ASC X12N/005010X214

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Claim Acknowledgment (277)

JANUARY 2007

Contact **Washington Publishing Company** for more Information.

www.wpc-edi.com

Table of Contents

1 Purpose and Business Information 7
1.1 Implementation Purpose and Scope 7
1.2 Version Information 7
1.3 Implementation Limitations 8
1.3.1 Batch and Real-time Usage 8
1.3.2 Other Usage Limitations 8
1.4 Business Usage 8
1.4.1 Transaction Participants 9
1.4.1.1 Defining the “Patient” Participant 10
1.4.2 Status Information (STC) Segment Usage 10
1.4.2.1 STC Composite and Code Use Rules 11
1.4.3 277 Transaction Usages 12
1.5 Business Terminology 13
1.6 Transaction Acknowledgments 13
1.6.1 997 Functional Acknowledgment 13
1.6.2 999 Implementation Acknowledgment 14
1.6.3 824 Application Advice 14
1.7 Related Transactions 14
1.7.1 The Claim (837) 14
1.8 Trading Partner Agreements 14
1.9 The HIPAA Role in Implementation Guides 15
1.10 Data Overview 15
1.10.1 Overall Data Architecture 15
2 Transaction Set 17
2.1 Presentation Examples 17
2.2 Implementation Usage 22
2.2.1 Industry Usage 22
2.2.1.1 Transaction Compliance Related to Industry Usage 23
2.2.2 Loops 23
2.3 Transaction Set Listing 25
2.3.1 Implementation 25
2.3.2 X12 Standard 28
2.4 277 Segment Detail 31
ST Transaction Set Header 32
BHT Beginning of Hierarchical Transaction 33
HL Information Source Level 35
NM1 Information Source Name 37
TRN Transmission Receipt Control Identifier 40
DTP Information Source Receipt Date 41
DTP Information Source Process Date 42
HL Information Receiver Level 44

NM1 Information Receiver Name 46
TRN Information Receiver Application Trace Identifier 49
STC Information Receiver Status Information 50
QTY Total Accepted Quantity 55
QTY Total Rejected Quantity 56
AMT Total Accepted Amount 57
AMT Total Rejected Amount 58
HL Billing Provider of Service Level 59
NM1 Billing Provider Name 61
TRN Provider of Service Information Trace Identifier 64
STC Billing Provider Status Information 65
REF Provider Secondary Identifier 70
QTY Total Accepted Quantity 71
QTY Total Rejected Quantity 72
AMT Total Accepted Amount 73
AMT Total Rejected Amount 74
HL Patient Level 75
NM1 Patient Name 77
TRN Claim Status Tracking Number 79
STC Claim Level Status Information 80
REF Payer Claim Control Number 85
REF Claim Identifier Number For Clearinghouse and Other Transmission Intermediaries 86
REF Institutional Bill Type Identification 87
DTP Claim Level Service Date 89
SVC Service Line Information 90
STC Service Line Level Status Information 94
REF Service Line Item Identification 99
REF Pharmacy Prescription Number 100
DTP Service Line Date 101
SE Transaction Set Trailer 102

3 Examples 103

3.1 Business Scenario 1: Clearinghouse Example - Accepted File (some claims rejected) 103

3.2 Business Scenario 2: Clearinghouse Example - Rejected File (invalid submitter) 105

3.3 Business Scenario 3: Payer Response - Accepted File (some claims rejected) 105

3.4 Business Scenario 4: Payer Response - 1st Provider - Claims Accepted and 2nd Provider - Claims Rejected 107

A External Code Sources A.1

130 Healthcare Common Procedural Coding System A.1
132 National Uniform Billing Committee (NUBC) Codes A.1
135 American Dental Association A.1
507 Health Care Claim Status Category Code A.2
508 Health Care Claim Status Code A.2
513 Home Infusion EDI Coalition (HIEC) Product/Service Code List A.2
537 Centers for Medicare and Medicaid Services National Provider Identifier A.2
540 Centers for Medicare and Medicaid Services PlanID A.3
576 Workers Compensation Specific Procedure and Supply Codes A.3
716 Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities A.4
843 Advanced Billing Concepts (ABC) Codes A.4

B Nomenclature B.1

B.1 ASC X12 Nomenclature B.1
B.1.1 Interchange and Application Control Structures B.1
B.1.1.1 Interchange Control Structure B.1
B.1.1.2 Application Control Structure Definitions and Concepts B.2
B.1.1.3 Business Transaction Structure Definitions and Concepts B.5
B.1.1.4 Envelopes and Control Structures B.13
B.1.1.5 Acknowledgments B.16

B.2 Object Descriptors B.17

C EDI Control Directory C.1

C.1 Control Segments C.1
ISA Interchange Control Header C.3
GS Functional Group Header C.7
GE Functional Group Trailer C.9
IEA Interchange Control Trailer C.10

D Change Summary D.1

D.1 Change Summary D.1

E Data Element Glossary E.1

E.1 Data Element Name Index E.1

1 Purpose and Business Information

1.1 Implementation Purpose and Scope

For the health care industry to achieve the potential administrative savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into an EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to provide standardized data requirements and content for all users of ASC X12, Health Care Information Status Notification (277). This implementation guide focuses on the use of the 277 as an acknowledgment of receipt of claim submission(s). This implementation guide provides a detailed explanation of the transaction set by defining uniform data content, identifying valid code tables and specifying values applicable for the business focus of the 277 claim submission acknowledgment. The intention of the developers of the 277 is represented in this guide.

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

Organizations sending this application of the 277 include payers, who may be insurance companies; Third Party Administrators (TPA); service corporations; state and federal agencies and their contractors; plan purchasers; and any other entity that processes health care claims.

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

1.2 Version Information

This implementation guide is based on the October 2003 ASC X12 standards, referred to as Version 5, Release 1, Sub-release 0 (005010).

The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010**X214**.

The two-character Functional Identifier Code for the transaction set included in this implementation guide:

- ***HN Health Care Information Status Notification (277)***

The Version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted in the Functional Group Header (GS segment) that begins a functional group of these transaction sets. For more information, see the descriptions of GS01 and GS08 in Appendix C.

1.3 Implementation Limitations

1.3.1 Batch and Real-time Usage

There are multiple methods available for sending and receiving business transactions electronically. Two common modes for EDI transactions are batch and real-time.

Batch - In a batch mode the sender does not remain connected while the receiver processes the transactions. Processing is usually completed according to a set schedule. If there is an associated business response transaction (such as a 271 Response to a 270 Request for Eligibility), the receiver creates the response transaction and stores it for future delivery. The sender of the original transmission reconnects at a later time and picks up the response transaction. This implementation guide does not set specific response time parameters for these activities.

Real Time - In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender. This implementation guide does not set specific response time parameters for implementers.

This implementation guide is intended to support use in batch mode. This implementation guide is not intended to support use in real-time mode. A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners.

1.3.2 Other Usage Limitations

There are usage limitations.

There are Category Code usage limitations between Batch and Real Time. See Section 1.4.2.1 for more information.

While not specifically precluded from use, the authors of this implementation guide do not recommend this transaction be used as a “real-time” function. This philosophy is consistent with that expressed in the Health Care Claim submission (ASC X12 837) implementation guides (Dental, Institutional, Professional).

1.4 Business Usage

The ASC X12 Health Care Claim Acknowledgement (277) implementation guide is a business application level acknowledgement for the ASC X12 Health Care Claim (837) transaction(s). This acknowledges the validity and acceptability of the claims at the pre-processing stage.

Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This pre-adjudication process is performed so claims that are incorrectly formatted or missing information can be corrected and resubmitted by the provider.

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 acknowledgement of claims. The business function identifies

claims that are accepted for adjudication as well as those that are not accepted. This 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).

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 835. See Section 1.4.3 Figure 1.2 for the entire transaction flow.

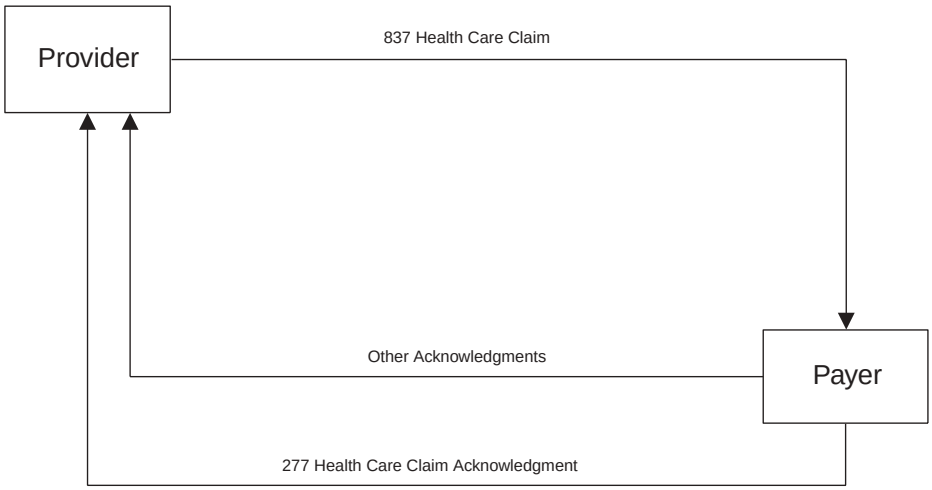


Figure 1.1. Information Flow of ASC X12 Health Care Claim Acknowledgment

1.4.1 Transaction Participants

The relationships between the hierarchical levels are described by the hierarchical level code data elements, also known as HL01 and HL02. The data element, HL03, identifies the participants within the transaction.

When HL03 = 20, the hierarchical level contains the Information Source. This entity is the decision maker in the business transaction. For this business use, this entity is the payer or clearinghouse generating the 277 Health Care Claim Acknowledgement.

When HL03 = 21, the hierarchical level contains the Information Receiver. This entity expects the response from the Information Source

When HL03 = 19, the hierarchical level contains the Provider of Service. This entity delivered the health care service.

When HL03 = PT, the hierarchical level contains the Patient information. This entity is the receiver of the health care service.

A detailed view of the segments and data elements used to describe the participants and their relationship is presented below. The segments and data elements are found in Loop ID-2000 and Loop ID-2100.

The Information Receiver and the Provider of Service hierarchical levels have a unique relationship. Information Receiver refers to the entity that processes the

detailed information contained within the transaction set. In some cases the Information Receiver is a service bureau entity acting on behalf of the Provider of Service. When this occurs, the service bureau entity is described when the HL03 = 21, and the Provider of Service is described when the HL03 = 19. In other instances, the Information Receiver also is the Provider of Service. When this occurs, the same entity is described at two hierarchical levels (e.g., HL03 = 21 and HL03 = 19).

The coding examples are presented sequentially as found within an actual transaction set; however, for reading ease each segment begins on a new line.

The following is a coding example of the Information Source hierarchical level:

```
HL*1**20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
```

The following is a coding example of the Information Receiver hierarchical level:

```
HL*2*1*21*1~
NM1*41*2*ST HOLY HILL HOSPITAL*****46*39999000B~
```

The following is a coding example of the Provider of Service hierarchical level:

```
HL*3*2*19*1~
NM1*85*2*FAMILY CLINIC*****FI*401001234~
```

The following is a coding example of the Patient Hierarchical level:

```
HL*4*3*PT~
NM1*QC*1*SMITH*JOHN*Q**IV*MI*99887777~
```

1.4.1.1 Defining the “Patient” Participant

The Patient information identified in the 277 Claim Acknowledgement Transaction is derived from two possible locations within the 837 Transaction.

- When the patient is the subscriber, the patient name and identification information resides in the 2000B loop of the 837 for Dental, Institutional and Professional transactions.
- When the patient is a dependent of a subscriber but can be uniquely identified to the payer by a unique identification number, the 837 transaction considers the patient to be the subscriber and the patient name and identification information resides in the 2000B loop of the 837 for Dental, Institutional and Professional transactions.
- When the patient is a dependent of the subscriber (for example, spouse, children, others) and does not have a unique Identification Number separate from the subscriber, the patient identification number resides in the subscriber 2000B loop while the patient name information resides in the 2000C loop of the 837 for the Dental, Institutional and Professional transactions.

1.4.2 Status Information (STC) Segment Usage

The primary vehicle for the claim status information in the 277 Transaction is the Status Information (STC) Segment. The level of information returned in the STC Segment may vary from payer to payer. Payers are urged to provide the greatest

level of detail information. See Section 1.4.2.1, STC Composite and Code Use Rules, for additional information.

The STC segment contains three iterations of the C043 (Health Care Claim Status) composite within STC01, STC10 and STC11.

The Health Care Claim Status composite (C043) consists of four elements:

The first element in the C043 composite (C043-01) is the Health Care Claim Status Category Code (Code Source 507). The Category Code indicates the level of pre-adjudication status of the claim. This implementation guide will only utilize Category Codes indicating Acknowledgement (Ax) and Errors (Ex).

The second element in the C043 composite (C043-02) is the Health Care Claim Status Code (Code Source 508). The Status Code provides more specific information about the claim or line item. Examples of status messages include “19 - entity acknowledges receipt of claim/encounter” or “122 - missing/invalid data prevents payer from processing claim”.

The third element in the C043 composite (C043-03) is the Entity Identifier Code (ASC X12 data element 98). The Entity Identifier code is used to clarify the entity when referred to in the status message (CO43-02). The code list identifies an organizational entity, a physical location, property, or an individual. A list of appropriate code values for data element 98 appears within the STC segments in Section 2.4.

The fourth element in the C043 composite (C043-04) is the Code List Qualifier Code (ASC X12 data element 1270). This element is Not Used in this version of the implementation guide.

A committee of health care industry representatives from payer, provider and vendor organizations maintains the Health Care Claim Status Category Codes and Health Care Claim Status Codes (Code Sources 507 and 508). They are updated after each ASC X12 trimester meeting. Version specific code additions or deactivations are noted on the code lists.

The Blue Cross Blue Shield Association (BCBSA) is the owner of these code lists. The primary distribution source is the Washington Publishing Company web site (www.wpc-edi.com). This web site offers an online conferencing facility that allows interested parties to submit requests for new codes, changes to existing codes, or simply view comments on pending requests. Individuals who are unable to access the Internet may contact BCBSA directly.

1.4.2.1 STC Composite and Code Use Rules

The following rules apply to use of the composites and codes within the STC segment:

- STC01 is required
- STC10 and STC11 are situational and provide additional clarification to STC01 when needed.
- The Status Category Code for STC10 and STC11 must be within the same Status Category Code group as that used in STC01, but not necessarily the same Status Category Code. (For example, if STC01 uses the Category Code ‘A8 - Acknowledgement / Rejected for relational field in error’, STC10 and STC11 must use Category Codes from the ‘Acknowledgments Category Group’ but not necessarily the ‘A8’ value. STC10 and STC11 could use Category

Codes A6 - Acknowledgement/Rejected for Missing Information or A7 - Acknowledgement/Rejected for Invalid Information.)

- For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'Ax' for batch. For real time acknowledgements category types 'Ax' and 'Ex' may be used except for E0. Use of the category type 'Ex' is limited to indicating the business application system is unavailable.
- Use of STC12 and Health Care Status Code value '448 - Invalid billing combination' is limited to Claim and Service level status (Loops 2200D and 2220D).
- Use of STC12 and Health Care Status Code value '448 - Invalid billing combination' may be used when the assignment of a Health Care Claim Status Code is pending review and publication (between meetings of the Claim Adjustment Reason and Claim Status Code Committee).
- Additional use of STC12 and Health Care Status Code value '448 - Invalid billing combination' is strongly discouraged by the guide authors as use of the free form text element dilutes the transaction's business purpose and automation capabilities. Use of Category Code A8 - Acknowledgement / Rejected for relational field in error' is encouraged over use of the 448 status code.
- Multiple STC segments must be reported for unrelated edits or statuses.

1.4.3 277 Transaction Usages

The Health Care Information Status Notification (277) transaction set has multiple implementation conventions to meet various business needs of the health care industry. The transaction set can be used to provide health care claim information in the following business scenarios:

- **ASC X12 Health Care Claim Acknowledgement (277),** which is a business application response to the ASC X12 837 claim/encounter transactions. This function is supported in this implementation guide.
- **ASC X12 Health Care Claim Status Request and Response (276/277),** where the 277 is a response to a request for claim status information. This function is not supported in this implementation guide.
- **ASC X12 Health Care Claim Request for Additional information (277),** which is a payer's request for additional information to support a health care claim. This function is not supported in this implementation guide.
- **ASC X12 Health Care Payer Unsolicited Claim Status (277),** which is used as an unsolicited listing of claims pending adjudication in a payer's system. This function is not supported in this implementation guide.

Element BHT06, in addition to the ST03 and GS08 values, is used to distinguish between these varied business functions. The various 277 - BHT06 code values are:

- NO - Notice (Health Care Payer Unsolicited Claim Status)
- TH - Receipt Acknowledgement Advice (Health Care Claim Acknowledgement)
- RQ - Request (Care Claim Request for Additional Information)
- DG - Response (Health Care Claim Status Request and Response)

Figure 1.2 illustrates the flow of information related to several usages of the 277.

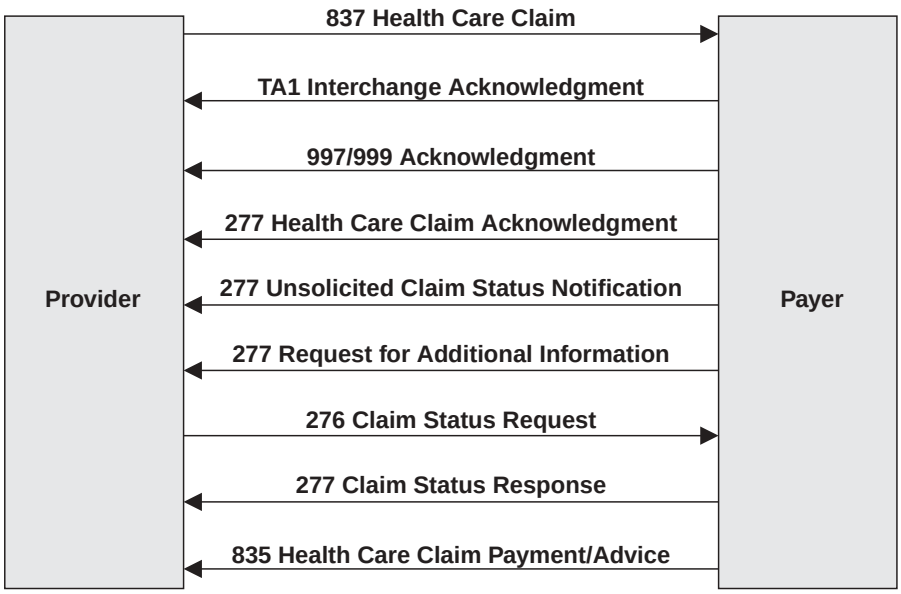


Figure 1.2. General ASC X12 Health Care Claim Information Flow

1.5 Business Terminology

The following business terms are used in this implementation guide.

