC) Identification</i>	X ID 1/2
Required	NM109	67	Payer NAIC Code Code identifying a party or other code This is the NAIC code of the payer providing the confirmation. 89070 – United Concordia 54771 - Highmark Claims (Includes Pennsylvania Blue Shield)	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **HL** Information Receiver Hierarchical Level
Position: 010
Loop: 2000B Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:
Semantic Notes:

Notes: This loop will identify the United Concordia Trading Partner ID that will receive the 277 information. There will only be one Information Receiver per 277. This loop identifies the provider/billing service/ clearinghouse that submitted the original 837 transaction for the related claims.

Example: HL*2*1*21*1~

Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
Required	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from the previous HL01 elements within the transaction, incremented by 1.	M AN 1/12
Required	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will always point back to the Information Source. This will always be "1".	O AN 1/12
Required	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure <i>21 Information Receiver Identifies the provider or party(ies) who are the recipient(s) of the information</i>	M ID 1/2
Required	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described <i>1 Additional Subordinate HL Data Segment in This Hierarchical Structure.</i>	O ID 1/1

Segment: **NM1** Information Receiver Name
Position: 050
Loop: 2100 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: **Example: NM1*40*2*BEST BILLING SERVICE*****93*949999~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual 40 Receiver Entity to accept transmission	M ID 2/3
Required	NM102	1065	Entity Type Qualifier Code qualifying the type of entity 2 Non-Person Entity	M ID 1/1
Not Used	NM103	1035	Name Last or Organization Name Individual last name or organizational name	O AN 1/35
Not Used	NM104	1036	Name First Individual first name	O AN 1/25
Not Used	NM105	1037	Name Middle Individual middle name or initial	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Not Used	NM107	1039	Name Suffix Suffix to individual name	O AN 1/10
Required	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) 93 Code assigned by the organization originating the transaction set	X ID 1/2
Required	NM109	67	Trading Partner Number Code identifying a party or other code This will always be the United Concordia assigned Trading Partner ID for the entity that submitted the original 837 transaction.	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **HL** Provider Hierarchical Level
Position: 010
Loop: 2000C Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:
Semantic Notes:
Notes:

One Provider Hierarchical level will be written for each provider receiving claim confirmations. All claims for a specific provider are nested under that provider's hierarchical loop.
Example: HL*3*2*19*1~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	M AN 1/12
Required	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will always point back to the Information Receiver level. This will always contain "2".	O AN 1/12
Required	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure 19 Provider of Service	M ID 1/2
Required	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	O ID 1/1

Segment: **NM1** Billing Provider Name
Position: 050
Loop: 2100 Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: **Example: NM1*85*1*SMITH*JOHN*Q**MD*FI*123456789~**

Data Element Summary

Ref.	Data Des.	Element	Name	Attributes
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
Required	NM102	1065	85 Billing Provider Entity Type Qualifier Code qualifying the type of entity 1 Person 2 Non-Person Entity	M ID 1/1
Required	NM103	1035	Billing Provider Name Individual last name or organizational name This is the complete billing provider name when NM102 is "2" and the billing provider last name when NM102 is "1".	O AN 1/35
Sit.	NM104	1036	Name First Individual first name This is Required when NM102 is "1". This is not used when NM101 is "2".	O AN 1/25
Sit.	NM105	1037	Name Middle Individual middle name or initial This is Required when NM102 is "1" and it is known. This is not used when NM101 is "2".	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Sit.	NM107	1039	Name Suffix Suffix to individual name This is Required when NM102 is "1" and it is known. This is not used when NM101 is "2".	O AN 1/10
Required	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number XX Health Care Financing Administration National Provider Identifier Only used when the National Provider Identifier is mandated for use.	X ID 1/2
Required	NM109	67	Identification Code Code identifying a party or other code This will be the Federal Tax ID Number of the billing provider, unless the National Provider Identifier is mandated for use.	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **HL** Subscriber Hierarchical Level
Position: 010
Loop: 2000D Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:
Semantic Notes:
Notes:

Example: HL*4*3*22*1~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	M AN 1/12
Required	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This must contain the Hierarchical ID Number for the 2000C loop that identifies the Billing Provider related to the claim identified under this subscriber or this subscriber's dependent.	O AN 1/12
Required	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure 22 <i>Subscriber</i> <i>Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits</i>	M ID 1/2
Required	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described 0 <i>No Subordinate HL Segment in This Hierarchical Structure.</i> Required when the subscriber is the patient for the claim being confirmed, and there are no subservient 2000E Hierarchical Levels. 1 <i>Additional Subordinate HL Data Segment in This Hierarchical Structure.</i> This is required whenever there will be 2000E Hierarchical Levels subservient to this subscriber level identifying claims for dependents as patients.	O ID 1/1

Segment: **DMG** Demographic Information
Position: 040
Loop: 2000D Required
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: 1 If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: 1 DMG02 is the date of birth.
Notes: Required when the subscriber is the patient for a claim being confirmed.
Example: DMG*D8*19581010~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	DMG01	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <i>D8 Date Expressed in Format CCYYMMDD</i>	X ID 2/3
Required	DMG02	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times This is the subscriber's (patient) Date of Birth in CCYYMMDD format.	X AN 1/35
Not Used	DMG03	1068	Gender Code Code indicating the sex of the individual	O ID 1/1
Not Used	DMG04	1067	Marital Status Code Code defining the marital status of a person	O ID 1/1
Not Used	DMG05	1109	Race or Ethnicity Code Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	O ID 1/1
Not Used	DMG06	1066	Citizenship Status Code Code indicating citizenship status	O ID 1/2
Not Used	DMG07	26	Country Code Code identifying the country	O ID 2/3
Not Used	DMG08	659	Basis of Verification Code Code indicating the basis of verification	O ID 1/2
Not Used	DMG09	380	Quantity Numeric value of quantity	O R 1/15

Segment: **NM1** Subscriber Name
Position: 050
Loop: 2100D Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: **Example: NM1*IL*1*JONES*STEPHEN*Q***MI*YYZ987654321~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual <i>IL Insured or Subscriber</i>	M ID 2/3
Required	NM102	1065	Entity Type Qualifier Code qualifying the type of entity <i>1 Person</i>	M ID 1/1
Required	NM103	1035	Subscriber Last Name Individual last name or organizational name	O AN 1/35
Required	NM104	1036	Subscriber First Name Individual first name	O AN 1/25
Sit.	NM105	1037	Subscriber Middle Initial Individual middle name or initial This will be provided when submitted on the 837 or when known from the database.	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Sit.	NM107	1039	Name Suffix Suffix to individual name This will be provided when submitted on the 837 or when known from the database.	O AN 1/10
Required	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) <i>MI Member Identification Number</i>	X ID 1/2
Required	NM109	67	Identification Code Code identifying a party or other code This is the Payer's identification number for the subscriber.	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **TRN** Claim Identification
Position: 090
Loop: 2200D Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes: 1 TRN02 provides unique identification for the transaction.
Notes: Required when the subscriber is the patient for a claim being confirmed.
Example: TRN*2*6352453~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	TRN01	481	Trace Type Code Code identifying which transaction is being referenced	M ID 1/2
			2 Referenced Transaction Trace Numbers	
Required	TRN02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Claim Submitter's Identifier from the original 837 claim (CLM01). At least 20 characters will be returned unaltered.	M AN 1/30
Not Used	TRN03	509	Originating Company Identifier A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9	O AN 10/10
Not Used	TRN04	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30

Segment: STC Status Information

Position: 100
Loop: 2200D Situational
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line

Syntax Notes:
Semantic Notes: 1 STC04 is the amount of original submitted charges.
Notes: **Example: STC*A2:20***576~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	STC01	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	M
Required	STC01-1	1271	Claim Status Category Code Code indicating a code from a specific industry code list This is from an external code list. The values possible here are: A0 - Acknowledgement/Forwarded to another entity. A2 - Acknowledgement/Acceptance into the adjudication system. A3 - Acknowledgement/Returned as unprocessable.	M AN 1/30
Required	STC01-2	1271	Claim Status Reason Code Code indicating a code from a specific industry code list This is an external code list. Access www.wpc-edi.com for a complete listing of the codes. 16 - Claim/encounter has been forwarded to entity. This code will be used when STC01-1 equals "A0". 20 - Accepted for Processing. This code will be used when STC01-1 equals "A2". 247 - Line Information. This code will be used when STC01-1 equals "A3" and the reason for the rejection is line specific.	M AN 1/30
Sit.	STC01-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual This element provides identification of the entity related to the reason in STC01-2 when appropriate.	O ID 2/3
			41 Submitter	
			Entity transmitting transaction set	
			82 Rendering Provider	
			85 Billing Provider	
			87 Pay-to Provider	
			DD Assistant Surgeon	
			DN Referring Provider	
			IL Insured or Subscriber	
			P3 Primary Care Provider	
			PR Payer	
			QC Patient	
			Individual receiving medical care	
Not Used	STC02	373	Date Date expressed as CCYYMMDD	O DT 8/8
Sit.	STC03	306	Action Code	O ID 1/2

			Code indicating type of action	
			This is required for claim rejections (STC01-1=A3) and not used otherwise.	
			15	Correct and Resubmit Claim
			F	Final
			Do not resubmit the claim.	
Required	STC04	782	Claim Submitted Charge Amount	O R 1/18
			Monetary amount	
Not Used	STC05	782	Monetary Amount	O R 1/18
			Monetary amount	
Not Used	STC06	373	Date	O DT 8/8
			Date expressed as CCYYMMDD	
Not Used	STC07	591	Payment Method Code	O ID 3/3
			Code identifying the method for the movement of payment instructions	
Not Used	STC08	373	Date	O DT 8/8
			Date expressed as CCYYMMDD	
Not Used	STC09	429	Check Number	O AN 1/16
			Check identification number	
Sit.	STC10	C043	Health Care Claim Status	O
			Used to convey status of the entire claim or a specific service line	
			Only used when STC01-1="A3" and additional status information is necessary to explain the rejection reason.	
Required	STC10-1	1271	Claim Status Category Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			"A3" is the only applicable value.	
Required	STC10-2	1271	Claim Status Reason Code	M AN 1/30
			Code indicating a code from a specific industry code list	
			This is the external list that is available from www.wpc-edi.com.	
Sit.	STC10-3	98	Entity Identifier Code	O ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.	
			41	Submitter
			<i>Entity transmitting transaction set</i>	
			82	Rendering Provider
			85	Billing Provider
			87	Pay-to Provider
			DD	Assistant Surgeon
			DN	Referring Provider
			IL	Insured or Subscriber
			P3	Primary Care Provider
			PR	Payer
			QC	Patient
			<i>Individual receiving medical care</i>	
Sit.	STC11	C043	Health Care Claim Status	O
			Used to convey status of the entire claim or a specific service line	
			Required when STC01-1 equals "A3" and a third status reason is necessary to explain the rejection. Usage of the sub-elements matches the usage of STC10's sub-elements.	
Required	STC11-1	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
Required	STC11-2	1271	Industry Code	M AN 1/30
			Code indicating a code from a specific industry code list	
Sit.	STC11-3	98	Entity Identifier Code	O ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.	
			41	Submitter
			<i>Entity transmitting transaction set</i>	

			82	<i>Rendering Provider</i>	
			85	<i>Billing Provider</i>	
			87	<i>Pay-to Provider</i>	
			DD	<i>Assistant Surgeon</i>	
			DN	<i>Referring Provider</i>	
			IL	<i>Insured or Subscriber</i>	
			P3	<i>Primary Care Provider</i>	
			PR	<i>Payer</i>	
			QC	<i>Patient</i>	
				<i>Individual receiving medical care</i>	
Not Used	STC12	933	Free-Form Message Text		O AN 1/264
			Free-form message text		