Claims
Throughout this implementation guide, the reference to “claim(s)” means claims or encounters or groupings of claims or encounters.

Information Source Process Date
The Information Source Process Date applies to the processing of the 837 claim transaction file through a pre-adjudication/electronic data interchange (EDI) system.

1.6 Transaction Acknowledgments

There are several acknowledgment implementation transactions available for use. The IG developers have noted acknowledgment requirements in this section. Other acknowledgment transactions may be used at the discretion of the trading partners. A statement that the acknowledgment is not required does not preclude its use between willing trading partners.

1.6.1 997 Functional Acknowledgment

The 997 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

A 997 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.2 999 Implementation Acknowledgment

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the implementation guide compliance.

The Functional Acknowledgment (999) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Functional Acknowledgment (999) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

A 999 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.3 824 Application Advice

The 824 informs the submitter of the results of the receiving application system's data content edits of transaction sets.

The Application Advice (824) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Application Advice (824) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

An 824 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.7 Related Transactions

There are one or more transactions related to the transactions described in this implementation guide.

1.7.1 The Claim (837)

Submitting a claim using the 837 format initiates the creation of the Health Care Claim Acknowledgment (277) transaction. This transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.

1.8 Trading Partner Agreements

Trading partner agreements are used to establish and document the relationship between trading partners. A trading partner agreement must not override the

specifications in this implementation guide if a transmission is reported in GS08 to be a product of this implementation guide.

1.9 The HIPAA Role in Implementation Guides

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191 - known as HIPAA) direct the Secretary of Health and Human Services to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

This implementation guide has been developed for use as an insurance industry implementation guide. At the time of publication it has not been adopted as a HIPAA standard. Should the Secretary adopt this implementation guide as a standard, the Secretary will establish compliance dates for its use by HIPAA covered entities.

1.10 Data Overview

This section introduces the structure of the 277 Health Care Information Status Notification 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. For a review, see Appendix B, Nomenclature and Appendix C, EDI Control Directory.

1.10.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set: the implementation view and the standard view. The intent of the implementation view is to clarify the purpose and use of the segments by restricting the view to display only those segments used with their assigned health care names. The implementation view for the 277 is presented in Section 2.3.1, Implementation. The standard view for the 277 displays all segments available within the transaction set with their assigned ASC X12 names. This view is presented in Section 2.3.2, X12 Standard.

The transaction set is divided into two levels, or tables, Table 1 and Table 2.

Table 1

Table 1 is named the Header Level and contains the transaction control information. The ST segment identifies the start of a transaction and the specific transaction set. The BHT identifies the transactions business purpose and the hierarchical structure used in Table 2.

Table 2

Table 2 is named the Detail Level because it contains the detail information for the business function of the transactions. This table uses the hierarchical level structure. Each hierarchical level (HL) is a series of loops, which are identified by numbers. The hierarchical level that identifies the patient is Loop ID- 2000D. The patient name is contained in Loop ID-2100D. Specific claim details begin with Loop ID-2200D.

The following are HL segment coding examples and the data element significance within the HL segments:

HL*120*1~**	Information Source level
HL*2*1*21*1~	Information Receiver level
HL*3*2*19*1~	Service Provider level
HL*4*3*PT~	Patient level

- HLs are sequentially numbered. The sequential number is found in HL01, which is the first data element in the HL segment.
- The second element, HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level is subordinate. The absence of a data value in HL02, indicates it is the highest hierarchical level. In this example, the Information Source is the highest parent. The Information Receiver level is subordinate to the Information Source hierarchical level numbered 1 (HL01 =1). The provider of service level is subordinate to the Information Receiver hierarchical level numbered 2 (HL01=2), etc.
- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 = 20, the hierarchical level is the Information Source. When HL03 = PT, the hierarchical level is the Patient.
- Data element HL04 indicates whether or not child (subordinate) hierarchical levels exist. A value of “1" indicates subordinate hierarchical levels exist. A value of ”0" or the absence of a data value indicates that no subordinate hierarchical levels exist.

2 Transaction Set

NOTE
See Appendix B, Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

2.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable.

This implementation guide uses a format that depicts both the generalized standard and the insurance industry-specific implementation. In this implementation guide, **IMPLEMENTATION** specifies the requirements for this implementation. **X12 STANDARD** is included as a reference only.

The transaction set presentation is comprised of two main sections with subsections within the main sections:

2.3 Transaction Set Listing

There are two sub-sections under this general title. The first sub-section concerns this implementation of a generic X12 transaction set. The second sub-section concerns the generic X12 standard itself.

IMPLEMENTATION

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail.

STANDARD

This section is included as a reference.

2.4 Segment Detail

There are three sub-sections under this general title. This section repeats once for each segment used in this implementation providing segment specific detail and X12 standard detail.

SEGMENT DETAIL

This section is included as a reference.

DIAGRAM

This section is included as a reference. It provides a pictorial view of the standard and shows which elements are used in this implementation.

ELEMENT DETAIL

This section specifies the implementation details of each data element.

These illustrations (Figures 2.1 through 2.5) are examples and are not extracted from the Section 2 detail in this implementation guide. Annotated illustrations, presented below in the same order they appear in this implementation guide, describe the format of the transaction set that follows.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

8XX Insurance Transaction Set

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	0100	ST	Transaction Set Header	R	1	
54	0200	BPR	Financial Information	R	1	
60	0400	TRN	Reassociation Key	R	1	
62	0500	CUR	Non-US Dollars Currency	S	1	
65	0600	REF	Receiver ID	S	1	
66	0600	REF	Version Number	S	1	
68	0700	DTM	Production Date	S	1	
			PAYER NAME			1
70	0800	N1	Payer Name	R	1	
72	1000	N3	Payer Address	S	1	
75	1100	N4	Payer City, State, Zip	S	1	
76	1200	REF	Additional Payer Reference Number	S	1	
78	1300	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	0800	N1	Payee Name	R	1	
81	1000	N3	Payee Address	S	1	
82	1100	N4	Payee City, State, Zip	S	1	
84	1200	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 2.1. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix B.1, ASC X12 Nomenclature* for a complete description of the standard

8XX Insurance Transaction Set

Functional Group ID: XX

This Draft Standard for Trial Use contains the format and establishes the data contents of the Insurance Transaction Set (8XX) within the context of the Electronic Data Interchange (EDI) environment.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BPR	Beginning Segment	M	1	
0300	NTE	Note/Special Instruction	O	>1	
0400	TRN	Trace	O	1	

Figure 2.2. Transaction Set Key — Standard

SEGMENT DETAIL

Industry assigned Segment Name → **NM1 - PATIENT NAME**

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

See section B.1.1.3.8 for a description of these values

Industry assigned Loop ID and Loop Name

Industry Loop Repeat

Industry Segment Repeat

Loop:	**2100B — PATIENT NAME Loop Repeat: 1**
Segment Repeat:	**1**
Industry usage → Usage:	**SITUATIONAL**
Situational Rule:	**Required when the patient is different from the insured. If not required by this implementation guide, do not send.**
Industry Notes → TR3 Notes:	**1. Any necessary identification number must be provided in NM109.**
TR3 Example:	**NM1*QC*1*Shepard*Sam*A***34*452114586~**

Situational Rule

Example

Figure 2.3. Segment Key — Implementation

DIAGRAM

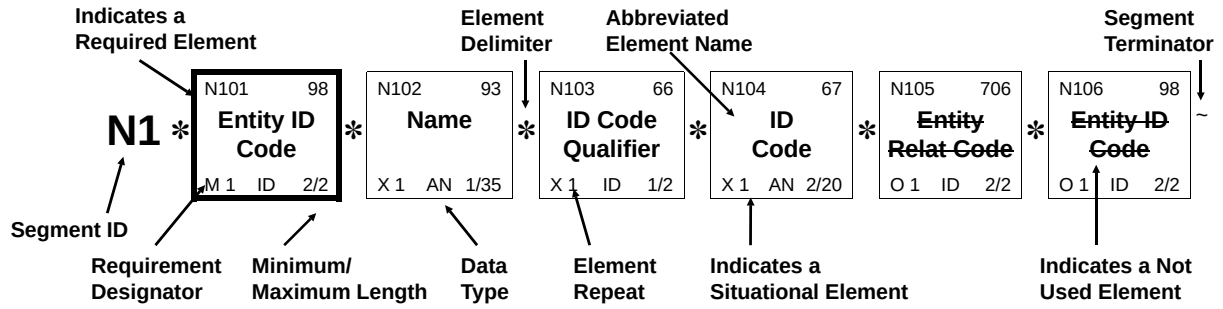


Figure 2.4. Segment Key — Diagram

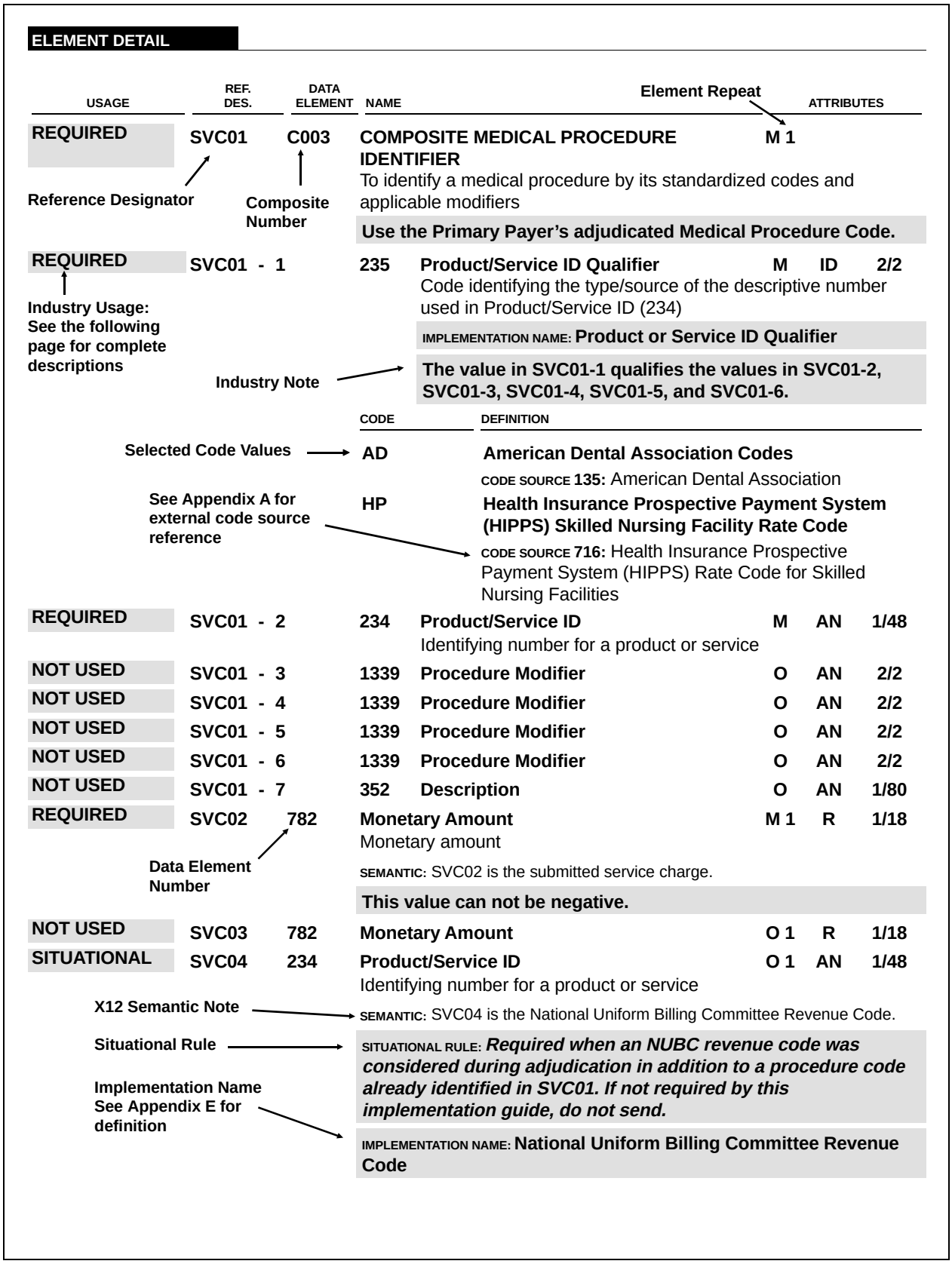


Figure 2.5. Segment Key — Element Summary

2.2 Implementation Usage

2.2.1 Industry Usage

Industry Usage describes when loops, segments, and elements are to be sent when complying with this implementation guide. The three choices for Usage are required, not used, and situational. To avoid confusion, these are named differently than the X12 standard Condition Designators (mandatory, optional, and relational).

Required This loop/segment/element must always be sent.

Required segments in Situational loops only occur when the loop is used.

Required elements in Situational segments only occur when the segment is used.

Required component elements in Situational composite elements only occur when the composite element is used.

Not Used This element must never be sent.

Situational Use of this loop/segment/element varies, depending on data content and business context as described in the defining rule. The defining rule is documented in a Situational Rule attached to the item.

There are two forms of Situational Rules.

The first form is “Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender’s discretion, but cannot be required by the receiver.” The data qualified by such a situational rule cannot be required or requested by the receiver, transmission of this data is solely at the sender’s discretion.

The alternative form is “Required when <explicit condition statement>. If not required by this implementation guide, do not send.” The data qualified by such a situational rule cannot be sent except as described in the explicit condition statement.

2.2.1.1 Transaction Compliance Related to Industry Usage

A transmitted transaction complies with an implementation guide when it satisfies the requirements as defined within the implementation guide. The presence or absence of an item (loop, segment, or element) complies with the industry usage specified by this implementation guide according to the following table.

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

This table specifies how an entity is to evaluate a transmitted transaction for compliance with industry usage. It is not intended to require or imply that the receiver must reject non-compliant transactions. The receiver will handle non-compliant transactions based on its business process and any applicable regulations.

2.2.2 Loops

Loop requirements depend on the context or location of the loop within the transaction. See Appendix B for more information on loops.

- A nested loop can be used only when the associated higher level loop is used.
- The usage of a loop is the same as the usage of its beginning segment.
  - If a loop's beginning segment is Required, the loop is Required and must occur at least once unless it is nested in a loop that is not being used.
  - If a loop's beginning segment is Situational, the loop is Situational.
- Subsequent segments within a loop can be sent only when the beginning segment is used.
- Required segments in Situational loops occur only when the loop is used.

2.3 Transaction Set Listing

2.3.1 Implementation

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail. Refer to section 2.1 Presentation Examples for detailed information on the components of the Implementation section.

IMPLEMENTATION

277 Health Care Claim Acknowledgment

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
32	0100	ST	Transaction Set Header	R	1	
33	0200	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Information Source Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			1
35	0100	HL	Information Source Level	R	1	
			LOOP ID - 2100A INFORMATION SOURCE NAME			1
37	0500	NM1	Information Source Name	R	1	
			LOOP ID - 2200A TRANSMISSION RECEIPT CONTROL IDENTIFIER			1
40	0900	TRN	Transmission Receipt Control Identifier	R	1	
41	1200	DTP	Information Source Receipt Date	R	1	
42	1200	DTP	Information Source Process Date	R	1	

Table 2 - Information Receiver Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			1
44	0100	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
46	0500	NM1	Information Receiver Name	R	1	
			LOOP ID - 2200B INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER			1
49	0900	TRN	Information Receiver Application Trace Identifier	R	1	
50	1000	STC	Information Receiver Status Information	R	>1	
55	1210	QTY	Total Accepted Quantity	S	1	
56	1210	QTY	Total Rejected Quantity	S	1	
57	1220	AMT	Total Accepted Amount	S	1	
58	1220	AMT	Total Rejected Amount	S	1	

Table 2 - Billing Provider of Service Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C BILLING PROVIDER OF SERVICE LEVEL			**>1**
59	**0100**	**HL**	Billing Provider of Service Level	**S**	**1**	
			LOOP ID - 2100C BILLING PROVIDER NAME			**1**
61	**0500**	**NM1**	Billing Provider Name	**R**	**1**	
			LOOP ID - 2200C PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER			**1**
64	**0900**	**TRN**	Provider of Service Information Trace Identifier	**S**	**1**	
65	**1000**	**STC**	Billing Provider Status Information	**S**	**>1**	
70	**1100**	**REF**	Provider Secondary Identifier	**S**	**3**	
71	**1210**	**QTY**	Total Accepted Quantity	**S**	**1**	
72	**1210**	**QTY**	Total Rejected Quantity	**S**	**1**	
73	**1220**	**AMT**	Total Accepted Amount	**S**	**1**	
74	**1220**	**AMT**	Total Rejected Amount	**S**	**1**	

Table 2 - Patient Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D PATIENT LEVEL			**>1**
75	**0100**	**HL**	Patient Level	**S**	**1**	
			LOOP ID - 2100D PATIENT NAME			**1**
77	**0500**	**NM1**	Patient Name	**R**	**1**	
			LOOP ID - 2200D CLAIM STATUS TRACKING NUMBER			**>1**
79	**0900**	**TRN**	Claim Status Tracking Number	**R**	**1**	
80	**1000**	**STC**	Claim Level Status Information	**R**	**>1**	
85	**1100**	**REF**	Payer Claim Control Number	**S**	**1**	
86	**1100**	**REF**	Claim Identifier Number For Clearinghouse and Other Transmission Intermediaries	**S**	**1**	
87	**1100**	**REF**	Institutional Bill Type Identification	**S**	**1**	
89	**1200**	**DTP**	Claim Level Service Date	**R**	**1**	
			LOOP ID - 2220D SERVICE LINE INFORMATION			**>1**
90	**1800**	**SVC**	Service Line Information	**S**	**1**	
94	**1900**	**STC**	Service Line Level Status Information	**R**	**>1**	
99	**2000**	**REF**	Service Line Item Identification	**R**	**1**	
100	**2000**	**REF**	Pharmacy Prescription Number	**S**	**1**	
101	**2100**	**DTP**	Service Line Date	**S**	**1**	
102	**2700**	**SE**	Transaction Set Trailer	**R**	**1**	

2.3.2 X12 Standard

This section is included as a reference. The implementation guide reference clarifies actual usage. Refer to section 2.1 Presentation Examples for detailed information on the components of the X12 Standard section.