Segment: **DTP** Date or Time or Period
Position: 120
Loop: 2200D Situational
Level: Detail
Usage: Required
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Notes: One iteration of this DTP segment identifying the receipt date of the claim is required.
 A second iteration identifying the claim statement period start date is required except in cases where dates were not supplied on the original claim, such as in cases of dental predetermination of benefits.
Example: DTP*050*D8*20020118~

Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
Required	DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time <i>050</i> Received <i>232</i> Claim Statement Period Start	M ID 3/3
Required	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <i>D8</i> Date Expressed in Format CCYYMMDD	M ID 2/3
Required	DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times This is either the Claim Received date (DTP01 equals "050") or the Claim Statement Period Start date (DTP01 equals "232") in CCYYMMDD format.	M AN 1/35

Segment: **SVC** Service Information
Position: 180
Loop: 2220D Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service

Syntax Notes:
Semantic Notes:

- 1 SVC01 is the procedure upon which adjudication is based.
- 2 SVC02 is the submitted service charge.

Notes:

This loop is REQUIRED when a claim is rejected for errors within a specific service. Only those services with errors will be reported. One 2220D loop will be provided for each service line with errors.

Example: SVC*AD:D1110*65~

Data Element Summary

	Ref.	Data		
	<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
Required	SVC01	C003	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers	M
Required	SVC01-1	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M ID 2/2
Required	SVC01-2	234	AD American Dental Association Codes Product/Service ID Identifying number for a product or service	M AN 1/48
Sit.	SVC01-3	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-4	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-5	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-6	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Not Used	SVC01-7	352	Description A free-form description to clarify the related data elements and their content	O AN 1/80
Required	SVC02	782	Submitted Service Line Charge Monetary amount	M R 1/18
Not Used	SVC03	782	Monetary Amount Monetary amount	O R 1/18
Not Used	SVC04	234	Product/Service ID Identifying number for a product or service	O AN 1/48
Not Used	SVC05	380	Quantity Numeric value of quantity	O R 1/15
Not Used	SVC06	C003	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers	O
Not Used	SVC06-1	235	Product/Service ID Qualifier	M ID 2/2

Code	Product/Service ID	Quantity	Description	Segment	Reference
Not Used	SVC06-2	234	Product/Service ID Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M	AN 1/48
Not Used	SVC06-3	1339	Procedure Modifier Identifying number for a product or service	O	AN 2/2
Not Used	SVC06-4	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-5	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-6	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-7	352	Description A free-form description to clarify the related data elements and their content	O	AN 1/80
Not Used	SVC07	380	Quantity Numeric value of quantity	O	R 1/15

Segment: STC Status Information

Position: 190
Loop: 2220D Situational
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line

Syntax Notes:
Semantic Notes:
Notes:

Example: STC*A3:477~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	STC01	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	M
Required	STC01-1	1271	Service Status Category Code Code indicating a code from a specific industry code list This will always be "A3" - Acknowledgement/Returned as unprocessable.	M AN 1/30
Required	STC01-2	1271	Service Status Reason Code Code indicating a code from a specific industry code list This is a code from the code list available from www.wpc-edi.com.	M AN 1/30
Sit.	STC01-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual This is required when an entity type is necessary to further identify the reason for the rejection. <i>41 Submitter Entity transmitting transaction set 82 Rendering Provider 85 Billing Provider 87 Pay-to Provider DD Assistant Surgeon DN Referring Provider IL Insured or Subscriber P3 Primary Care Provider PR Payer QC Patient Individual receiving medical care</i>	O ID 2/3
Not Used	STC02	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC03	306	Action Code Code indicating type of action	O ID 1/2
Not Used	STC04	782	Monetary Amount Monetary amount	O R 1/18
Not Used	STC05	782	Monetary Amount Monetary amount	O R 1/18
Not Used	STC06	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC07	591	Payment Method Code Code identifying the method for the movement of payment instructions	O ID 3/3
Not Used	STC08	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC09	429	Check Number Check identification number	O AN 1/16
Sit.	STC10	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line Required when a second status identification is necessary to identify the	O

			reject reason. Use the same instructions as for STC01 for the elements of this composite.		
Required	STC10-1	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Required	STC10-2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Sit.	STC10-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O	ID 2/3
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.		
			41	Submitter	
				Entity transmitting transaction set	
			82	Rendering Provider	
			85	Billing Provider	
			87	Pay-to Provider	
			DD	Assistant Surgeon	
			DN	Referring Provider	
			IL	Insured or Subscriber	
			P3	Primary Care Provider	
			PR	Payer	
			QC	Patient	
				Individual receiving medical care	
Sit.	STC11	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	O	
			Required when a third status identification is necessary to identify the reject reason. Use the same instructions as for STC01 for the elements of this composite.		
Required	STC11-1	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Required	STC11-2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Sit.	STC11-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O	ID 2/3
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.		
			41	Submitter	
				Entity transmitting transaction set	
			82	Rendering Provider	
			85	Billing Provider	
			87	Pay-to Provider	
			DD	Assistant Surgeon	
			DN	Referring Provider	
			IL	Insured or Subscriber	
			P3	Primary Care Provider	
			PR	Payer	
			QC	Patient	
				Individual receiving medical care	
Not Used	STC12	933	Free-Form Message Text Free-form message text	O	AN 1/264

Segment: **REF** Service Identification
Position: 200
Loop: 2220D Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes:
Notes:

This REF segment will supply either the Provider Control Number from the original claim or the line item sequence number when no Provider Control Number was supplied.

Example: REF*6R*7364563~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification 6R <i>Provider Control Number Number assigned by information provider company for tracking and billing purposes</i>	M ID 2/3
Required	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Provider Control Number supplied in the 837 using the same REF01 qualifier of 6R for this service. If no line item control number was supplied, the line item sequence number will be supplied.	X AN 1/30
Not Used	REF03	352	Description A free-form description to clarify the related data elements and their content	X AN 1/80
Not Used	REF04	C040	Reference Identifier To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
Not Used	REF04-1	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3
Not Used	REF04-2	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
Not Used	REF04-3	128	Reference Identification Qualifier Code qualifying the Reference Identification	X ID 2/3
Not Used	REF04-4	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
Not Used	REF04-5	128	Reference Identification Qualifier Code qualifying the Reference Identification	X ID 2/3
Not Used	REF04-6	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

Segment: **DTP** Date or Time or Period
Position: 210
Loop: 2220D Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Notes: The Service Start Date will always be supplied.
Example: DTP*472*D8*20020114~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time <i>472 Service</i> <i>Begin and end dates of the service being rendered</i> This is used for the start date only.	M ID 3/3
Required	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <i>D8 Date Expressed in Format CCYYMMDD</i>	M ID 2/3
Required	DTP03	1251	Service Start Date Expression of a date, a time, or range of dates, times or dates and times This is the start date for the service from the original claim.	M AN 1/35

Segment: **HL** Dependent Hierarchical Level
Position: 010
Loop: 2000E Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

Syntax Notes:
Semantic Notes:

Notes: Required when the dependent is the patient.
Example: HL*5*4*23*0~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure Continued numbering from previous HL01 elements within the transaction, incremented by 1.	M AN 1/12
Required	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to This will contain the Hierarchical ID Number for the 2000D loop that identifies the Subscriber related to the claim identified under this dependent.	O AN 1/12
Required	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a hierarchical structure 23 <i>Dependent</i> <i>Identifies the individual who is affiliated with the subscriber, such as spouse, child, etc., and therefore may be entitled to benefits</i>	M ID 1/2
Required	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described 0 <i>No Subordinate HL Segment in This Hierarchical Structure.</i>	O ID 1/1

Segment: **DMG** Demographic Information
Position: 040
Loop: 2000E Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply demographic information
Syntax Notes: 1 If either DMG01 or DMG02 is present, then the other is required.
Semantic Notes: 1 DMG02 is the date of birth.
Notes: **Example: DMG*D8*19911207~**

Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
Required	DMG01	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD	X ID 2/3
Required	DMG02	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times This is the Dependent's (patient) Date of Birth in CCYYMMDD format.	X AN 1/35
Not Used	DMG03	1068	Gender Code Code indicating the sex of the individual	O ID 1/1
Not Used	DMG04	1067	Marital Status Code Code defining the marital status of a person	O ID 1/1
Not Used	DMG05	1109	Race or Ethnicity Code Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	O ID 1/1
Not Used	DMG06	1066	Citizenship Status Code Code indicating citizenship status	O ID 1/2
Not Used	DMG07	26	Country Code Code identifying the country	O ID 2/3
Not Used	DMG08	659	Basis of Verification Code Code indicating the basis of verification	O ID 1/2
Not Used	DMG09	380	Quantity Numeric value of quantity	O R 1/15

Segment: **NM1** **Dependent Name**
Position: 050
Loop: 2100E Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: 1 If either NM108 or NM109 is present, then the other is required.
Semantic Notes: 1 NM102 qualifies NM103.
Notes: **Example: NM1*03*1*JONES*SAMANTHA*T~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
			<i>03</i> <i>Dependent</i>	
Required	NM102	1065	Entity Type Qualifier Code qualifying the type of entity	M ID 1/1
			<i>1</i> <i>Person</i>	
Required	NM103	1035	Dependent Last Name Individual last name or organizational name	O AN 1/35
Required	NM104	1036	Dependent First Name Individual first name	O AN 1/25
Sit.	NM105	1037	Dependent Middle Initial Individual middle name or initial This will be provided when submitted on the 837 or when known from the database.	O AN 1/25
Not Used	NM106	1038	Name Prefix Prefix to individual name	O AN 1/10
Sit.	NM107	1039	Name Suffix Suffix to individual name This will be provided when submitted on the 837 or when known from the database.	O AN 1/10
Sit.	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) Required when NM109 is used.	X ID 1/2
			<i>MI</i> <i>Member Identification Number</i>	
Sit.	NM109	67	Identification Code Code identifying a party or other code This is the Payer's identification number for the Member, when the member has an ID different than the Subscriber. This is required when the dependent has a unique ID with the payer.	X AN 2/80
Not Used	NM110	706	Entity Relationship Code Code describing entity relationship	X ID 2/2
Not Used	NM111	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

Segment: **TRN** Claim Identification
Position: 090
Loop: 2200E Required
Level: Detail
Usage: Required
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes: 1 TRN02 provides unique identification for the transaction.
Notes: **Example: TRN*2*837484783~**

Data Element Summary

	<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Attributes</u>
Required	TRN01	481	Trace Type Code Code identifying which transaction is being referenced 2 <i>Referenced Transaction Trace Numbers</i>	M ID 1/2
Required	TRN02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Claim Submitter's Identifier from the original 837 claim (CLM01). At least 20 characters will be returned unaltered.	M AN 1/30
Not Used	TRN03	509	Originating Company Identifier A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9	O AN 10/10
Not Used	TRN04	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30

Segment: **STC** Status Information

Position: 100
Loop: 2200E Required
Level: Detail
Usage: Required
Max Use: >1
Purpose: To report the status, required action, and paid information of a claim or service line

Syntax Notes:
Semantic Notes:
Notes:

Example: STC*A3:247*576~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	STC01	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	M
Required	STC01-1	1271	Claim Status Category Code Code indicating a code from a specific industry code list This is from an external code list. The values possible here are: A0 - Acknowledgement/Forwarded to another entity. A2 - Acknowledgement/Acceptance into the adjudication system. A3 - Acknowledgement/Returned as unprocessable.	M AN 1/30
Required	STC01-2	1271	Claim Status Reason Code Code indicating a code from a specific industry code list This is an external code list. Access www.wpc-edi.com for a complete listing of the codes. 16 - Claim/encounter has been forwarded to entity. This code will be used when STC01-1 equals "A0". 20 - Accepted for Processing. This code will be used whenever STC01-1 equals "A2". 247 - Line Information. This code will be used whenever STC01-1 equals "A3" and the reason for the rejection is line specific.	M AN 1/30
Sit.	STC01-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual This element provides identification of the entity related to the reason in STC01-2 when appropriate. 41 Submitter <i>Entity transmitting transaction set</i> 82 Rendering Provider <i>Rendering Provider</i> 85 Billing Provider <i>Billing Provider</i> 87 Pay-to Provider <i>Pay-to Provider</i> DD Assistant Surgeon <i>Assistant Surgeon</i> DN Referring Provider <i>Referring Provider</i> IL Insured or Subscriber <i>Insured or Subscriber</i> P3 Primary Care Provider <i>Primary Care Provider</i> PR Payer <i>Payer</i> QC Patient <i>Individual receiving medical care</i> This will be used when STC01-1 equals "A0".	O ID 2/3
Not Used	STC02	373	Date Date expressed as CCYYMMDD	O DT 8/8
Sit.	STC03	306	Action Code	O ID 1/2

			Code indicating type of action		
			This is required for claim rejections (STC01-1=A3) and not used otherwise.		
			15	Correct and Resubmit Claim	
			F	Final	
			Do not resubmit the claim.		
Required	STC04	782	Claim Submitted Charge Amount	O	R 1/18
			Monetary amount		
Not Used	STC05	782	Monetary Amount	O	R 1/18
			Monetary amount		
Not Used	STC06	373	Date	O	DT 8/8
			Date expressed as CCYYMMDD		
Not Used	STC07	591	Payment Method Code	O	ID 3/3
			Code identifying the method for the movement of payment instructions		
Not Used	STC08	373	Date	O	DT 8/8
			Date expressed as CCYYMMDD		
Not Used	STC09	429	Check Number	O	AN 1/16
			Check identification number		
Sit.	STC10	C043	Health Care Claim Status	O	
			Used to convey status of the entire claim or a specific service line		
			Only used when STC01-1="A3" and additional status information is necessary to explain the rejection reason.		
Required	STC10-1	1271	Claim Status Category Code	M	AN 1/30
			Code indicating a code from a specific industry code list		
			"A3" is the only applicable value.		
Required	STC10-2	1271	Claim Status Reason Code	M	AN 1/30
			Code indicating a code from a specific industry code list		
			This is the external list that is available from www.wpc-edi.com.		
Sit.	STC10-3	98	Entity Identifier Code	O	ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual		
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.		
			41	Submitter	
				Entity transmitting transaction set	
			82	Rendering Provider	
			85	Billing Provider	
			87	Pay-to Provider	
			DD	Assistant Surgeon	
			DN	Referring Provider	
			IL	Insured or Subscriber	
			P3	Primary Care Provider	
			PR	Payer	
			QC	Patient	
				Individual receiving medical care	
Sit.	STC11	C043	Health Care Claim Status	O	
			Used to convey status of the entire claim or a specific service line		
			Only used when STC01-1 equals "A3" and a third status reason is necessary to explain the rejection. Usage of the sub-elements matches the usage of STC10's sub-elements.		
Required	STC11-1	1271	Industry Code	M	AN 1/30
			Code indicating a code from a specific industry code list		
Required	STC11-2	1271	Industry Code	M	AN 1/30
			Code indicating a code from a specific industry code list		
Sit.	STC11-3	98	Entity Identifier Code	O	ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual		
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.		
			41	Submitter	
				Entity transmitting transaction set	

			82	<i>Rendering Provider</i>	
			85	<i>Billing Provider</i>	
			87	<i>Pay-to Provider</i>	
			DD	<i>Assistant Surgeon</i>	
			DN	<i>Referring Provider</i>	
			IL	<i>Insured or Subscriber</i>	
			P3	<i>Primary Care Provider</i>	
			PR	<i>Payer</i>	
			QC	<i>Patient</i>	
				<i>Individual receiving medical care</i>	
Not Used	STC12	933	Free-Form Message Text		O AN 1/264
			Free-form message text		

Segment: **DTP** Date or Time or Period
Position: 120
Loop: 2200E Required
Level: Detail
Usage: Required
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.
Notes:

One iteration of this DTP segment identifying the received date of the claim is required.
 A second iteration identifying the claim statement period start date is required except in cases where dates were not supplied on the original claim, such as in cases of dental predetermination of benefits.
Example: DTP*232*D8*20020115~

Data Element Summary

Ref.	Data	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
Required	DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time <i>050</i> Received <i>232</i> Claim Statement Period Start	M ID 3/3
Required	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <i>D8</i> Date Expressed in Format CCYYMMDD	M ID 2/3
Required	DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times This is either the Claim Received date (DTP01 equals "050") or the Claim Statement Period Start date (DTP01 equals "232") in CCYYMMDD format.	M AN 1/35

Segment: **SVC** Service Information
Position: 180
Loop: 2220E Situational
Level: Detail
Usage: Situational
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service

Syntax Notes:

- Semantic Notes:**
- 1 SVC01 is the procedure upon which adjudication is based.
 - 2 SVC02 is the submitted service charge.