STANDARD

277 Health Care Information Status Notification

Functional Group ID: HN

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Information Status Notification Transaction Set (277) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter, health care services review, or transactions related to the provisions of health care. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BHT	Beginning of Hierarchical Transaction	M	1	
0300	REF	Reference Information	O	10	
		LOOP ID - 1000			>1
0400	NM1	Individual or Organizational Name	O	1	
0500	N2	Additional Name Information	O	2	
0600	N3	Party Location	O	2	
0700	N4	Geographic Location	O	1	
0800	REF	Reference Information	O	2	
0900	PER	Administrative Communications Contact	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
0100	HL	Hierarchical Level	M	1	
0200	SBR	Subscriber Information	O	1	
0300	PAT	Patient Information	O	1	
0400	DMG	Demographic Information	O	1	
		LOOP ID - 2100			>1
0500	NM1	Individual or Organizational Name	O	1	
0600	N3	Party Location	O	2	
0700	N4	Geographic Location	O	1	
0800	PER	Administrative Communications Contact	O	1	
		LOOP ID - 2200			>1
0900	TRN	Trace	O	1	
1000	STC	Status Information	O	>1	
1100	REF	Reference Information	O	9	
1200	DTP	Date or Time or Period	O	2	
1210	QTY	Quantity Information	O	5	

1220	AMT	Monetary Amount Information	O	5	
		LOOP ID - 2210			>1
1300	PWK	Paperwork	O	1	
1400	PER	Administrative Communications Contact	O	1	
1500	N1	Party Identification	O	1	
1600	N3	Party Location	O	1	
1700	N4	Geographic Location	O	1	
		LOOP ID - 2220			>1
1800	SVC	Service Information	O	1	
1900	STC	Status Information	O	>1	
2000	REF	Reference Information	O	1	
2100	DTP	Date or Time or Period	O	1	
		LOOP ID - 2225			>1
2200	PWK	Paperwork	O	1	
2300	PER	Administrative Communications Contact	O	1	
2400	N1	Party Identification	O	1	
2500	N3	Party Location	O	1	
2600	N4	Geographic Location	O	1	
2700	SE	Transaction Set Trailer	M	1	

NOTES:

2/0200 The SBR segment may only appear at the Subscriber (HL03=22) level.

2/0400 The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

2/1300 The 2210 loop may be used when there is a status notification or a request for additional information about a particular claim.

2/2200 The 2225 loop may be used when there is a status notification or a request for additional information about a particular service line.

2.4 277 Segment Detail

This section specifies the segments, data elements, and codes for this implementation. Refer to section 2.1 Presentation Examples for detailed information on the components of the Segment Detail section.

SEGMENT DETAIL

ST - TRANSACTION SET HEADER

X12 Segment Name: Transaction Set Header

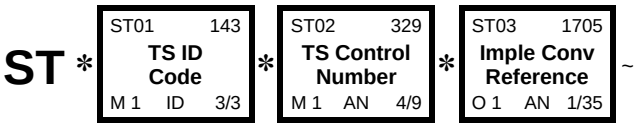
X12 Purpose: To indicate the start of a transaction set and to assign a control number

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **ST*277*0001*005010X214~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** 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). **CODE** / **DEFINITION** **277** **Health Care Information Status Notification**	**M 1 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 must 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 1 AN 4/9**
REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention **SEMANTIC:** The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08. **IMPLEMENTATION NAME: Version, Release, or Industry Identifier** **This field contains the same value as data element GS08. The value is 005010X214. Some translator products strip off the ISA and GS segments prior to application (ST - SE) processing. Providing the information from GS08 at this level will help ensure the appropriate application mapping is utilized at translation time.**	**O 1 AN 1/35**

SEGMENT DETAIL

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

X12 Segment Name: Beginning of Hierarchical Transaction

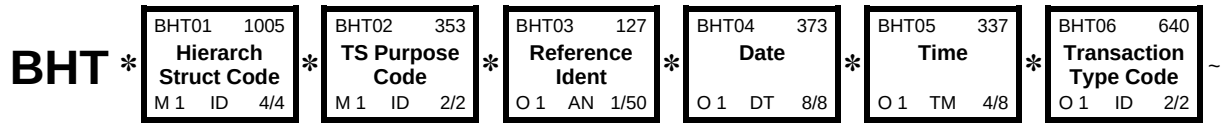
X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **BHT*0085*08*0000221*20060201*1635*TH~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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 CODE: **0085** DEFINITION: **Information Source, Information Receiver, Provider of Service, Patient**	**M 1 ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set CODE: **08** DEFINITION: **Status**	**M 1 ID 2/2**
REQUIRED	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. **The inventory file number of the transmission assigned by the Information Source's system. This number operates as a transaction (batch) control number.**	**O 1 AN 1/50**
REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year SEMANTIC: BHT04 is the date the transaction was created within the business application system. IMPLEMENTATION NAME: **Transaction Set Creation Date**	**O 1 DT 8/8**

REQUIRED **BHT05** **337** **Time** **O 1** **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)

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

IMPLEMENTATION NAME: **Transaction Set Creation Time**

REQUIRED **BHT06** **640** **Transaction Type Code** **O 1** **ID** **2/2**

Code specifying the type of transaction

CODE	DEFINITION
TH	**Receipt Acknowledgment Advice**

SEGMENT DETAIL

HL - INFORMATION SOURCE LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000A — INFORMATION SOURCE LEVEL Loop Repeat: 1**

Segment Repeat: **1**

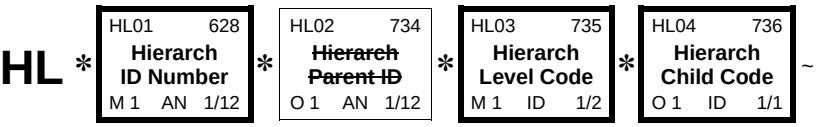
Usage: **REQUIRED**

TR3 Notes:

1. **This entity is the decision maker in the business transaction. For this business use, this entity is the payer or clearinghouse receiving the ASC X12 837 transaction.**

TR3 Example: **HL*1**20*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **HL01 must begin with the value "1" and increment by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M 1 AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - INFORMATION SOURCE NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

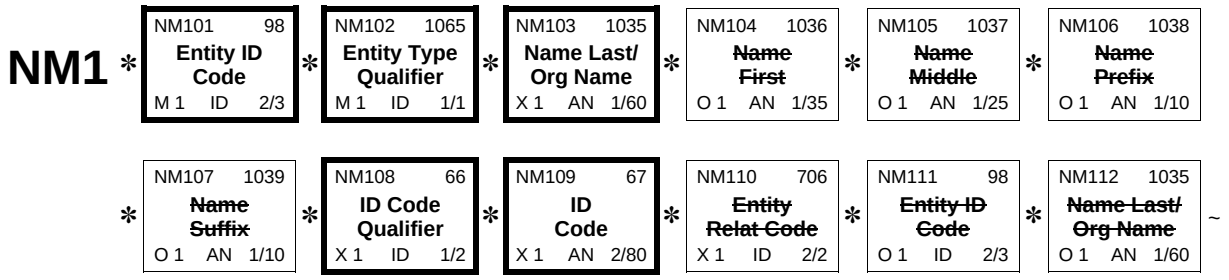
Loop: **2100A — INFORMATION SOURCE NAME Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **NM1*PR*2*ABC INSURANCE*****PI*12345~ OR**
NM1*AY*2*NATIONAL CLEARINGHOUSE***46*123456789012~ OR**
NM1*AY*2*SINGLE BILLING SERVICE***FI*109876543~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**
			CODE / **DEFINITION**	
			AY — **Clearinghouse**	
			Health care clearinghouse means a public or private entity that does either of the following: **(1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.** **(2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.**	
			PR — **Payer**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**
			CODE / **DEFINITION**	
			2 — **Non-Person Entity**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Information Source Name**	**X 1 AN 1/60**
NOT USED	**NM104**	**1036**	**Name First**	**O 1 AN 1/35**
NOT USED	**NM105**	**1037**	**Name Middle**	**O 1 AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1 AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O 1 AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X 1 ID 1/2**
			CODE / **DEFINITION**	
			46 — **Electronic Transmitter Identification Number (ETIN)**	
			This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities.	
			FI — **Federal Taxpayer's Identification Number**	
			PI — **Payor Identification**	

			XV	**Centers for Medicare and Medicaid Services PlanID** CODE SOURCE **540:** Centers for Medicare and Medicaid Services PlanID			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: **Information Source Identifier**		**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**		**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**		**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**		**O 1**	**AN**	**1/60**

SEGMENT DETAIL

TRN - TRANSMISSION RECEIPT CONTROL IDENTIFIER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

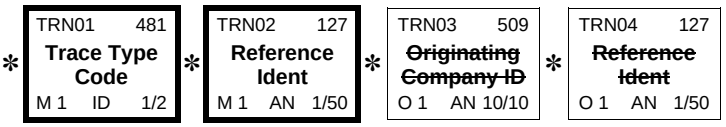
Loop: **2200A — TRANSMISSION RECEIPT CONTROL IDENTIFIER Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **TRN*1*20060831001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **1** — **Current Transaction Trace Numbers**	**M 1 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 SEMANTIC: TRN02 provides unique identification for the transaction. IMPLEMENTATION NAME: **Information Source Application Trace Identifier** **This is a unique trace number that identifies a specific transaction. This number is assigned by the Information Source.**	**M 1 AN 1/50**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O 1 AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O 1 AN 1/50**

SEGMENT DETAIL

DTP - INFORMATION SOURCE RECEIPT DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

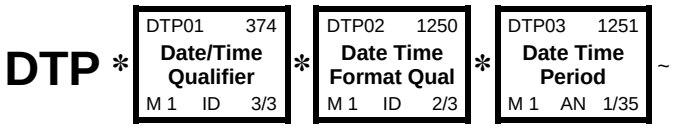
Loop: **2200A — TRANSMISSION RECEIPT CONTROL IDENTIFIER**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **DTP*050*D8*20060228~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: **Date Time Qualifier**	
			CODE: **050** DEFINITION: **Received**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	**M 1 ID 2/3**
			CODE: **D8** DEFINITION: **Date Expressed in Format CCYYMMDD**	
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1 AN 1/35**
			IMPLEMENTATION NAME: **Information Source Receipt Date**	
			This is the receipt date of the 837 by the entity creating the 277 acknowledgment. This date may or may not be the same date as the Information Source's Process Date.	

SEGMENT DETAIL

DTP - INFORMATION SOURCE PROCESS DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2200A — TRANSMISSION RECEIPT CONTROL IDENTIFIER**

Segment Repeat: **1**

Usage: **REQUIRED**

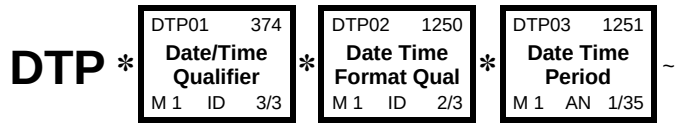
TR3 Notes:

1. **Payers and clearinghouses often collect claim transmissions throughout the business day. A process which is usually called "batch" is initiated at least once per business day. Some entities may initiate this process more than one time per day. As claim transmission files are processed, EDI reports and or data files are generated from the entity's computer system(s) and are distributed to the Information Receiver.**

2. **The Information Source Process Date applies to the processing of the 837 claim transaction file through a pre-adjudication/electronic data interchange (EDI) system. This date may or may not be the same date as the Information Source Receipt Date.**

TR3 Example: **DTP*009*D8*20060301~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: **Date Time Qualifier**	
			CODE / DEFINITION **009** **Process**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	**M 1 ID 2/3**
			CODE / DEFINITION **D8** **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**1**	**AN**	**1/35**

IMPLEMENTATION NAME: **Information Source Process Date**

SEGMENT DETAIL

HL - INFORMATION RECEIVER LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000B — INFORMATION RECEIVER LEVEL Loop Repeat: 1**

Segment Repeat: **1**

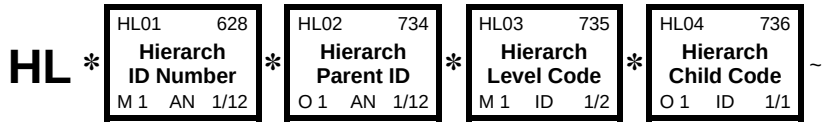
Usage: **REQUIRED**

TR3 Notes:

1. **The Information Receiver is the entity that expects the response from the Information Source. For this business use, this entity can be a provider, a provider group, a claims clearinghouse, a service bureau, an agency, an employer etc.**

TR3 Example: **HL*2*1*21*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 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 COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
	Used when the Information Receiver STC03=U, reject entire transaction.
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**
	Used when the Information Receiver STC03 = WQ, accept entire transmission.

SEGMENT DETAIL

NM1 - INFORMATION RECEIVER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100B — INFORMATION RECEIVER NAME Loop Repeat: 1**

Segment Repeat: **1**

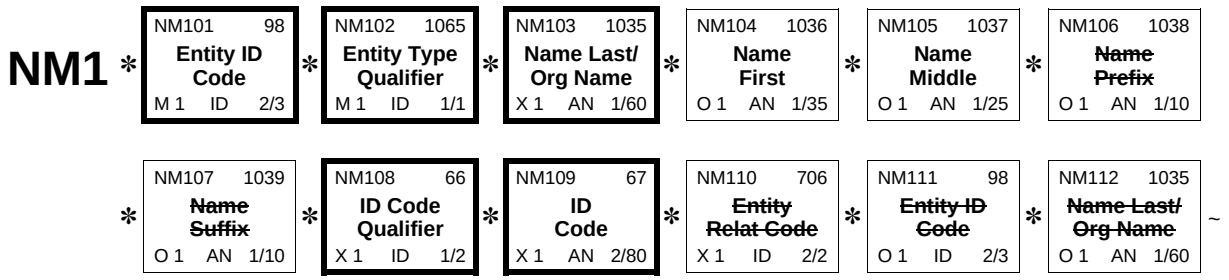
Usage: **REQUIRED**

TR3 Notes:

1. **The Information Receiver identified in the NM1 is always the electronic connection to the Information Source EDI environment. The Information Receiver has a trading partner profile set up at the Information Source's site and is generally the entity that submitted the claim transaction(s) for processing.**
2. **For situations where a person such as a single practitioner submits claim transactions to a payer, the entity identified in the Provider of Service Loop (HL03 = 19) will be the same entity identified here in the Information Receiver Loop (HL03 = 21). The difference may be that the trading partner profile set up in the EDI environment is a separate identification scheme from the identification number set up for the entity in the adjudication system.**
3. **In the situation where there is more than one clearinghouse involved in the transmission of the Health Care Claim Acknowledgement as part of the Trading Partner Agreement, this segment will be used to identify the clearinghouse that is passing the information. This segment will be changed to display the information for the next clearinghouse before they continue passing on the transmission. This process will continue until the transmission reaches the initiator of the claim/encounter.**

TR3 Example: **NM1*41*2*ST HOLY HILL HOSPITAL*****46*39999000B~ OR NM1*41*1*SMITH*ROBERT*J***46*188888000A~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **41** **Submitter**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** **Person** **2** **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Information Receiver Last or Organization Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the value in NM102 is "1". If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Information Receiver First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***Required if additional name information is needed to identify the Information Receiver and the value in NM102 is "1". If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Information Receiver Middle Name**	**O 1 AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1 AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O 1 AN 1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X 1**	**ID**	**1/2**
			CODE **DEFINITION** **46** **Electronic Transmitter Identification Number (ETIN)**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **IMPLEMENTATION NAME: Information Receiver Primary Identifier**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

TRN - INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**
Loop Repeat: 1

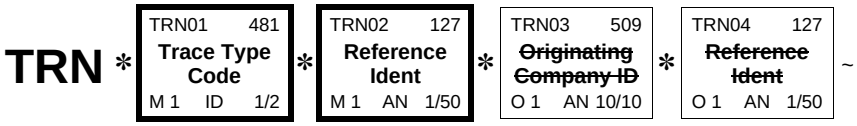
Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes:
1. **This segment contains the value submitted in the BHT03 data element from the 837.**

TR3 Example: **TRN*2*20060828001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **2** — **Referenced Transaction Trace Numbers**	**M 1 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 SEMANTIC: TRN02 provides unique identification for the transaction. IMPLEMENTATION NAME: **Claim Transaction Batch Number** **This element contains the value submitted in the BHT03 data element from the 837.**	**M 1 AN 1/50**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O 1 AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O 1 AN 1/50**

SEGMENT DETAIL

STC - INFORMATION RECEIVER STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**

Segment Repeat: **>1**

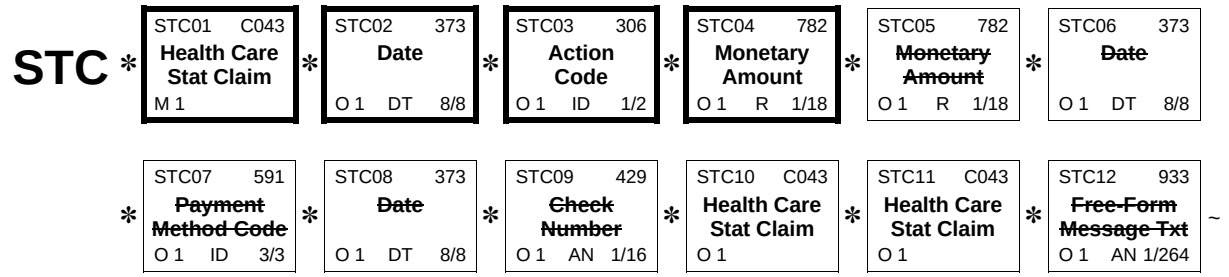
Usage: **REQUIRED**

TR3 Notes:

1. **This segment will be used to convey information about an entire unit of work (e.g. single transaction of claims). Information contained at this level will be summary details pertaining to the unit of work being acknowledged. Examples include but are not limited to accepted for processing, trading partner not authorized to submit to the Information Source's system, etc.**
2. **See Section 1.4.2 - Status Information (STC) Segment Usage for specific STC segment information, composites and code use.**

TR3 Example: **STC*A1:19*20060301*WQ*432.55~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** **M 1** Used to convey status of the entire claim or a specific service line	
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list **SEMANTIC:** C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). **IMPLEMENTATION NAME:** **Health Care Claim Status Category Code**	

For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'A' for batch. For real time acknowledgements category types 'A' and 'E' may be used except for E0. Use of the category type 'E' is limited to indicating the business application system is unavailable.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

CODE	DEFINITION
36	Employer
40	Receiver
41	Submitter
AY	Clearinghouse
PR	Payer

NOT USED **STC01 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

REQUIRED **STC02** **373** **Date** **O 1 DT 8/8**
Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

SEMANTIC: STC02 is the effective date of the status information.