Notes: This loop is required when a claim is rejected for errors within a specific service. Only those services with errors will be reported. One 2220E loop will be provided for each service line with errors.
Example: SVC*AD:D1110*60~

Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
Required	SVC01	C003	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers	M
Required	SVC01-1	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M ID 2/2
			<i>AD American Dental Association Codes</i>	
Required	SVC01-2	234	Product/Service ID Identifying number for a product or service This is the procedure code from the original claim/service line in the 837.	M AN 1/48
Sit.	SVC01-3	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-4	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-5	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Sit.	SVC01-6	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners This is required when the original claim submitted this modifier.	O AN 2/2
Not Used	SVC01-7	352	Description A free-form description to clarify the related data elements and their content	O AN 1/80
Required	SVC02	782	Submitted Service Line Charge Monetary amount	M R 1/18
Not Used	SVC03	782	Monetary Amount Monetary amount	O R 1/18
Not Used	SVC04	234	Product/Service ID Identifying number for a product or service	O AN 1/48
Not Used	SVC05	380	Quantity Numeric value of quantity	O R 1/15
Not Used	SVC06	C003	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers	O

Not Used	SVC06-1	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M	ID 2/2
Not Used	SVC06-2	234	Product/Service ID Identifying number for a product or service	M	AN 1/48
Not Used	SVC06-3	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-4	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-5	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-6	1339	Procedure Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners	O	AN 2/2
Not Used	SVC06-7	352	Description A free-form description to clarify the related data elements and their content	O	AN 1/80
Not Used	SVC07	380	Quantity Numeric value of quantity	O	R 1/15

Segment: STC Status Information

Position: 190
Loop: 2220E Situational
Level: Detail
Usage: Required
Max Use: >1

Purpose: To report the status, required action, and paid information of a claim or service line

Syntax Notes:
Semantic Notes:
Notes:

Example: STC*A3:21***A3:454~**

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	STC01	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	M
Required	STC01-1	1271	Service Status Category Code Code indicating a code from a specific industry code list This will always be "A3" - Acknowledgement/Returned as unprocessable.	M AN 1/30
Required	STC01-2	1271	Service Status Reason Code Code indicating a code from a specific industry code list This is a code from the code list available from www.wpc-edi.com.	M AN 1/30
Sit.	STC01-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual This is required when an entity type is necessary to further identify the reason for the rejection. <i>41 Submitter Entity transmitting transaction set 82 Rendering Provider 85 Billing Provider 87 Pay-to Provider DD Assistant Surgeon DN Referring Provider IL Insured or Subscriber P3 Primary Care Provider PR Payer QC Patient Individual receiving medical care</i>	O ID 2/3
Not Used	STC02	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC03	306	Action Code Code indicating type of action	O ID 1/2
Not Used	STC04	782	Monetary Amount Monetary amount	O R 1/18
Not Used	STC05	782	Monetary Amount Monetary amount	O R 1/18
Not Used	STC06	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC07	591	Payment Method Code Code identifying the method for the movement of payment instructions	O ID 3/3
Not Used	STC08	373	Date Date expressed as CCYYMMDD	O DT 8/8
Not Used	STC09	429	Check Number Check identification number	O AN 1/16
Sit.	STC10	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line Required when a second status identification is necessary to identify the	O

			reject reason. Use the same instructions as for STC01 for the elements of this composite.		
Required	STC10-1	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Required	STC10-2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Sit.	STC10-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O	ID 2/3
			This is required when the value in STC10-2 requires identification of the entity for complete understanding.		
			41 <i>Submitter</i>		
			82 <i>Entity transmitting transaction set</i>		
			85 <i>Rendering Provider</i>		
			87 <i>Billing Provider</i>		
			DD <i>Pay-to Provider</i>		
			DN <i>Assistant Surgeon</i>		
			IL <i>Referring Provider</i>		
			P3 <i>Insured or Subscriber</i>		
			PR <i>Primary Care Provider</i>		
			QC <i>Payer</i>		
			QC <i>Patient</i>		
			QC <i>Individual receiving medical care</i>		
Sit.	STC11	C043	Health Care Claim Status Used to convey status of the entire claim or a specific service line	O	
			Required when a third status identification is necessary to identify the reject reason. Use the same instructions as for STC01 for the elements of this composite.		
Required	STC11-1	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Required	STC11-2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN 1/30
Sit.	STC11-3	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	O	ID 2/3
			This is required when the value in STC11-2 requires identification of the entity for complete understanding.		
			41 <i>Submitter</i>		
			82 <i>Entity transmitting transaction set</i>		
			85 <i>Rendering Provider</i>		
			87 <i>Billing Provider</i>		
			DD <i>Pay-to Provider</i>		
			DN <i>Assistant Surgeon</i>		
			IL <i>Referring Provider</i>		
			P3 <i>Insured or Subscriber</i>		
			PR <i>Primary Care Provider</i>		
			QC <i>Payer</i>		
			QC <i>Patient</i>		
			QC <i>Individual receiving medical care</i>		
Not Used	STC12	933	Free-Form Message Text Free-form message text	O	AN 1/264

Segment: REF Service Identification
Position: 200
Loop: 2220E Situational
Level: Detail
Usage: Required
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
Semantic Notes:
Notes:

This REF segment will supply either the Provider Control Number from the original claim or the line item sequence number when no Provider Control Number was supplied.

Example: REF*6R*34562973~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification 6R <i>Provider Control Number</i> <i>Number assigned by information provider company for tracking and billing purposes</i>	M ID 2/3
Required	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This is the Provider Control Number supplied in the 837 using the same REF01 qualifier of 6R for this service. If no line item control number was supplied, the line item sequence number will be supplied.	X AN 1/30
Not Used	REF03	352	Description A free-form description to clarify the related data elements and their content	X AN 1/80
Not Used	REF04	C040	Reference Identifier To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
Not Used	REF04-1	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3
Not Used	REF04-2	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
Not Used	REF04-3	128	Reference Identification Qualifier Code qualifying the Reference Identification	X ID 2/3
Not Used	REF04-4	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
Not Used	REF04-5	128	Reference Identification Qualifier Code qualifying the Reference Identification	X ID 2/3
Not Used	REF04-6	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

Segment: **DTP** Date or Time or Period

Position: 210
Loop: 2220E Situational
Level: Detail
Usage: Required
Max Use: 1

Purpose: To specify any or all of a date, a time, or a time period

Syntax Notes:

Semantic Notes: 1 DTP02 is the date or time or period format that will appear in DTP03.