IMPLEMENTATION NAME: **Status Information Effective Date**

REQUIRED	**STC03**	**306**	**Action Code** Code indicating type of action	**O 1**	**ID**		**1/2**

STC03 at this level is intended to convey the electronic transmission status of the ST - SE envelope. The terms "Accept" and "Reject" refer to the electronic transmission status of the 837 transaction not the billing status.

CODE	DEFINITION
U	**Reject**
	Required when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.
WQ	**Accept**
	Required when code value "U" is not used. At least one subordinate HL loop must be reported.

REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: STC04 is the amount of original submitted charges.

IMPLEMENTATION NAME: **Total Submitted Charges for Unit Work**

This will be the sum of all CLM02 values (claim charge) for the claims being acknowledged. In most instances, this will be the sum of charges submitted from ST to SE of a single 837 transaction set.

In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged.

NOT USED	**STC05**	**782**	**Monetary Amount**	**O 1**	**R**		**1/18**
NOT USED	**STC06**	**373**	**Date**	**O 1**	**DT**		**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**	**O 1**	**ID**		**3/3**
NOT USED	**STC08**	**373**	**Date**	**O 1**	**DT**		**8/8**
NOT USED	**STC09**	**429**	**Check Number**	**O 1**	**AN**		**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**O 1**			

SITUATIONAL RULE: ***Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.***

REQUIRED	**STC10 - 1**		**1271** **Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**		**1/30**

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC10 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED **STC10 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O 1**
Used to convey status of the entire claim or a specific service line

SITUATIONAL RULE: ***Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.***

REQUIRED **STC11 - 1** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL	**STC11 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **SEMANTIC:** C043-03 identifies the entity associated with the Health Care Claim Status Code. **SITUATIONAL RULE:** ***Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.*** **See STC01-3 for valid values.**	**O**	**ID**	**2/3**
NOT USED	**STC11 - 4**	**1270**	**Code List Qualifier Code**	**O**	**ID**	**1/3**
NOT USED	**STC12**	**933**	**Free-form Message Text**	**O 1**	**AN**	**1/264**

SEGMENT DETAIL

QTY - TOTAL ACCEPTED QUANTITY

X12 Segment Name: Quantity Information

X12 Purpose: To specify quantity information

X12 Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

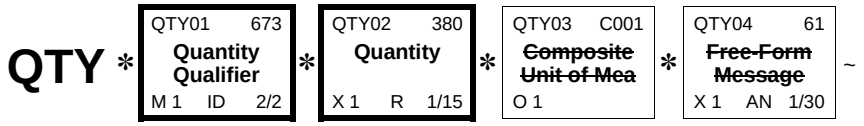
Situational Rule: **Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total number of claims accepted by the Information Source.**

TR3 Example: **QTY*90*102~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity CODE / DEFINITION **90 Acknowledged Quantity**	**M 1 ID 2/2**
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity SYNTAX: R0204, E0204 IMPLEMENTATION NAME: **Total Accepted Quantity**	**X 1 R 1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**
NOT USED	**QTY04**	**61**	**Free-form Information**	**X 1 AN 1/30**

SEGMENT DETAIL

QTY - TOTAL REJECTED QUANTITY

X12 Segment Name: Quantity Information

X12 Purpose: To specify quantity information

X12 Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

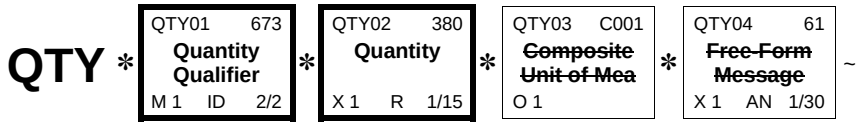
Situational Rule: **Required when at least one claim is rejected for this Information Receiver. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total number of claims rejected for this Information Receiver (e.g. not accepted) by the Information Source.**

TR3 Example: **QTY*AA*98~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity CODE / DEFINITION **AA** **Unacknowledged Quantity**	**M 1 ID 2/2**
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity SYNTAX: R0204, E0204 IMPLEMENTATION NAME: **Total Rejected Quantity**	**X 1 R 1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**
NOT USED	**QTY04**	**61**	**Free-form Information**	**X 1 AN 1/30**

SEGMENT DETAIL

AMT - TOTAL ACCEPTED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

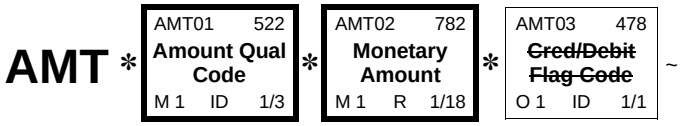
Situational Rule: **Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total dollar amount of claims accepted by the Information Source.**

TR3 Example: **AMT*YU*5053.52~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE: **YU** DEFINITION: **In Process**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Total Accepted Amount**	**M 1 R 1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

AMT - TOTAL REJECTED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

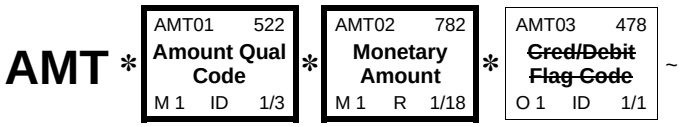
Situational Rule: **Required when at least one claim is rejected for this Information Receiver. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total dollar amount of claims rejected for this Information Receiver (e.g. not accepted) by the Information Source.**

TR3 Example: **AMT*YY*99.5~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **YY** — **Returned**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Total Rejected Amount**	**M 1 R 1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

HL - BILLING PROVIDER OF SERVICE LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000C — BILLING PROVIDER OF SERVICE LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

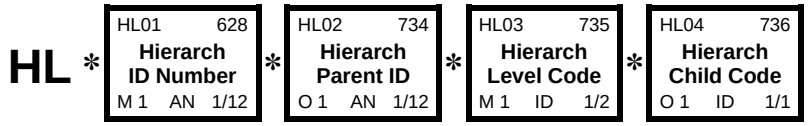
Situational Rule: **Required when STC03 at the Information Receiver Level (2200B) is equal to "WQ" (ACCEPTED). If not required by this implementation guide, do not send.**

TR3 Notes:

1. **This loop and all subsequent loops are not used when the Information Receiver STC03 is equal to "U" (REJECT).**

TR3 Example: **HL*3*2*19*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 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 **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
19	**Provider of Service**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O 1 ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
	Used for Provider level rejections only.
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

SEGMENT DETAIL

NM1 - BILLING PROVIDER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

Loop: **2100C — BILLING PROVIDER NAME Loop Repeat: 1**

Segment Repeat: **1**

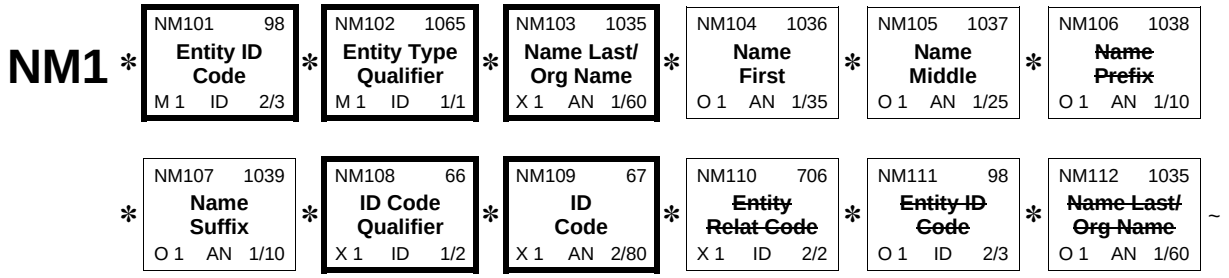
Usage: **REQUIRED**

TR3 Notes:

1. **This segment contains information which can be found in the 837 Dental, Institutional, and Professional implementation guides at the 2010AA loop.**

TR3 Example: **NM1*85*1*SMITH*JOHN*C***FI*754632678~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**
			CODE / **DEFINITION** **85** — **Billing Provider**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**
			CODE / **DEFINITION** **1** — **Person** **2** — **Non-Person Entity**	

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: **Provider Last or Organization Name**	**X 1**	**AN**	**1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name SITUATIONAL RULE: ***Required when the value in NM102 is "1" and supplied on submitted claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Provider First Name**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: ***Required when the value in NM102 is "1" and supplied on submitted claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Provider Middle Name**	**O 1**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name SITUATIONAL RULE: ***Required when the value in NM102 is "1" and supplied on submitted claim. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Provider Name Suffix**	**O 1**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X 1**	**ID**	**1/2**

CODE	DEFINITION
FI	**Federal Taxpayer's Identification Number**
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **The "XX" qualifier is required only when the National Provider ID is mandated for use.** **After the National Provider ID implementation period, enumerated providers use only the NM108 and NM109 data elements and discontinue the generation of the REF segment in Loop ID 2200C.**

CODE SOURCE **537:** Centers for Medicare and Medicaid Services National Provider Identifier

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: **Billing Provider Identifier**	**X 1**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**

NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

TRN - PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**
Loop Repeat: 1

Segment Repeat: **1**

Usage: **SITUATIONAL**

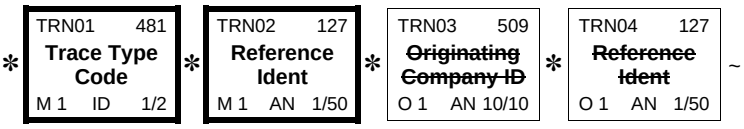
Situational Rule: **Required when 2200C Loop is used to provide the status of a specific provider's group of claims in the STC segment or a secondary provider identifier needs to be reported in the Provider Secondary REF segment. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.**

TR3 Notes:

1. **Because the TRN segment is syntactically required in order to use Loop 2200C, TRN02 can either be a sender assigned value or a default value of zero (0).**

TR3 Example: **TRN*1*0~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **1 — Current Transaction Trace Numbers**	**M 1 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 **SEMANTIC:** TRN02 provides unique identification for the transaction. **IMPLEMENTATION NAME: Provider of Service Information Trace Identifier**	**M 1 AN 1/50**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O 1 AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O 1 AN 1/50**

SEGMENT DETAIL

STC - BILLING PROVIDER STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

Segment Repeat: **>1**

Usage: **SITUATIONAL**

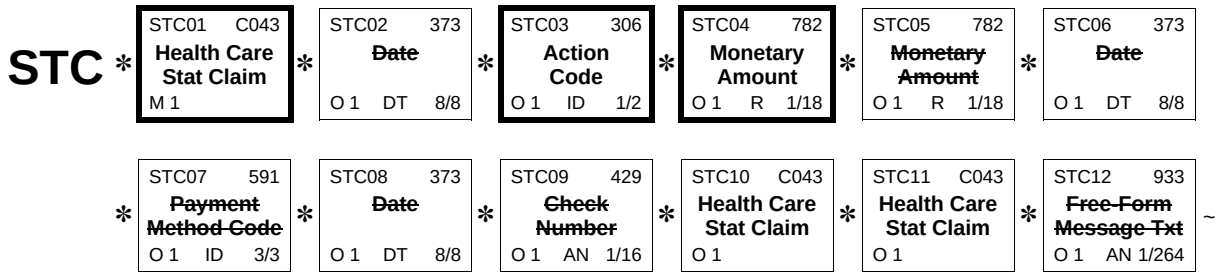
Situational Rule: **Required when needed to provide the status of a specific Billing Provider's group of claims. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.**

TR3 Notes:

1. **See Section 1.4.2 - Status Information (STC) Segment Usage for specific STC segment information, composites and code use.**

TR3 Example: **STC*A1:19**WQ*432.55~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**M 1**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M AN 1/30**

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'A' for batch. For real time acknowledgements category types 'A' and 'E' may be used except for E0. Use of the category type 'E' is limited to indicating the business application system is unavailable.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

CODE	DEFINITION
36	Employer
40	Receiver
41	Submitter
77	Service Location
82	Rendering Provider
85	Billing Provider
87	Pay-to Provider
AY	Clearinghouse
PR	Payer

NOT USED **STC01 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

NOT USED **STC02** **373** **Date** **O 1 DT 8/8**

REQUIRED **STC03** **306** **Action Code** **O 1 ID 1/2**
Code indicating type of action

STC03 at this level is intended to convey the electronic claim status of the Billing Provider Claims. The terms "Accept" and "Reject" refer to the status of claims for the Billing Provider not the billing status.

CODE	DEFINITION
U	Reject
	Use this code to indicate the provider's group of claims has been rejected. If any portion of the provider's group of claims is accepted then the code "WQ" - Accept must be used.

WQ Accept

REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: STC04 is the amount of original submitted charges.

IMPLEMENTATION NAME: Total Submitted Charges for Unit Work

Sum of the Billing Provider claims within the 837 transaction being acknowledged.

In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged.

NOT USED	**STC05**	**782**	**Monetary Amount**	**O 1**	**R**		**1/18**
NOT USED	**STC06**	**373**	**Date**	**O 1**	**DT**		**8/8**
NOT USED	**STC07**	**591**	**Payment Method Code**	**O 1**	**ID**		**3/3**
NOT USED	**STC08**	**373**	**Date**	**O 1**	**DT**		**8/8**
NOT USED	**STC09**	**429**	**Check Number**	**O 1**	**AN**		**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**O 1**			

SITUATIONAL RULE: ***Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.***

REQUIRED	**STC10 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**		**1/30**

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: Health Care Claim Status Category Code

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	**STC10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**		**1/30**

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Health Care Claim Status Code

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED **STC10 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O 1**
Used to convey status of the entire claim or a specific service line

SITUATIONAL RULE: ***Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.***

REQUIRED **STC11 - 1** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC11 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED	STC11 - 4		1270	Code List Qualifier Code	O	ID	1/3
NOT USED	STC12	933		Free-form Message Text	O 1	AN	1/264

SEGMENT DETAIL

REF - PROVIDER SECONDARY IDENTIFIER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

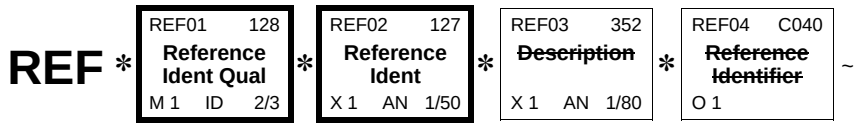
Segment Repeat: **3**

Usage: **SITUATIONAL**

Situational Rule: **Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.**

TR3 Example: **REF*G2*123456789~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**
			CODE / DEFINITION **0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number **LU** Location Number **SY** Social Security Number **TJ** Federal Taxpayer's Identification Number	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Billing Provider Additional Identifier**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

QTY - TOTAL ACCEPTED QUANTITY

X12 Segment Name: Quantity Information

X12 Purpose: To specify quantity information

X12 Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

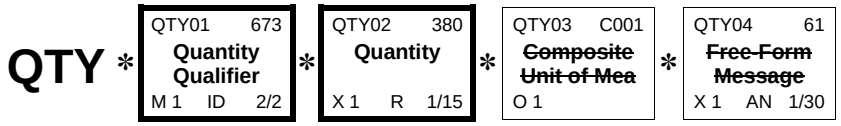
Situational Rule: **Required when reporting status for a specific provider's group of claims and at least one claim is accepted. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total number of claims (sum of CLM02) accepted to the adjudication process by the Information Source for the Billing Provider in this acknowledgment.**

TR3 Example: **QTY*QA*5~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**M 1 ID 2/2**
			CODE / DEFINITION **QA** **Quantity Approved**	
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity SYNTAX: R0204, E0204 IMPLEMENTATION NAME: **Total Accepted Quantity**	**X 1 R 1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**
NOT USED	**QTY04**	**61**	**Free-form Information**	**X 1 AN 1/30**

SEGMENT DETAIL

QTY - TOTAL REJECTED QUANTITY

X12 Segment Name: Quantity Information

X12 Purpose: To specify quantity information

X12 Syntax:

1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

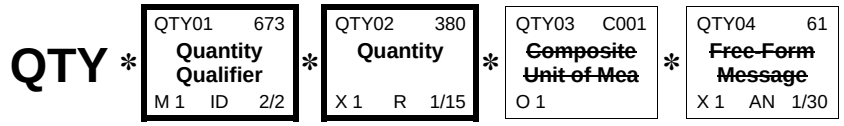
Situational Rule: **Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total number of claims rejected by the Information Source for the Billing Provider.**

TR3 Example: **QTY*QC*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity CODE / DEFINITION **QC** **Quantity Disapproved**	**M 1 ID 2/2**
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity SYNTAX: R0204, E0204 IMPLEMENTATION NAME: **Total Rejected Quantity**	**X 1 R 1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O 1**
NOT USED	**QTY04**	**61**	**Free-form Information**	**X 1 AN 1/30**

SEGMENT DETAIL

AMT - TOTAL ACCEPTED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

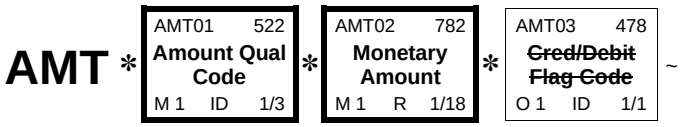
Situational Rule: **Required when reporting status for a specific provider's group of claims and at least one claim is accepted. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) accepted by the Information Source for the Billing Provider in this acknowledgment.**

TR3 Example: **AMT*YU*1000.5~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **YU** **In Process**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Total Accepted Amount**	**M 1 R 1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

AMT - TOTAL REJECTED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: **2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER**

Segment Repeat: **1**

Usage: **SITUATIONAL**

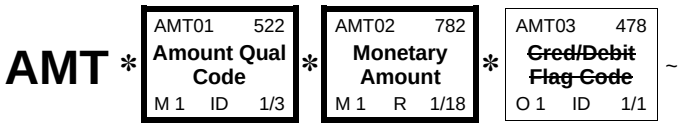
Situational Rule: **Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment.**

TR3 Example: **AMT*YY*52~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **YY** **Returned**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Total Rejected Amount**	**M 1 R 1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O 1 ID 1/1**

SEGMENT DETAIL

HL - PATIENT LEVEL

X12 Segment Name: Hierarchical Level

X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

X12 Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.

Loop: **2000D — PATIENT LEVEL Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

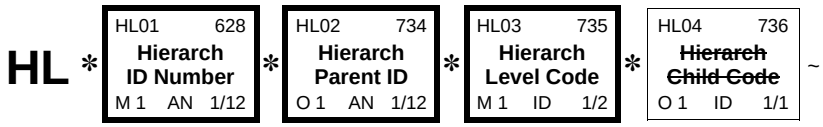
Situational Rule: **Required when reporting claim status at the patient level. If not required by this guide, do not send.**

TR3 Notes:

1. **This HL level contains information about the Patient identified in the 837 transaction. See Section 1.4.1.1 - Defining the Patient Participant for information on identifying the Patient data from the 837 Transaction.**

TR3 Example: **HL*4*3*PT~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 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 **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O 1 AN 1/12**

REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure	**M 1**	**ID**	**1/2**

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
PT	**Patient**

NOT USED	**HL04**	**736**	**Hierarchical Child Code**	**O 1**	**ID**	**1/1**

SEGMENT DETAIL

NM1 - PATIENT NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.
3. **C1203**
   If NM112 is present, then NM103 is required.

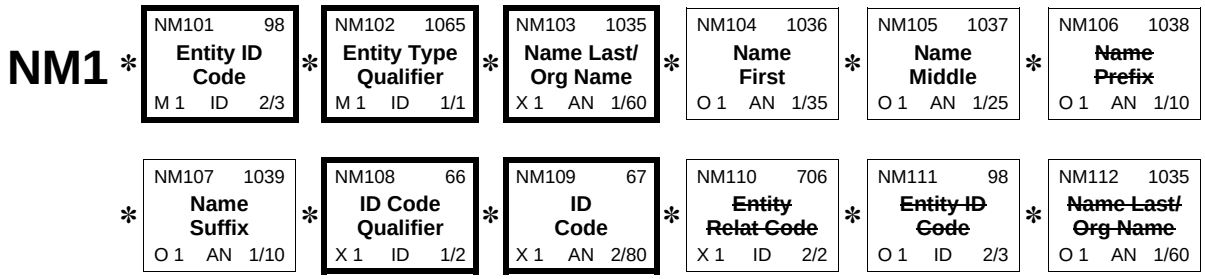
Loop: **2100D — PATIENT NAME Loop Repeat: 1**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **NM1*QC*1*SMITH*JOHN*Q**IV*MI*99887777~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**
			CODE / DEFINITION **QC** **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Patient Last Name**	**X 1 AN 1/60**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O 1**	**AN**	**1/35**
			SITUATIONAL RULE: ***Required when information was submitted on the claim. If not required by this implementation guide, do not send.***			
			IMPLEMENTATION NAME: Patient First Name			
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1**	**AN**	**1/25**
			SITUATIONAL RULE: ***Required when information was submitted on the claim. If not required by this implementation guide, do not send.***			
			IMPLEMENTATION NAME: Patient Middle Name or Initial			
NOT USED	**NM106**	**1038**	**Name Prefix**	**O 1**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O 1**	**AN**	**1/10**
			SITUATIONAL RULE: ***Required when information was submitted on the claim. If not required by this implementation guide, do not send.***			
			IMPLEMENTATION NAME: Patient Name Suffix			
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **II** — **Standard Unique Health Identifier for each Individual in the United States** **Required if the HIPAA Individual Patient Identifier is mandated for use. If not required use MI.** **MI** — **Member Identification Number**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809	**X 1**	**AN**	**2/80**
			IMPLEMENTATION NAME: Patient Identification Number			
			This may be a unique identification number for the patient or it may be the subscriber's identification number. This data element is the value from the NM109 identifying the patient in the submitted claim. **When the payer does not use a unique member identification number for the patient, the subscriber identification number should be used.**			
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X 1**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O 1**	**ID**	**2/3**
NOT USED	**NM112**	**1035**	**Name Last or Organization Name**	**O 1**	**AN**	**1/60**

SEGMENT DETAIL

TRN - CLAIM STATUS TRACKING NUMBER

X12 Segment Name: Trace

X12 Purpose: To uniquely identify a transaction to an application

Loop: **2200D — CLAIM STATUS TRACKING NUMBER Loop Repeat: >1**

Segment Repeat: **1**

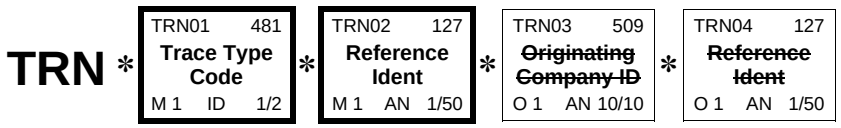
Usage: **REQUIRED**

TR3 Notes:

1. **This segment is the patient control number submitted in the CLM01 of the 837.**
2. **This number must be returned exactly as submitted in the 837 up to the 20 character limit as defined in the 837 guide.**

TR3 Example: **TRN*2*SMITHSON20060801~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE: **2** DEFINITION: **Referenced Transaction Trace Numbers**	**M 1 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 **SEMANTIC:** TRN02 provides unique identification for the transaction. **IMPLEMENTATION NAME: Patient Control Number**	**M 1 AN 1/50**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O 1 AN 10/10**
NOT USED	**TRN04**	**127**	**Reference Identification**	**O 1 AN 1/50**

SEGMENT DETAIL

STC - CLAIM LEVEL STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2200D — CLAIM STATUS TRACKING NUMBER**

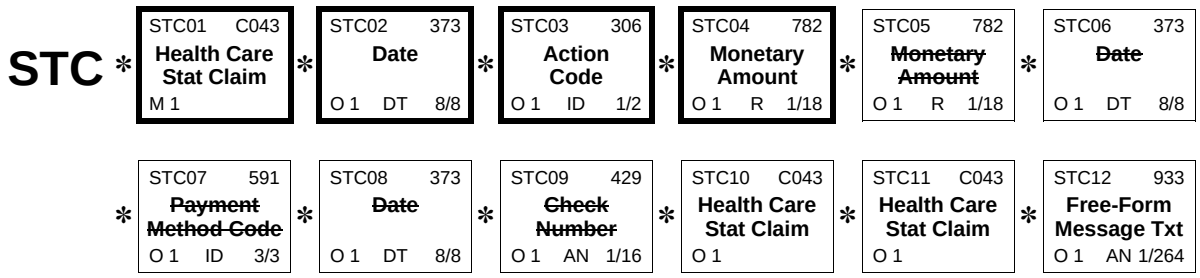
Segment Repeat: **>1**

Usage: **REQUIRED**

TR3 Notes:
1. **See Section 1.4.2 - Status Information (STC) Segment Usage for specific STC segment information, composites and code use.**

TR3 Example:
STC*A6:125:82*20060830*WQ*432.65~ OR
STC*A6:131:82*20060830*U*65.32~
STC*A8:187*20060830*U*70****A8:453*A8:454~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**M 1**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M AN 1/30**

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'A' for batch. For real time acknowledgements category types 'A' and 'E' may be used except for E0. Use of the category type 'E' is limited to indicating the business application system is unavailable.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: Health Care Claim Status Code

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

CODE	DEFINITION
03	Dependent
1P	Provider
1Z	Home Health Care
40	Receiver
41	Submitter
71	Attending Physician
72	Operating Physician
73	Other Physician
77	Service Location
82	Rendering Provider
85	Billing Provider
87	Pay-to Provider
DK	Ordering Physician
DN	Referring Provider
DQ	Supervising Physician
FA	Facility
GB	Other Insured
HK	Subscriber
IL	Insured or Subscriber
LI	Independent Lab
MSC	Mammography Screening Center
PR	Payer
PRP	Primary Payer
QB	Purchase Service Provider
QC	Patient

			QD	**Responsible Party**				
			SEP	**Secondary Payer**				
			TL	**Testing Laboratory**				
			TTP	**Tertiary Payer**				
			TU	**Third Party Repricing Organization (TPO)**				
NOT USED	**STC01 - 4**		**1270**	**Code List Qualifier Code**	**O**	**ID**	**1/3**	
REQUIRED	**STC02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** STC02 is the effective date of the status information. **IMPLEMENTATION NAME: Status Information Effective Date**		**O 1**	**DT**	**8/8**	
REQUIRED	**STC03**	**306**	**Action Code** Code indicating type of action **IMPLEMENTATION NAME: Status Information Action Code**		**O 1**	**ID**	**1/2**	
			CODE	**DEFINITION**				
			U	**Reject**				
			WQ	**Accept**				
REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** STC04 is the amount of original submitted charges. **IMPLEMENTATION NAME: Total Claim Charge Amount** **Zero is an acceptable amount.** **Sum of the charges (CLM02) submitted from original claim. If an original claim is split, report the original claim total here. Note that this amount may be reported in two or more claims.**		**O 1**	**R**	**1/18**	
NOT USED	**STC05**	**782**	**Monetary Amount**		**O 1**	**R**	**1/18**	
NOT USED	**STC06**	**373**	**Date**		**O 1**	**DT**	**8/8**	
NOT USED	**STC07**	**591**	**Payment Method Code**		**O 1**	**ID**	**3/3**	
NOT USED	**STC08**	**373**	**Date**		**O 1**	**DT**	**8/8**	
NOT USED	**STC09**	**429**	**Check Number**		**O 1**	**AN**	**1/16**	
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SITUATIONAL RULE:** ***Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.***		**O 1**			
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). **IMPLEMENTATION NAME: Health Care Claim Status Category Code** **See STC01-1 for valid values.** **CODE SOURCE 507: Health Care Claim Status Category Code**	**M**	**AN**	**1/30**

REQUIRED **STC10 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED **STC10 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O 1**
Used to convey status of the entire claim or a specific service line

SITUATIONAL RULE: ***Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.***

REQUIRED **STC11 - 1** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL	**STC11 - 3**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED	**STC11 - 4**	**1270**	**Code List Qualifier Code**	**O**	**ID**	**1/3**
SITUATIONAL	**STC12**	**933**	**Free-form Message Text** Free-form message text	**O 1**	**AN**	**1/264**

SEMANTIC: STC12 allows additional free-form status information.

SITUATIONAL RULE: ***Required when Health Care Claim Status Code 448 is used in STC01-2, STC10-2, or STC11-2. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Free Form Message Text**

See Section 1.4.2.1 for more information on use of STC12 and Status Code '448'.

SEGMENT DETAIL

REF - PAYER CLAIM CONTROL NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — CLAIM STATUS TRACKING NUMBER**

Segment Repeat: **1**

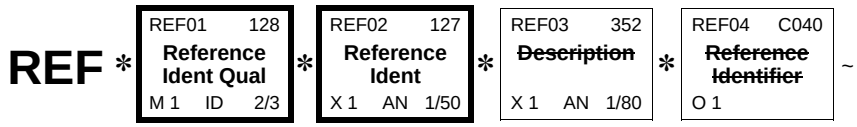
Usage: **SITUATIONAL**

Situational Rule: **Required when a payer assigns a specific number to the claim for processing and the number is available at the time of this acknowledgment. If not required by this implementation guide, do not send.**

TR3 Notes: **1. This number will be used to track the adjudication of the claim throughout the adjudication system.**

TR3 Example: **REF*1K*012421017500~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **1K** **Payor's Claim Number**	**M 1 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 SYNTAX: R0203 IMPLEMENTATION NAME: **Payer Claim Control Number**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - CLAIM IDENTIFIER NUMBER FOR CLEARINGHOUSE AND OTHER TRANSMISSION INTERMEDIARIES

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — CLAIM STATUS TRACKING NUMBER**

Segment Repeat: **1**

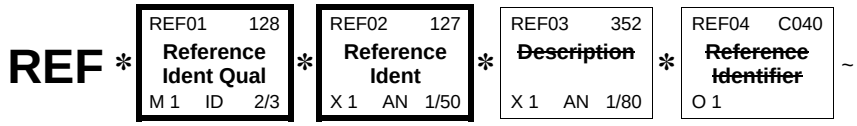
Usage: **SITUATIONAL**

Situational Rule: **Required when the Claim Identifier Number for Clearinghouse and Other Transmission Intermediary was sent in the 837. If not required by this implementation guide, do not send.**

TR3 Notes: **1. This number must be returned as received in the 837.**

TR3 Example: **REF*D9*012421017501~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: **D9** DEFINITION: **Claim Number**	**M 1 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 SYNTAX: R0203 IMPLEMENTATION NAME: **Clearinghouse Trace Number**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - INSTITUTIONAL BILL TYPE IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2200D — CLAIM STATUS TRACKING NUMBER**

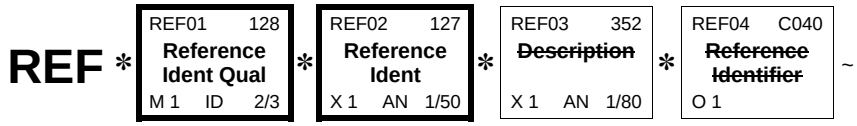
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required for Institutional claims when Institutional Type of Bill was received on the claim. If not required by this implementation guide, do not send.**

TR3 Example: **REF*BLT*111~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M 1 ID 2/3**
			CODE: **BLT** — DEFINITION: **Billing Type** **Use this code only for an Institutional Claim.**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Bill Type Identifier** **See 837 Institutional Implementation Guide for definition of Institutional Bill Type components.** **Concatenate the 837I CLM05-1 (Facility Type Code) and CLM05-3 (Claim Frequency Code) values. Code Source = 236 - Uniform Billing Claim Form Bill Type, Code Source 235 - Claim Frequency Type Code respectively.**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

DTP - CLAIM LEVEL SERVICE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2200D — CLAIM STATUS TRACKING NUMBER**

Segment Repeat: **1**

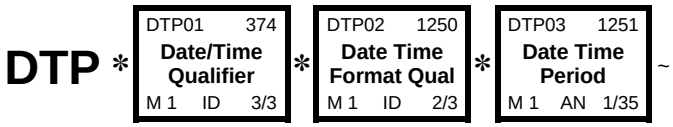
Usage: **REQUIRED**

TR3 Notes:

1. **For Institutional claims, it is the statement period in loop 2300 (DTP01 - 434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01-472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472).**

TR3 Example: **DTP*472*RD8*20060820-20060825~ OR**
DTP*472*D8*20060823~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: **Date Time Qualifier**	
			CODE / DEFINITION **472** — **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD** **RD8** — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1 AN 1/35**
			IMPLEMENTATION NAME: **Claim Service Period**	

SEGMENT DETAIL

SVC - SERVICE LINE INFORMATION

X12 Segment Name: Service Information

X12 Purpose: To supply payment and control information to a provider for a particular service

Loop: **2220D — SERVICE LINE INFORMATION Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

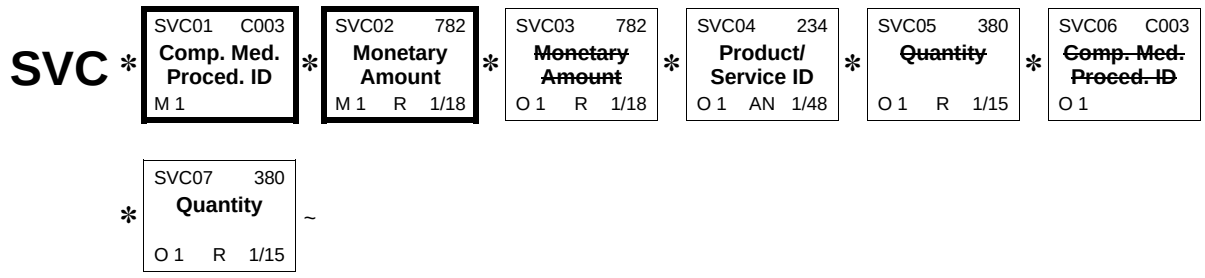
Situational Rule: **Required when a service line is being rejected and caused the rejection of a claim. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **Not used if the claim is being accepted into the adjudication system.**
2. **For Institutional claims, when both an NUBC revenue code and HCPCS or HIPPS code are reported, the HCPCS or HIPPS code is reported in SVC01-2 and the revenue code is reported in SVC04. When only a revenue code is used, it is reported in SVC01-2.**

TR3 Example: **SVC*NU:0710*15.61~ OR**
SVC*HC:99213*35~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**M 1**
REQUIRED	**SVC01 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) **SEMANTIC:** C003-01 qualifies C003-02 and C003-08. **IMPLEMENTATION NAME: Procedure Code**	**M ID 2/2**

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association

ER **Jurisdiction Specific Procedure and Supply Codes**

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:
If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA,
OR
The Secretary grants an exception to use the code set as a pilot project as allowed under the law,
OR
For claims which are not covered under HIPAA.

CODE SOURCE **576:** Workers Compensation Specific Procedure and Supply Codes

HC **Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**

CODE SOURCE **130:** Healthcare Common Procedural Coding System

HP **Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code**

CODE SOURCE **716:** Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

IV **Home Infusion EDI Coalition (HIEC) Product/Service Code**

CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List

NU **National Uniform Billing Committee (NUBC) UB92 Codes**

This is the NUBC code.

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

WK **Advanced Billing Concepts (ABC) Codes**

CODE SOURCE **843:** Advanced Billing Concepts (ABC) Codes

REQUIRED **SVC01 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

SEMANTIC:
If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.

IMPLEMENTATION NAME: **Procedure Code**

If the value in SVC01-1 is "NU", then this element is an NUBC Revenue Code. If the Revenue Code is present in SVC01-2, then SVC04 is not used.

Value submitted on the original claim.

SITUATIONAL **SVC01 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SEMANTIC:
C003-03 modifies the value in C003-02 and C003-08.

SITUATIONAL RULE: ***Required if submitted on the original claim service line. If not required by this implementation guide, do not send.***

SITUATIONAL	**SVC01 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-04 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required if submitted on the original claim service line. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-05 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required if submitted on the original claim service line. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVC01 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **SEMANTIC:** C003-06 modifies the value in C003-02 and C003-08. **SITUATIONAL RULE:** ***Required if submitted on the original claim service line. If not required by this implementation guide, do not send.***	**O**	**AN**	**2/2**
NOT USED	**SVC01 - 7**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**SVC01 - 8**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**
REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** SVC02 is the submitted service charge. **IMPLEMENTATION NAME:** **Line Item Charge Amount** **Zero is an acceptable amount.**	**M 1**	**R**	**1/18**
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O 1**	**R**	**1/18**
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service **SEMANTIC:** SVC04 is the National Uniform Billing Committee Revenue Code. **SITUATIONAL RULE:** ***Required on institutional claims to report a NUBC revenue code when a HCPCS or HIPPS code is reported in the SVC01-2. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Revenue Code**	**O 1**	**AN**	**1/48**
NOT USED	**SVC05**	**380**	**Quantity**	**O 1**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O 1**		

SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**1**	**R**	**1/15**

SEMANTIC: SVC07 is the original submitted units of service.