Notes: The Service Start Date will always be supplied.

Example: DTP*472*D8*20020114~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time <i>472 Service</i> <i>Begin and end dates of the service being rendered</i>	M ID 3/3
			This is used for the start date only.	
Required	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <i>D8 Date Expressed in Format CCYYMMDD</i>	M ID 2/3
Required	DTP03	1251	Service Start Date Expression of a date, a time, or range of dates, times or dates and times This is the start date for the service from the original claim.	M AN 1/35

Segment: **SE** Transaction Set Trailer
Position: 270
Loop:
Level: Detail
Usage: Required
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

Syntax Notes:
Semantic Notes:
Notes:

Example: SE*27*0001~

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	SE01	96	Number of Included Segments Total number of segments included in a transaction set including ST and SE segments	M NO 1/10
Required	SE02	329	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Numbers in ST02 and SE02 will be identical. The number will be unique within a specific functional group (GS to GE) and interchange (ISA to IEA), but can be repeated in other groups and interchanges. This unique number also aids in error resolution research.	M AN 4/9

Segment: **GE** Functional Group Trailer
Position: 280
Loop:
Level: Detail
Usage: Required
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: 1 The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Notes: **Example: GE*1*22755***

Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
Required	GE01	97	Number of Transaction Sets Included Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	M NO 1/6
Required	GE02	28	Group Control Number Assigned number originated and maintained by the sender	M NO 1/9

External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

SOURCE

Codes for Representation of Names of Countries, ISO 3166-(Latest Release)

Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM

American National Standards Institute

11 West 42nd Street, 13th Floor

New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entities in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service

National Information Data Center

P.O. Box 2977

Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

ASC X12N • INSURANCE SUBCOMMITTEE 004010X093 • 276/277 IMPLEMENTATION GUIDE HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

MAY 2000 **C.1**

Microfiche available from NTIS (same as address above).

The Canadian Post Office lists the following as "official" codes for Canadian Provinces:

AB - Alberta

BC - British Columbia

MB - Manitoba

NB - New Brunswick

NF - Newfoundland

NS - Nova Scotia

NT - North West Territories

ON - Ontario

PE - Prince Edward Island

PQ - Quebec

SK - Saskatchewan

YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service

Washington, DC 20260

New Orders

Superintendent of Documents

P.O. Box 371954

Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes. The USPS Domestic Mail Manual includes information on the use of the new 11-digit zip code.

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C.2 MAY 2000

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary

X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)

Suite 200

1800 Diagonal Road

Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/AD, 1270/JO, 1270/JP

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

Salable Materials

American Dental Association

211 East Chicago Avenue

Chicago, IL 60611-2678

ABSTRACT

The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

www.wpc-edi.com

Washington Publishing Company

PMB 161

5284 Randolph Road

Rockville, MD 20852-2116

ABSTRACT

Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

ASC X12N • INSURANCE SUBCOMMITTEE 004010X093 • 276/277 IMPLEMENTATION GUIDE HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

MAY 2000 **C.5**

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee

American Hospital Association

840 Lake Shore Drive

Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department

12th Street, Suite 1100

Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

004010X093 • 276/277 ASC X12N • INSURANCE SUBCOMMITTEE

HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE IMPLEMENTATION GUIDE

C.6 MAY 2000

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Category Code

AVAILABLE FROM

Washington Publishing Company

<http://www.wpc-edi.com>

ABSTRACT

Code used to organize the Health Care Claim Status Codes into logical groupings

508 Health Care Claim Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Code

AVAILABLE FROM

Washington Publishing Company

<http://www.wpc-edi.com>

ABSTRACT

Code identifying the status of an entire claim or service line

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration

Center for Beneficiary Services

Administration Group

Division of Membership Operations

S1-05-06

7500 Security Boulevard

Baltimore, MD 21244-1850

ABSTRACT

The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

004010X093 • 276/277 ASC X12N • INSURANCE SUBCOMMITTEE HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE IMPLEMENTATION GUIDE