SITUATIONAL RULE: ***Required if submitted on the original claim service line. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Original Units of Service Count**

SEGMENT DETAIL

STC - SERVICE LINE LEVEL STATUS INFORMATION

X12 Segment Name: Status Information

X12 Purpose: To report the status, required action, and paid information of a claim or service line

Loop: **2220D — SERVICE LINE INFORMATION**

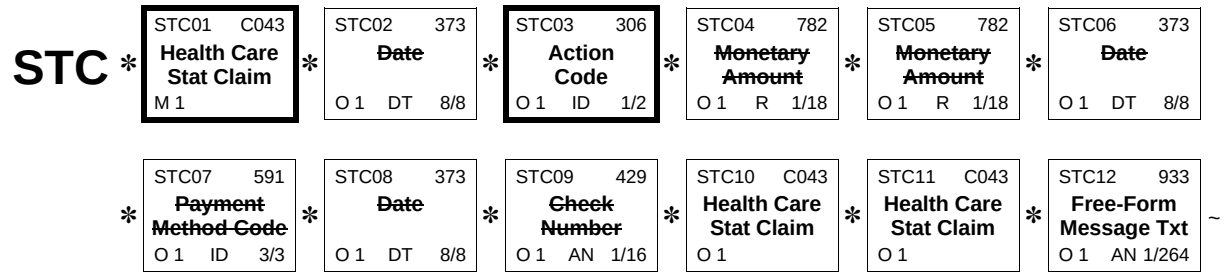
Segment Repeat: **>1**

Usage: **REQUIRED**

TR3 Notes:
1. **See Section 1.4.2 - Status Information (STC) Segment Usage for specific STC segment information, composites and code use.**

TR3 Example:
STC*A1:19U~**
STC*A8:187U*******A8:453*A8:454~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line	**M 1**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M AN 1/30**

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'A' for batch. For real time acknowledgements category types 'A' and 'E' may be used except for E0. Use of the category type 'E' is limited to indicating the business application system is unavailable.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

CODE	DEFINITION
03	Dependent
1P	Provider
1Z	Home Health Care
40	Receiver
41	Submitter
71	Attending Physician
72	Operating Physician
73	Other Physician
77	Service Location
82	Rendering Provider
85	Billing Provider
87	Pay-to Provider
DK	Ordering Physician
DN	Referring Provider
DQ	Supervising Physician
FA	Facility
GB	Other Insured
HK	Subscriber
IL	Insured or Subscriber
LI	Independent Lab
MSC	Mammography Screening Center
PR	Payer
PRP	Primary Payer
QB	Purchase Service Provider
QC	Patient

			QD	Responsible Party			
			SEP	Secondary Payer			
			TL	Testing Laboratory			
			TTP	Tertiary Payer			
			TU	Third Party Repricing Organization (TPO)			
NOT USED	STC01 - 4		1270	Code List Qualifier Code	O	ID	1/3
NOT USED	STC02	373	Date		O 1	DT	8/8
REQUIRED	STC03	306	Action Code Code indicating type of action		O 1	ID	1/2

CODE	DEFINITION
U	Reject

NOT USED	STC04	782	Monetary Amount		O 1	R	1/18
NOT USED	STC05	782	Monetary Amount		O 1	R	1/18
NOT USED	STC06	373	Date		O 1	DT	8/8
NOT USED	STC07	591	Payment Method Code		O 1	ID	3/3
NOT USED	STC08	373	Date		O 1	DT	8/8
NOT USED	STC09	429	Check Number		O 1	AN	1/16
SITUATIONAL	STC10	C043	HEALTH CARE CLAIM STATUS Used to convey status of the entire claim or a specific service line		O 1		

SITUATIONAL RULE: ***Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.***

REQUIRED	STC10 - 1		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED	STC10 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED **STC10 - 4** **1270** **Code List Qualifier Code** **O ID 1/3**

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O 1**
Used to convey status of the entire claim or a specific service line

SITUATIONAL RULE: ***Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.***

REQUIRED **STC11 - 1** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

IMPLEMENTATION NAME: **Health Care Claim Status Category Code**

See STC01-1 for valid values.

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

SEMANTIC:
C043-02 is used to identify the status of an entire claim or a serviceline. Code Source 508 is referenced unless qualified by C043-04.

IMPLEMENTATION NAME: **Health Care Claim Status Code**

This code provides further detail of the status. See Section 1.4.2 Status Information (STC Segment Usage).

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC11 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SEMANTIC:
C043-03 identifies the entity associated with the Health Care Claim Status Code.

SITUATIONAL RULE: ***Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.***

See STC01-3 for valid values.

NOT USED	**STC11 - 4**		**1270 Code List Qualifier Code**	**O**	**ID**	**1/3**
SITUATIONAL	**STC12**	**933**	**Free-form Message Text** Free-form message text	**O 1**	**AN**	**1/264**

SEMANTIC: STC12 allows additional free-form status information.

SITUATIONAL RULE: ***Required when Health Care Claim Status Code 448 is used in STC01-2, STC10-2, or STC11-2. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Free Form Message Text**

See Section 1.4.2.1 for more information on use of STC12 and Status Code '448'.

SEGMENT DETAIL

REF - SERVICE LINE ITEM IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2220D — SERVICE LINE INFORMATION**

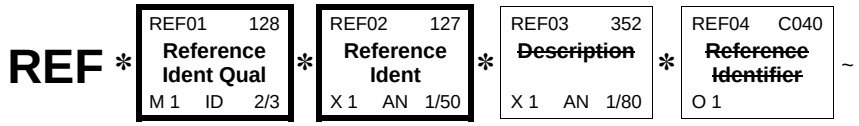
Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Notes: **1. This is the line Item Control Number exactly as submitted on the original claim in Loop 2400, REF02 (REF01-6R). If a Line Item Control Number is not submitted, this will be the line sequence number (LX01) of the service line.**

TR3 Example: **REF*FJ*001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: **FJ** DEFINITION: **Line Item Control Number**	**M 1 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 SYNTAX: R0203 IMPLEMENTATION NAME: **Line Item Control Number**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

REF - PHARMACY PRESCRIPTION NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

Loop: **2220D — SERVICE LINE INFORMATION**

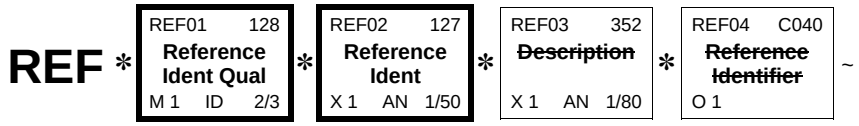
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when a Pharmacy Prescription Number was sent in the 837 at the Service Line. If not required by this implementation guide, do not send.**

TR3 Example: **REF*XZ*1234567~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **XZ** **Pharmacy Prescription Number**	**M 1 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 **SYNTAX:** R0203 **IMPLEMENTATION NAME: Pharmacy Prescription Number**	**X 1 AN 1/50**
NOT USED	**REF03**	**352**	**Description**	**X 1 AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O 1**

SEGMENT DETAIL

DTP - SERVICE LINE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: **2220D — SERVICE LINE INFORMATION**

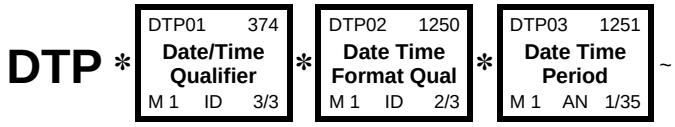
Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the Date of Service from the original submitted claim for a specific line item is present. If not required by this implementation guide, do not send.**

TR3 Example: **DTP*472*RD8*20060822-20060825~ OR**
DTP*472*D8*20060823~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M 1 ID 3/3**
			IMPLEMENTATION NAME: Date Time Qualifier	
			CODE — DEFINITION **472 — Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE — DEFINITION** **D8 — Date Expressed in Format CCYYMMDD** **RD8 — Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 1 AN 1/35**
			IMPLEMENTATION NAME: Service Line Date	

SEGMENT DETAIL

SE - TRANSACTION SET TRAILER

X12 Segment Name: Transaction Set Trailer

X12 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)

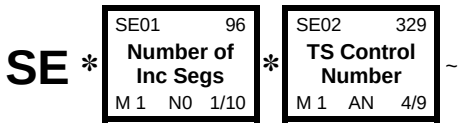
X12 Comments: **1.** SE is the last segment of each transaction set.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **SE*55*0001~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments IMPLEMENTATION NAME: **Transaction Segment Count**	**M 1 N0 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 **Data value in SE02 must be identical to ST02.**	**M 1 AN 4/9**

3 Examples

3.1 Business Scenario 1: Clearinghouse Example - Accepted File (some claims rejected)

In the following example, Best Billing Service (Electronic Transmitter ID Number S00001) submitted an 837 Professional claim file to First Clearinghouse (Electronic Transmitter ID Number CLHR00) on February 5, 2006 for Smith Clinic (Employer Tax ID Number 123456789). First Clearinghouse processed the file on February 5, 2006 and notified Best Billing Service that although the file for charges totaling $1,000.00 was accepted, there were individual claims that were rejected. Following is the status information for the claims contained in the 837 claims transmission file:

John Doe's (Member ID Number 00ABCD1234) claim for $200.00 for dates of service January 28, 2006 through January 31, 2006 was accepted and forwarded to the payer.

Jane Doe's (Member ID Number 45613027602) claim for $500.00 for date of service January 15, 2006 was rejected because it is missing the rendering provider number on the service/detail line with the HCPC procedure code of "22305" with a modifier of "22" for a charge of $350.00. This is required for the payer to process the claim, so the clearinghouse has established an edit to prohibit acceptance of claims without the necessary identification number.

Helen Vest's (Member ID Number 45602708901) claim for $300.00 for date of service January 20, 2006 was rejected because the source of payment (claim filing indicator) was not valid for the payer for this claim.

```
ST*277*0001*005010X214~
BHT*0085*08*277X2140001*20060205*1635*TH~
HL*1**20*1~
NM1*AY*2*FIRST CLEARINGHOUSE*****46*CLHR00~
TRN*1*200102051635S00001ABCDEF~
DTP*050*D8*20060205~
DTP*009*D8*20060205~
HL*2*1*21*1~
NM1*41*2*BEST BILLING SERVICE*****46*S00001~
TRN*2*2002020542857~
STC*A0:16:PR*20060205*WQ*1000~
QTY*90*1~
QTY*AA*2~
```

```
AMT*YU*200~
AMT*YY*800~
HL*3*2*19*1~
NM1*85*2*SMITH CLINIC*****FI*123456789~
HL*4*3*PT~
NM1*QC*1*DOE*JOHN****MI*00ABCD1234~
TRN*2*DOE01428~
STC*A0:16:PR*20060205*WQ*200~
REF*1K*22029500123407X~
DTP*472*RD8*20060128-20060131~
HL*5*3*PT~
NM1*QC*1*DOE*JANE****MI*45613027602~
TRN*2*DOE0221~
STC*A3:21:82*20060205*U*500~
DTP*472*D8*20060115~
SVC*HC:22305:22*350*****1~
STC*A3:122**U*******A3:153:82~
REF*FJ*11~
HL*6*3*PT~
NM1*QC*1*VEST*HELEN****MI*45602708901~
TRN*2*VEST0303~
STC*A3:401*20060205*U*300~
DTP*472*RD8*20060120-20060120~
SE*37*0001~
```

3.2 Business Scenario 2: Clearinghouse Example - Rejected File (invalid submitter)

In the following example, Last Billing Service (Electronic transmitter ID number S00002) submitted an 837 Professional claim file with 3 claims totaling $800.00 to First Clearinghouse (Electronic transmitter ID number CLHR00) on January 31, 2006 for Smith Clinic. This file was transmitted after the cutoff time for same day processing, so First Clearinghouse processed the file on February 1, 2006 and notified Last Billing Service on February 1, 2006 that their file was rejected as they have not completed the trading partner enrollment process, therefore, they are not a valid trading partner with First Clearinghouse. Please note that the 277 acknowledgment is immediately terminated and no additional hierarchical levels are sent/acknowledged.

```
ST*277*0002*005010X214~
BHT*0085*08*277X2140002*20060201*0405*TH~
HL*1**20*1~
NM1*AY*2*FIRST CLEARINGHOUSE*****46*CLHR00~
TRN*1*200201312005S00002XYZABC~
DTP*050*D8*20060131~
DTP*009*D8*20060201~
HL*2*1*21*0~
NM1*41*2*LAST BILLING SERVICE*****46*S00002~
TRN*2*20020131052389~
STC*A3:24:41**U~
QTY*AA*3~
AMT*YY*800~
SE *14*00002~
```

3.3 Business Scenario 3: Payer Response - Accepted File (some claims rejected)

In the following example, Dr. Harry B. Jones (Electronic Transmitter ID Number S00003) submitted an 837 Professional claim file with inventory file number 2002022045678 in BHT03 directly to “Your Insurance Company” (Payer ID Number YIC01) on February 20, 2006 for himself (Tax ID Number 234567894). Your Insurance Company processed the file on February 21, 2006 and notified Dr. Jones that although the file containing five claims for charges totaling $365.50 was accepted, there were two individual claims that were rejected. Following is the status information for the claims contained in the 837 claims transmission file:

Female Patient's (Member ID Number 2222222222) claim for $100.00 for date of service February 14, 2006 was accepted and an internal claim control number of 220216359803X was assigned to this claim.

Male Patient's (Member ID Number 3333333333) claim for $65.00 was rejected because the date of service was either missing or invalid. (Note that the DTP segment is not present within this loop since most translators will not generate/echo an invalid date.)

Larry Jones' (Member ID Number 4444444444) claim for $100.00 for date of service February 11, 2006 was rejected because the place of service was missing or invalid.

Mary Johnson's (Member ID Number 5555555555) claim for $50.50 for date of service February 10, 2006 was accepted and an internal claim control number of 220216359806X was assigned to this claim.

Harriett Mills' (Member ID Number 6666666666) claim for $50.00 for date of service February 5, 2006 was accepted and an internal claim control number of 220216359807X was assigned to this claim.

```
ST*277*0003*005010X214~
BHT*0085*08*277X2140003*20060221*1025*TH~
HL*1**20*1~
NM1*PR*2*YOUR INSURANCE COMPANY*****PI*YIC01~
TRN*1*0091182~
DTP*050*D8*20060220~
DTP*009*D8*20060221~
HL*2*1*21*1~
NM1*41*1*JONES*HARRY*B**MD*46*S00003~
TRN*2*2002022045678~
STC*A1:19:PR*20060221*WQ*365.5~
QTY*90*3~
QTY*AA*2~
AMT*YU*200.5~
AMT*YY*165~
HL*3*2*19*1~
NM1*85*1*JONES*HARRY*B**MD*FI*234567894~
HL*4*3*PT~
NM1*QC*1*PATIENT*FEMALE****MI*2222222222~
TRN*2*PATIENT22222~
STC*A2:20:PR*20060221*WQ*100~
```

```
REF*1K*220216359803X~
DTP*472*RD8*20060214~
HL*5*3*PT~
NM1*QC*1*PATIENT*MALE****MI*3333333333~
TRN*2*PATIENT33333~
STC*A3:187:PR*20060221*U*65~
DTP*472*20090221~
HL*6*3*PT~
NM1*QC*1*JONES*LARRY****MI*4444444444~
TRN*2*JONES44444~
STC*A3:21:77*20060221*U*100~
DTP*472*D8*20060211~
HL*7*3*PT~
NM1*QC*1*JOHNSON*MARY****MI*5555555555~
TRN*2*JOHNSON55555~
STC*A2:20:PR*20060221*WQ*50.5~
REF*1K*220216359806X~
DTP*472*D8*20060210~
HL*8*3*PT~
NM1*QC*1*MILLS*HARRIETT****MI*6666666666~
TRN*2*MILLS66666~
STC*A2:20:PR*20060221*WQ*50~
REF*1K*220216359807X~
DTP*472*D8*20060205~
SE*46*0003~
```

3.4 Business Scenario 4: Payer Response - 1st Provider - Claims Accepted and 2nd Provider - Claims Rejected

In the following example, Dr. Ewell B King (Electronic transmitter ID number S00005) submitted an 837 Professional claim file to “Our Insurance Company” (Payer ID Number OIC02) on March 20, 2006 for himself and Dr. I. B. Reed (SSN-56701234). This file was transmitted after the cutoff time for same day processing, so Our Insurance Company processed the file on March 21, 2006 and notified Dr. King on March 21, 2006 that although the file of eight claims for charges

totaling $455.00 was accepted, there were individual claims (two) that were rejected and that all three of Dr. Reed's claims were rejected as he has not completed the trading partner enrollment process to be an electronic submitter. Please note that the 277 acknowledgment is immediately terminated and no additional hierarchical levels are sent related to Dr. Reed's claims.

Following is the status information for Dr. King's the claims contained in the 837 claims transmission file:

Female Patient's (Member ID Number 2222222222) claim for $55.00 for date of service March 14, 2006 was accepted and an internal claim control number of 220216359803X was assigned to this claim.

Male Patient's (Member ID Number 3333333333) claim for $50.00 was rejected because the date of service was either missing or invalid. (Note that the DTP segment is not present within this loop since most translators will not generate/echo an invalid date.)

Mary Jones' (Member ID Number 4444444444) claim for $100.00 for date of service March 11, 2006 was rejected because the claim was submitted to the wrong payer.

Jimmy Johnson's (Member ID Number 5555555555) claim for $50.00 for date of service March 10, 2006 was accepted and an internal claim control number of 220216359806X was assigned to this claim.

Haley Mills' (Member ID Number 6666666666) claim for $50.00 for date of service March 5, 2006 was accepted and an internal claim control number of 220216359807X was assigned to this claim.

All 3 of Dr. Reed's claims totaling $150.00 were rejected because the Billing Provider (Dr. Reed) is not approved as an electronic submitter.

```
ST*277*0004*005010X214~
BHT*0085*08*277X2140004*20060321*1025*TH~
HL*1**20*1~
NM1*PR*2*OUR INSURANCE COMPANY*****PI*OIC02~
TRN*1*00911232~
DTP*050*D8*20060320~
DTP*009*D8*20060321~
HL*2*1*21*1~
NM1*41*1*KING*EWELL*B**MD*46*S00005~
TRN*2*200203207890~
STC*A1:19:PR*20060321*WQ*455~
QTY*90*3~
QTY*AA*5~
AMT*YU*155~
AMT*YY*300~
```

```
HL*3*2*19*1~
NM1*85*1*KING*EWELL*B**MD*XX*5365432101~
TRN*2*00098765432~
STC*A1:19:PR**WQ*305~
HL*4*3*PT~
NM1*QC*1*PATIENT*FEMALE****MI*2222222222~
TRN*2*PATIENT22222~
STC*A2:20:PR*20060321*WQ*55~
REF*1K*220216359803X~
DTP*472*D8*20060314~
HL*5*3*PT~
NM1*QC*1*PATIENT*MALE****MI*3333333333~
TRN*2*PATIENT33333~
STC*A3:187:PR*20060321*U*50~
HL*6*3*PT~
NM1*QC*1*JONES*MARY****MI*4444444444~
TRN*2*JONES44444~
STC*A3:116*20060321*U*100~
DTP*472*D8*20060311~
HL*7*3*PT~
NM1*QC*1*JOHNSON*JIMMY****MI*5555555555~
TRN*2*JOHNSON55555~
STC*A2:20:PR*20060321*WQ*50~
REF*1K*220216359806X~
DTP*472*D8*20060310~
HL*8*3*PT~
NM1*QC*1*MILLS*HALEY****MI*6666666666~
TRN*2*MILLS66666~
STC*A2:20:PR*20060321*WQ*50~
REF*1K*220216359807X~
DTP*472*D8*20060305~
HL*9*2*19*0~
NM1*85*1*REED*I*B**MD*FI*567012345~
```

```
TRN*2*00023456789~
STC*A3:24:85*20060321*U*150~
QTY*QC*3~
AMT*YY*150~
SE*53*0004~
```

A External Code Sources

130 Healthcare Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Healthcare Common Procedural Coding System

AVAILABLE FROM

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT

HCPCS is Centers for Medicare & Medicaid Service's (CMS) coding scheme to group procedures performed for payment to providers.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/NU, 235/RB, 1270/BE, 1270/BG, 1270/BH, 1270/BI, 1270/NUB

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.

135 American Dental Association

SIMPLE DATA ELEMENT/CODE REFERENCES

1361, 235/AD, 1270/JO, 1270/JP, 1270/TQ, 1270/AAY

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT

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

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, 1270/65

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

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV, 1270/HO

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

537 Centers for Medicare and Medicaid Services National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XX, 128/HPI

SOURCE

National Provider System

AVAILABLE FROM

Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Provider/Supplier Enrollment
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare and Medicaid Services is developing the National Provider Identifier (NPI), which has been proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Centers for Medicare and Medicaid Services PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV, 128/ABY

SOURCE

PlanID Database

AVAILABLE FROM

Centers for Medicare and Medicaid Services
Center of Beneficiary Services, Membership Operations Group
Division of Benefit Coordination
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare and Medicaid Services has joined with other payers to develop a unique national payer identification number. The Centers for Medicare and Medicaid Services is the authorizing agent for enumerating payers through the services of a PlanID Registrar. It may also be used by other payers on a voluntary basis.

576 Workers Compensation Specific Procedure and Supply Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ER

SOURCE

IAIABC Jurisdiction Medical Bill Report Implementation Guide

AVAILABLE FROM

IAIABC EDI Implementation Manager
International Association of Industrial Accident Boards and Commissions
8643 Hauses - Suite 200
87th Parkway
Shawnee Mission, KS 66215

ABSTRACT

The IAIABC Jurisdiction Medical Bill Report Implementation Guide describes the requirements for submitting and the data contained within a jurisdiction medical report. The Implementation Guide includes: Reporting scenarios, data definitions, trading partner requirements tables, reference to industry codes, and IAIABC maintained code lists.

716 Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HP

SOURCE

Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

AVAILABLE FROM

Division of Institutional Claims Processing
Centers for Medicare and Medicaid Services
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare and Medicaid services develops and publishes the HIPPS codes to establish a coding system for claims submission and claims payment under prospective payment systems. These codes represent the case mix classification groups that are used to determine payment rates under prospective payment systems. Case mix classification groups include, but may not be limited to , resource utilization groups (RUGs) for skilled nursing facilities, home health resource groups (HHRGs) for home health agencies, and case mix groups (CMGs) for inpatient rehabilitation facilities.

843 Advanced Billing Concepts (ABC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/WK, 1270/CAH

SOURCE

The CAM and Nursing Coding Manual

AVAILABLE FROM

Alternative Link
6121 Indian School Road NE
Suite 131
Albuquerque, NM 87110

ABSTRACT

The manual contains the Advanced Billing Concepts (ABC) codes, descriptive terms and identifiers for reporting complementary or alternative medicine, nursing, and other integrative health care procedures.

B Nomenclature

B.1 ASC X12 Nomenclature

B.1.1 Interchange and Application Control Structures

Appendix B is provided as a reference to the X12 syntax, usage, and related information. It is not a full statement of Interchange and Control Structure rules. The full X12 Interchange and Control Structures and other rules (X12.5, X12.6, X12.59, X12 dictionaries, other X12 standards and official documents) apply unless specifically modified in the detailed instructions of this implementation guide (see Section B.1.1.3.1.2 for an example of such a modification).

B.1.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environ-

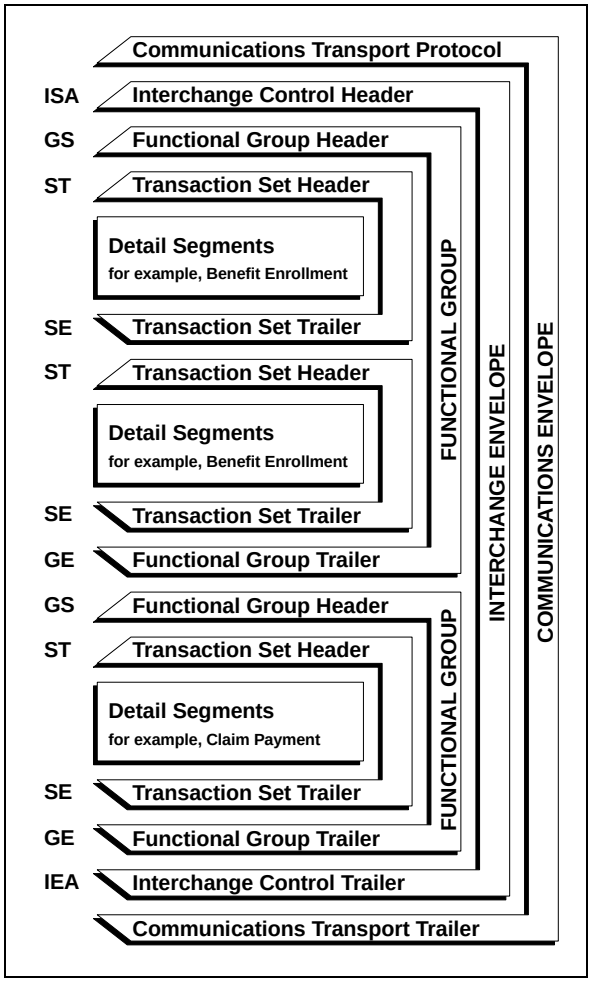


Figure B.1. Transmission Control Schematic

ment, the segments would be equivalent to records, and the elements equivalent to fields.

Similar transaction sets, called “functional groups,” can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure B.1., Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

B.1.1.2 Application Control Structure Definitions and Concepts

B.1.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

B.1.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in Figure B.2., Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure B.2. Basic Character Set

B.1.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in Figure B.3., Extended Character Set.

a..z	%	~	@	[	]	_	{
}	\	|	<	>	#	$	

Figure B.3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

For implementations compliant with this guide, either the entire extended character set must be acceptable, or the entire extended character set must not be used. In the absence of a specific trading partner agreement to the contrary, trading partners will assume that the extended character set is acceptable. Use of the extended character set allows the use of the "@" character in email addresses within the PER segment. Users should note that characters in the extended character set, as well as the basic character set, may be used as delimiters only when they do not occur in the data as stated in Section B.1.1.2.5.

B.1.1.2.4 Control Characters

Two control character groups are specified; they have restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the Matrix B.1., Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

B.1.1.2.4.1 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix B.1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

B.1.1.2.4.2 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in Matrix B.2., Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix B.2. Extended Control Set

B.1.1.2.5 Delimiters

A delimiter is a character used to separate two data elements or component elements or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment can be considered in implementations compliant with this guide (see Appendix C, ISA Segment Note 1) to be a 105 byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number 83; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in Matrix B.3., Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Caret	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

Matrix B.3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

B.1.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

B.1.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

A simple data element within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated data element occurs.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in Matrix B.4., Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix B.4. Data Element Types

The data element minimum and maximum lengths may be restricted in this implementation guide for a compliant implementation. Such restrictions may occur by virtue of the allowed qualifier for the data element or by specific instructions regarding length or format as stated in this implementation guide.

B.1.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

B.1.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point must be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point must be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

While the ASC X12 standard supports usage of exponential notation, this guide prohibits that usage.

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

EXAMPLE
For implementations mandated under HIPAA rules:

- The following transmitted value represents the largest positive dollar amount that can be sent:
  99999999.99
- The following transmitted value is the longest string of characters that can be sent representing whole dollars.
  99999999
- The following transmitted value is the longest string of characters that can be sent representing negative dollars and cents.
  -99999999.99
- The following transmitted value is the longest string of characters that can be sent representing negative whole dollars.
  -99999999

B.1.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces must be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

B.1.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The string data element must contain at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces must be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

B.1.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment and the TA1 segment where the century is easily determined because of the nature of an interchange header.

B.1.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

B.1.1.3.1.7 Binary

The binary data element is any sequence of octets ranging in value from binary 00000000 to binary 11111111. This data element type has no defined maximum length. Actual length is specified by the immediately preceding data element. Within the body of a transaction set (from ST to SE) implemented according to this technical report, the binary data element type is only used in the segments Binary Data Segment BIN, and Binary Data Structure BDS. Within those segments, Data Element 785 Binary Data is a string of octets which can assume any binary pattern from hexadecimal 00 to FF, and can be used to send text as well as coded data, including data from another application in its native format. The binary data type is also used in some control and security structures.

Not all transaction sets use the Binary Data Segment BIN or Binary Data Structure BDS.

B.1.1.3.2 Repeating Data Elements

Simple or composite data elements within a segment can be designated as repeating data elements. Repeating data elements are adjacent data elements that occur up to a number of times specified in the standard as number of repeats. The implementation guide may also specify the number of repeats of a repeating data element in a specific location in the transaction that are permitted in a compliant implementation. Adjacent occurrences of the same repeating simple data element or composite data structure in a segment shall be separated by a repetition separator.

B.1.1.3.3 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described in Sections B.1.1.3.8 and B.1.1.3.9.

A composite data structure within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated composite data structure occurs.

B.1.1.3.4 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be

further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

B.1.1.3.5 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See B.1.1.3.9, Condition Designator.

B.1.1.3.6 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

B.1.1.3.7 Comments

A segment comment provides additional information regarding the intended use of the segment.

B.1.1.3.8 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is prefixed with a hyphen and defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

B.1.1.3.9 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 2.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table B.5. Condition Designator

B.1.1.3.10 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed must be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their ab-

sence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

If a segment has no data in any data element within the segment (an "empty" segment), that segment must not be sent.

B.1.1.3.11 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

B.1.1.3.11.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

B.1.1.3.11.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

B.1.1.3.11.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

B.1.1.3.11.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

ST Transaction Set Header, starts a transaction set.

LS Loop Header, starts a bounded loop of data segments but is not part of the loop.

LS Loop Header, starts an inner, nested, bounded loop.

LE Loop Trailer, ends an inner, nested bounded loop.

LE Loop Trailer, ends a bounded loop of data segments but is not part of the loop.

SE Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

B.1.1.3.12 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See Figure B.1., Transmission Control Schematic.

B.1.1.3.12.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

B.1.1.3.12.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

B.1.1.3.12.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

B.1.1.3.12.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

B.1.1.3.12.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

B.1.1.3.12.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last consecutive occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

B.1.1.3.12.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

B.1.1.3.12.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

B.1.1.3.12.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

B.1.1.3.12.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by “>1.”

B.1.1.3.13 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See Figure B.1., Transmission Control Schematic.

B.1.1.4 Envelopes and Control Structures

B.1.1.4.1 Interchange Control Structures

Typically, the term “interchange” connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several “control” components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two elements are identical. In most translation software products, if these elements are different the interchange will be “suspended” in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. GS08 indicates the version of the transaction sets contained within the ISA/IEA envelope. The versions are not required to be the same. An Interchange Acknowledgment can be requested through data element ISA14. The interchange acknowlegement is the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a “test” or “production” mode. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrepancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix C, EDI Control Directory, for a complete detailing of the interchange control header and trailer. The authors recommend that when two transactions with different X12 versions numbers are sent in one interchange control structure (multiple functional groups within one ISA/IEA envelope), the Interchange Control version used should be that of the most recent transaction version included in the envelope. For the transmission of HIPAA transactions with mixed versions, this would be a compliant enveloping structure.

B.1.1.4.2 Functional Groups

Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender’s Code in GS02 can be used to identify the sending unit

of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, and GS06) can be used for debugging purposes. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix C, EDI Control Directory, for a complete detailing of the functional group header and trailer.

B.1.1.4.3 HL Structures

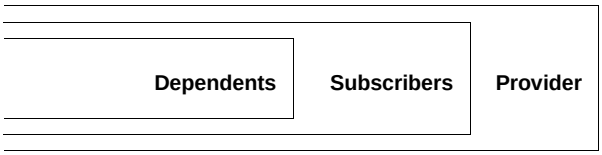
The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide.

For example, each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims.

Each guide states what levels are available, the level's usage, number of repeats, and whether that level has subordinate levels within a transaction set.

For implementations compliant with this guide, the repeats of the loops identified by the HL structure shall appear in the hierarchical order specified in BHT01, when those particular hierarchical levels exist. That is, an HL parent loop must be followed by the subordinate child loops, if any, prior to commencing a new HL parent loop at the same hierarchical level.

The following diagram, from transaction set 837, illustrates a typical hierarchy.



The two examples below illustrate this requirement:

Example 1 based on Implementation Guide 811X201:

INSURER
- First STATE in transaction (child of INSURER)
  - First POLICY in transaction (child of first STATE)
    - First VEHICLE in transaction (child of first POLICY)
  - Second POLICY in transaction (child of first STATE)
    - Second VEHICLE in transaction (child of second POLICY)
    - Third VEHICLE in transaction (child of second POLICY)
- Second STATE in transaction (child of INSURER)
  - Third POLICY in transaction (child of second STATE)
    - Fourth VEHICLE in transaction (child of third POLICY)

Example 2 based on Implementation Guide 837X141

First PROVIDER in transaction
  First SUBSCRIBER in transaction (child of first PROVIDER)
Second PROVIDER in transaction
  Second SUBSCRIBER in transaction (child of second PROVIDER)
    First DEPENDENT in transaction (child of second SUBSCRIBER)
    Second DEPENDENT in transaction (child of second SUBSCRIBER)
  Third SUBSCRIBER in transaction (child of second PROVIDER)
Third PROVIDER in transaction
  Fourth SUBSCRIBER in transaction (child of third PROVIDER)
  Fifth SUBSCRIBER in transaction (child of third PROVIDER
    Third DEPENDENT in transaction (child of fifth SUBSCRIBER)

B.1.1.5 Acknowledgments

B.1.1.5.1 Interchange Acknowledgment, TA1

The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See B.1.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

B.1.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. The 997 is used as a functional acknowledgment to a previously transmitted functional group.

The 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

B.2 Object Descriptors

Object Descriptors (OD) provide a method to uniquely identify specific locations within an implementation guide. There is an OD assigned at every level of the X12N implementation:

1. Transaction Set
2. Loop
3. Segment
4. Composite Data Element
5. Component Data Element
6. Simple Data Element

ODs at the first four levels are coded using X12 identifiers separated by under-bars:

Entity	Example
1. Transaction Set Identifier plus a unique 2 character value	837Q1
2. Above plus under bar plus Loop Identifier as assigned within an implementation guide	837Q1_2330C
3. Above plus under bar plus Segment Identifier	837Q1_2330C_NM1
4. Above plus Reference Designator plus under bar plus Composite Identifier	837Q1_2400_SV101_C003

The fifth and sixth levels add a name derived from the “Industry Term” defined in the X12N Data Dictionary. The name is derived by removing the spaces.

Entity	Example
5. Number 4 above plus composite sequence plus under bar plus name	837Q1_2400_SV101_C00302_ProcedureCode
6. Number 3 above plus Reference Designator plus two under bars plus name	837Q1_2330C_NM109__OtherPayerPatientPrimaryIdentifier

Said in another way, ODs contain a coded component specifying a location in an implementation guide, a separator, and a name portion. For example:

Since ODs are unique across all X12N implementation guides, they can be used for a variety of purposes. For example, as a cross reference to older data transmission systems, like the National Standard Format for health care claims, or to form XML tags for newer data transmission systems.