C.8 MAY 2000

APPENDIX B

STC01-1	STC01-2	STC01-3	Error Description
A2	20		No errors exist
A3	24	41	Trading Partner ID not found
A3	24	85/87	Provider not associated with Trading Partner ID
A3	32	IL	Subscriber/Member not found on our database
A3	116	PR	Invalid Payer NAIC code
A3	116		Misdirected Claim
A3	128	85	Tax ID required when NPI submitted for Billing Provider
A3	128	87	Tax ID required when NPI submitted for Pay-To Provider
A3	135	82	Claim Level Rendering Provider REF containing G2, 1A or 1B number not submitted
A3	135	82	Line Level Rendering Provider not associated with Billing Provider
A3	135	82	Line Level Rendering Provider REF containing G2, 1A or 1B number not submitted
A3	135	82	Claim Level Rendering Provider number is invalid
A3	135	82	Claim Level Rendering Provider not associated with Billing Provider
A3	135	85	Billing Provider REF containing G2, 1A or 1B number not submitted
A3	135	85	Invalid Billing Provider Number
A3	135	87	PAY-TO Provider REF containing G2, 1A, 1B number not submitted
A3	135	87	Invalid Pay-To Provider Number
A3	135	87/85	No Claim level Rendering Provider Number reported and Billing/Pay-To is a Multi-Specialty
A3	135	87/85	Claim Level Rendering Provider Number not associated with Billing Provider Number
A3	135	87/85	Line Level Assistant Surgeon Number not associated with Billing/Pay-To Provider Number
A3	135	DD	Claim Level Assistant Surgeon Number not associated with Billing Provider Number
A3	135	DD	Claim Level Assistant Surgeon REF containing a G2, 1A or 1B number not submitted
A3	135	DD	Line Level Assistant Surgeon REF containing G2, 1A or 1B number not submitted
A3	135	DD	Invalid Assistant Surgeon Provider Number
A3	135	DD	Claim Level Assistant Surgeon Number not associated with Billing Provider Number
A3	135	DD	Line Level Assistant Surgeon not associated with Billing Provider
A3	135	DN	Claim Level Referring Provider REF containing G2, 1A or 1B number not submitted on a Specialty Care claim (Referral)
A3	135	DN	Invalid Referring Provider Number on Specialty Care Claim (Referral)
A3	135	DN	Line Level Referring Provider REF containing G2, 1A or 1B number not submitted on a Specialty Care claim (Referral)
A3	135	P3	Claim Level Primary Care Provider REF containing G2, 1A or 1B number not submitted on a Specialty Care claim (Referral)
A3	135	P3	Invalid Primary Care Provider Number on Specialty Care Claim (Referral)
A3	135	P3	Line Level Primary Care Provider REF containing G2, 1A or 1B number not submitted on a Specialty Care claim (Referral)

STC01-1	STC01-2	STC01-3	Error Description
A3	155	IL	Patient Relationship reported in Subscriber Loop (SBR02 = 18) contradicts information reported in the Dependent Loop.
A3	158	IL	Invalid Subscriber Date of Birth
A3	158	QC	Invalid Patient Date of Birth
A3	178	85	Currency Code is not equal to USD (US Dollars) or spaces
A3	187		Date of Service End Date is greater than Date of Service Begin Date
A3	187		Invalid Date of Service End Date
A3	187		Invalid Date of Service (future date reported)
A3	189		Invalid Admission Date
A3	190		Invalid Discharge Date
A3	202		Invalid Prior Placement date
A3	240		Procedure Code requires Tooth Surface(s)
A3	240		Invalid Tooth Surface(s)
A3	240		Tooth Surface Code(s) should not be reported for this Procedure Code
A3	242		Tooth Number or Oral Cavity Designation Code is required for this Procedure Code
A3	244		Procedure Code requires Tooth Number(s)
A3	244		Submitted Procedure Code requires Quantity (Number of Procedures) to be equal to the number of Teeth submitted
A3	244		Procedure Code requires Tooth Number(s), Oral Cavity Designation Code(s) submitted.
A3	244		Tooth Number reported is not valid for the reported procedure code.
A3	245		Oral Cavity Designation Code "09 - Other Area of Oral Cavity" is not an acceptable value
A3	245		Invalid Oral Cavity Code
A3	245		Procedure Code requires Tooth Number(s) and/or Oral Cavity Designation Code(s)
A3	245		Invalid Tooth Number
A3	247		Line Level Error(s) Exist
A3	286		Claim indicates that other payer is Primary Insurer and required Coordination Of Benefit Information is not submitted
A3	306		Procedure Code reported requires Line Level Note Segment (NTE)
A3	352		Total length of orthodontic treatment required
A3	400		Total Line Item Charge Amounts do not equal Total Claim Charge Amount
A3	453		Invalid Modifier
A3	454		Invalid Procedure Code
A3	476		Procedure Count is less than one

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Appendix C EDI Reference Guide Changes for March 2004

November Minor typographical errors or wording corrections that do not alter meaning are not listed.

Page	Transaction	Segment/Section	Description
2.2		2.4	Added Valid Characters in Text Data
6.1		6.1	Added Command Prompt Values C, H and L.
7.1		7.1.1	Removed LineFeed (Hex Value 0A) and Hyphen “-“ (Hex Value 2D) from the Delimiter Listing.
10.2		10.1.5	Added statement regarding UNKNO being used in SVC01-2 data element.
12.3	270/271	12.1.12	Real-Time requests are not supported.
12.3	270/271	12.1.13	Real-Time requests are not supported.
12.6	270/271	GS02	Real-Time requests are not supported.
12.9	270/271	GS03	Real-Time requests are not supported.

Appendix C EDI Reference Guide Changes for November 2004

The items below were revised in the November 2004 version of this EDI Reference Guide.

Page	Transaction	Segment/Section	Description
B.1			Appendix B – Added STC01-2 Value 32 and description
B.2			Appendix B – Added STC01-2 Value 352 and description
B.2			Appendix B – Removed STC01-2 Value 164 and description

Appendix C EDI Reference Guide Changes for September 2005

The items below were revised in the September 2005 version of this EDI Reference Guide.

Page	Transaction	Segment/ Section	Description
4.2		4.3	Removed requirement to fax application to Dental Electronic Services.
6.1		6.1	Changed password command.
6.1.1			Section was added.
6.1.2			Section was added.
7.3			Note was added to the ^ delimiter.
7.6		7.5	Updated Functional Acknowledgement section.

Appendix C EDI Reference Guide Changes for November 2005

The items below were revised in the November 2005 version of this EDI Reference Guide.

Page	Transaction	Segment/ Section	Description
6.1		6	Renumbered entire section.

Appendix C EDI Reference Guide Changes for January 2007

The items below were revised in the January 2007 version of this EDI Reference Guide.

Page	Transaction	Segment/ Section	Description
B.1			Added Health Care Claim Status Code 128.

Appendix C EDI Reference Guide Changes for January 2008

The items below were revised in the January 2008 version of this EDI Reference Guide.

Page	Trans- action	Segment/ Section	Description
All			Deleted all references to Payer NAIC Code 83470 - Blue Cross/Blue Shield of Arkansas.