C EDI Control Directory

C.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **IEA**
  Interchange Control Trailer Segment

SEGMENT DETAIL

ISA - INTERCHANGE CONTROL HEADER

X12 Segment Name: Interchange Control Header

X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Segment Repeat: **1**

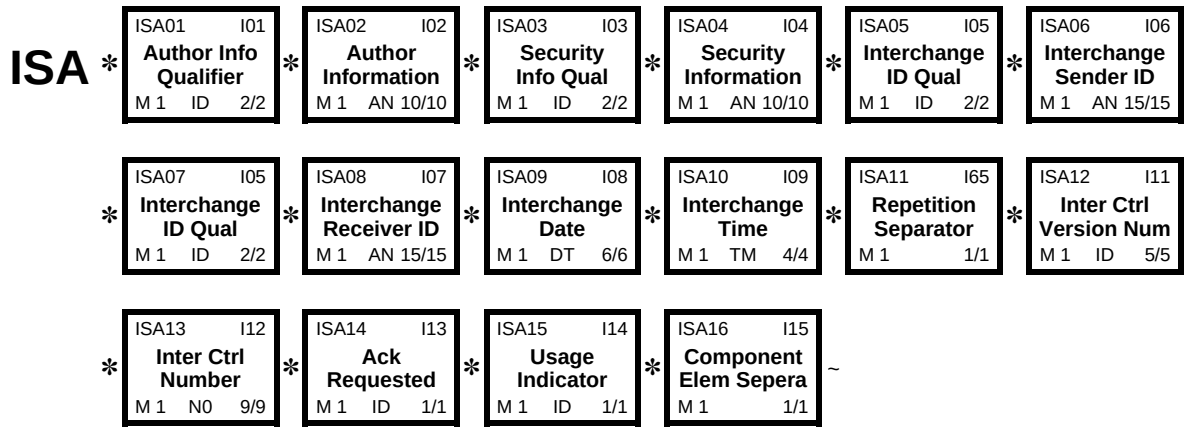
Usage: **REQUIRED**

TR3 Notes:

1. **All positions within each of the data elements must be filled.**
2. **For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.**
3. **The first element separator defines the element separator to be used through the entire interchange.**
4. **The ISA segment terminator defines the segment terminator used throughout the entire interchange.**
5. **Spaces in the example interchanges are represented by "." for clarity.**

TR3 Example: **ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*030101*1253*^*00501*000000905*1*T*:~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ISA01	I01	**Authorization Information Qualifier** Code identifying the type of information in the Authorization Information	M 1 ID 2/2
			CODE / DEFINITION **00** — **No Authorization Information Present (No Meaningful Information in I02)** **03** — **Additional Data Identification**	
REQUIRED	ISA02	I02	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	M 1 AN 10/10
REQUIRED	ISA03	I03	**Security Information Qualifier** Code identifying the type of information in the Security Information	M 1 ID 2/2
			CODE / DEFINITION **00** — **No Security Information Present (No Meaningful Information in I04)** **01** — **Password**	
REQUIRED	ISA04	I04	**Security Information** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)	M 1 AN 10/10
REQUIRED	ISA05	I05	**Interchange ID Qualifier** Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified	M 1 ID 2/2
			This ID qualifies the Sender in ISA06.	
			CODE / DEFINITION **01** — **Duns (Dun & Bradstreet)** **14** — **Duns Plus Suffix** **20** — **Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number **27** — **Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)** **28** — **Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)** **29** — **Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)** **30** — **U.S. Federal Tax Identification Number** **33** — **National Association of Insurance Commissioners Company Code (NAIC)** **ZZ** — **Mutually Defined**	
REQUIRED	ISA06	I06	**Interchange Sender ID** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element	M 1 AN 15/15

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M 1 ID 2/2**
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Number
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA08** **I07** **Interchange Receiver ID** **M 1 AN 15/15**
Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them

REQUIRED **ISA09** **I08** **Interchange Date** **M 1 DT 6/6**
Date of the interchange

The date format is YYMMDD.

REQUIRED **ISA10** **I09** **Interchange Time** **M 1 TM 4/4**
Time of the interchange

The time format is HHMM.

REQUIRED **ISA11** **I65** **Repetition Separator** **M 1 1/1**
Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator

REQUIRED **ISA12** **I11** **Interchange Control Version Number** **M 1 ID 5/5**
Code specifying the version number of the interchange control segments

CODE	DEFINITION
00501	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003**

REQUIRED **ISA13** **I12** **Interchange Control Number** **M 1 N0 9/9**
A control number assigned by the interchange sender

The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.

Must be a positive unsigned number and must be identical to the value in IEA02.

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M 1** **ID** **1/1**
Code indicating sender's request for an interchange acknowledgment

See Section B.1.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Interchange Acknowledgment Requested**
1	**Interchange Acknowledgment Requested (TA1)**

REQUIRED **ISA15** **I14** **Interchange Usage Indicator** **M 1** **ID** **1/1**
Code indicating whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M 1** **1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

SEGMENT DETAIL

GS - FUNCTIONAL GROUP HEADER

X12 Segment Name: Functional Group Header

X12 Purpose: To indicate the beginning of a functional group and to provide control information

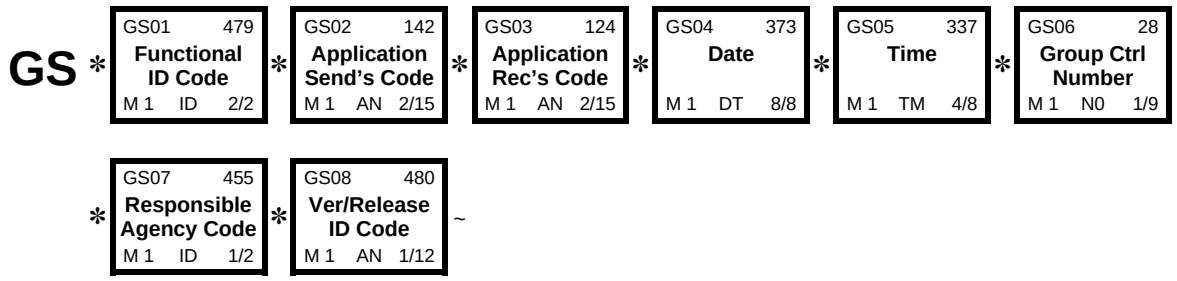
X12 Comments: **1.** A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **GS*XX*SENDER CODE*RECEIVER CODE*19991231*0802*1*X*005010X214~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **This is the 2-character Functional Identifier Code assigned to each transaction set by X12. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information.**	**M 1 ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M 1 AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M 1 AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M 1 DT 8/8**

REQUIRED **GS05** **337** **Time** **M 1 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)

SEMANTIC: GS05 is the group time.

Use this time for the creation time. The recommended format is HHMM.

REQUIRED **GS06** **28** **Group Control Number** **M 1 N0 1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.

REQUIRED **GS07** **455** **Responsible Agency Code** **M 1 ID 1/2**

Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M 1 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

CODE SOURCE 881: Version / Release / Industry Identifier Code

This is the unique Version/Release/Industry Identifier Code assigned to an implementation by X12N. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information.

CODE	DEFINITION
005010X214	**Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003**

SEGMENT DETAIL

GE - FUNCTIONAL GROUP TRAILER

X12 Segment Name: Functional Group Trailer

X12 Purpose: To indicate the end of a functional group and to provide control information

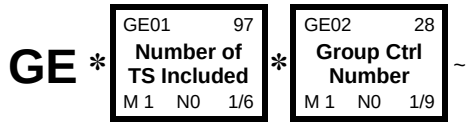
X12 Comments:
1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **GE*1*1~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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 1 N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M 1 N0 1/9**

SEGMENT DETAIL

IEA - INTERCHANGE CONTROL TRAILER

X12 Segment Name: Interchange Control Trailer

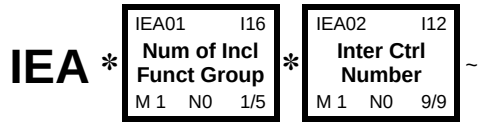
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **IEA*1*000000905~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M 1**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M 1**	**N0**	**9/9**

D Change Summary

This Implementation Guide defines X12N implementation 005010X214of the Health Care Claim Acknowledgment (277). It is based on version/release/sub-release 005010 of the ASC X12 standards.

The previous X12N implementation Guide of the Health Care Claim Acknowledgment (277) was 004040X167. It was based on version/release/ sub-release 004040 of the ASC X12 standards.

The 005010X214 Implementation Guide contains significant changes and clarifications. This appendix provides a high level description of changes between 004040X167 and 005010X214.

Overall Changes

1. Sections one and two were revised in accordance with version 5010 of the ASC X12N Implementation Guide Handbook.
2. All Situational loops, segments and data elements notes were modified in accordance with the ASC X12N Implementation Guide Handbook. See Section 2.2.1 Industry Usage and Section 2.2.2 Transaction Compliance Related to Industry Usage for further information about the Situational Rule format.
3. Appendix A and Appendix B have been revised in accordance with version 5010 of the X12N Implementation Guide Handbook.
4. The guide number (005010X214) is now documented in Section 1.2 Version Information. This identifier must be inserted as elements GS08 and ST03 in all Claim Acknowledgments created according to this implementation guide.
5. The Functional Identifier Code “HN” is now documented in Section 1.2 Version Information. This identifier must be inserted in element GS01 in all Claim Acknowledgments created according to this implementation guide.
6. All STC Segments have been revised to provide clarity and consistency.
7. All examples have been reviewed and brought up to date.
8. All Alias names have been deleted.

Front Matter Changes

9. The Front Matter sections were rewritten and condensed for the purpose of clarity and consistency.
10. Section 1.1.1 - Trading Partner Agreements is now Section 1.8.
11. Section 1.1.2 - HIPAA Role in Implementation Guides is now Section 1.9.
12. Section 1.1.3 - Disclaimers Within The Transactions was eliminated.
13. Section 1.3 - Business Use is now - Implementation Limitations
14. Section 1.4 - Information Flows is now Business Usage
15. Section 1.5 - Batch and Real Time Definitions is now - Business Terminology
16. Section 1.6 - Additional Syntax Support is now - Transaction Acknowledgments

17. Section 1.7 - Related Transactions has been added.

18. Section 2 - Data Overview is now Section 1.10

19. Section 2 - Transaction Set is now in accordance with version 5010 of the ASC X12N Implementation Guide Handbook.

20. Section 3 - Transactions Set has been eliminated. That information is now available in Section 2.

21. Section 2.3.2 - X12 Standard has been added.

277 Health Care Claim Acknowledgment Loop, Segment, Element Changes

Table 2 - Information Source Detail

22. Loop 2000A Information Source Level HL - Segment note added.

23. Loop 2200A TRN - Segment notes added.

24. Loop 2200A DTP*050 - Segment note moved to DTP03 element note.

25. Loop 2200A DTP*009 - Segment notes revised and condensed.

Table 2 - Information Receiver Detail

26. Loop 2000B Information Receiver Level HL04 - Element notes added.

27. Loop 2100B Information Receiver Name NM1 - Segment note 1 revised.

28. Loop 2100B Information Receiver Name NM106 changed to Not Used.

29. Loop 2100B Information Receiver Name NM107 changed to Not Used.

30. Loop 2200B TRN02 - Element note revised.

31. Loop 2200B STC - Segment note added.

32. Loop 2200B STC01-1 Element notes revised.

33. Loop 2200B STC01-2 Element note revised.

34. Loop 2200B STC01-4 Usage changed from Required to Not Used.

35. Loop 2200B STC03 - Qualifier definitions revised.

36. Loop 2200B STC04 - Element note revised.

37. Loop 2200B STC10-1 - Element note revised.

38. Loop 2200B STC10-2 Element note revised.

39. Loop 2200B STC10-3 Element note revised.

40. Loop 2200B STC10-4 - Usage changed from Required to Not Used.

41. Loop 2200B STC11-1 - Element note revised.

42. Loop 2200B STC11-2 Element note revised.

43. Loop 2200B STC11-3 Element note revised.

44. Loop 2200B STC11-4 - Usage changed from Required to Not Used.

45. Loop 2200B QTY*90 - Segment notes added.

46. QTY Implementation Names changed for consistency.

47. Loop 2200B QTY02 - Element note moved to TR3 Segment note.

48. Loop 2200B QTY*AA - Segment notes revised.

49. Loop 2200B AMT*YU - Segment note revised.

50. AMT implementation names changed for consistency.

51. Loop 2200B AMT02 - Element note moved to TR3 Segment note.

52. Loop 2200B AMT*YY - Segment note revised.

Table 2 - Billing Provider of Service Detail

53. Loop 2000C Billing Provider of Service Level - Name changed from 'Billing/Pay-To Provider' to 'Billing Provider of Service Detail' and usage changed from Required to Situational.

54. Loop 2000C Billing Provider of Service Level - Segment notes revised.

55. Loop 2000C Billing Provider of Service Level - HL04 - Additional code "0" added.

56. Loop 2100C Provider Name NM1 - Segment notes revised.

57. Loop 2100C Provider Name NM101 - Qualifier "87" deleted.

58. Loop 2100C Provider Name NM105 - Element note revised.

59. Loop 2100C Provider Name NM106 - Usage changed from Situational to Not Used.

60. Loop 2100C Provider Name NM107 - element note revised.

61. Loop 2100C, NM108 - Deleted 24 and 34 qualifiers and added FI qualifier.

62. Loop 2200C TRN - Provider of Service Information Trace Identifier - Segment note revised.

63. Loop 2200C STC - Billing Provider Status Information - Segment notes revised.

64. Loop 2200C STC01-1 Element notes revised.

65. Loop 2200C STC01-2 Element note revised.

66. Loop 2200C STC01-4 Usage changed from Required to Not Used.

67. Loop 2200C STC03 - Qualifier definitions revised.

68. Loop 2200C STC04 - Element note revised.

69. Loop 2200C STC10-1 - Element note revised.

70. Loop 2200C STC10-2 Element note revised.

71. Loop 2200C STC10-3 Element note revised.

72. Loop 2200C STC10-4 - Usage changed from Required to Not Used.

73. Loop 2200C STC11-1 - Element note revised.

74. Loop 2200C STC11-2 Element note revised.

75. Loop 2200C STC11-3 Element note revised.

76. Loop 2200C STC11-4 - Usage changed from Required to Not Used.

77. Loop 2200C REF - Provider Secondary Identifier - Segment notes revised.

78. QTY Implementation Names changed for consistency.

79. Loop 2200C AMT - Total Accepted Amount - Segment notes revised.

80. AMT implementation names changed for consistency.

Table 2 - Patient Detail

81. Loop 2000D Subscriber Level HL - Segment notes revised.

82. Loop 2000D HL04 - Usage changed from Required to Not Used.

83. Loop 2000D NM1 - Patient Name - Segment note removed.

84. Loop 2100D NM1 - Patient Name - NM104 usage changed from Required to Situational.

85. Loop 2200D TRN - Patient Control Number - Segment name and note revised.

86. Loop 2200D TRN02 - Element note removed.

87. Loop 2200D STC - Billing Provider Status Information - Segment notes revised.

88. Loop 2200D STC01-1 Element notes revised.

89. Loop 2200D STC01-2 Element note revised.

90. Loop 2200D STC01-4 Usage changed from Required to Not Used.

91. Loop 2200D STC03 - Qualifier definitions revised.

92. Loop 2200D STC04 - Element note revised.

93. Loop 2200D STC10-1 - Element note revised.

94. Loop 2200D STC10-2 Element note revised.

95. Loop 2200D STC10-3 Element note revised.

96. Loop 2200D STC10-4 - Usage changed from Required to Not Used.

97. Loop 2200D STC11-1 - Element note revised.

98. Loop 2200D STC11-2 Element note revised.

99. Loop 2200D STC11-3 Element note revised.

100. Loop 2200D STC11-4 - Usage changed from Required to Not Used.

101. Loop 2200D REF- Information Source Control Identification Number - Segment notes revised.

102. Loop 2200D REF02 - Element note moved to TR3 Note.

103. Loop 2200D REF- Claim Identifier Number for Clearinghouse and Other Transmission Intermediaries - Segment note revised.

104. Loop 2200D DTP - Claim Level Service Date - Segment notes revised and D8 qualifier added.

105. Loop 2220D SVC01-1 - Qualifiers ‘ID’, ‘N4’ and ‘ZZ’ were deleted and qualifiers ‘ER and ‘HP’ were added.

106. Loop 2220D SVC01-8 - Added as Not Used.

107. Loop 2220D STC - Billing Provider Status Information - Segment notes revised.

108. Loop 2220D STC01-1 Element notes revised.

109. Loop 2220D STC01-2 Element note revised.

110. Loop 2220D STC01-4 Usage changed from Required to Not Used.

111. Loop 2220D STC03 - Qualifier definitions revised.

112. Loop 2220D STC04 - Element note revised.

113. Loop 2220D STC10-1 - Element note revised.

114. Loop 2220D STC10-2 Element note revised.

115. Loop 2220D STC10-3 Element note revised.

116. Loop 2220D STC10-4 - Usage changed from Required to Not Used.

117. Loop 2220D STC11-1 - Element note revised.

118. Loop 2220D STC11-2 Element note revised.

119. Loop 2220D STC11-3 Element note revised.

120. Loop 2220D STC11-4 - Usage changed from Required to Not Used.

121. Loop 2220D REF- Service Line Item Identification - Segment note added.

122. Loop 2220D DTP - Service Line Date - Segment note revised and D8 qualifier added.

Appendix A changed from “ACS X12 Nomenclature” to “External Code Sources”

123. Code source 131 removed.

124. Code source 240 removed.

Appendix B changed from “EDI Control Directory” to “Nomenclature”

Appendix C changed from “External Code Sources” to “EDI Control Directory

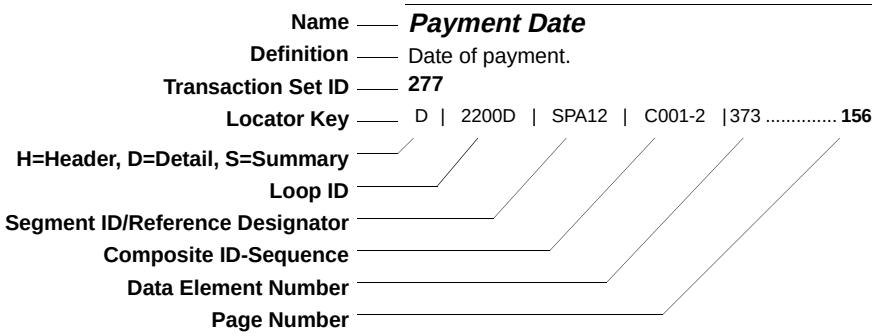
Appendix D Change Summary

125. Updated with changes from 004040X167 to 005010X214.

E Data Element Glossary

E.1 Data Element Name Index

This section contains an alphabetic listing of data elements used in this implementation guide. Consult the X12N Data Element Dictionary for a complete list of all X12N Data Elements. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Action Code

Code indicating type of action

D | 2200B | STC03 | - | 306 ..... **52**
D | 2200C | STC03 | - | 306 ..... **66**
D | 2220D | STC03 | - | 306 ..... **96**

Amount Qualifier Code

Code to qualify amount.

D | 2200B | AMT01 | - | 522 ..... **57**
D | 2200B | AMT01 | - | 522 ..... **58**
D | 2200C | AMT01 | - | 522 ..... **73**
D | 2200C | AMT01 | - | 522 ..... **74**

Bill Type Identifier

A code indicating the specific type of bill or claim.

D | 2200D | REF02 | - | 127 ..... **87**

Billing Provider Additional Identifier

Identifies another or additional distinguishing code number associated with the billing provider.

D | 2200C | REF02 | - | 127 ..... **70**

Billing Provider Identifier

Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2100C | NM109 | - | 67 ..... **62**

Claim Service Period

The beginning and end dates for the service period covered by a claim.

D | 2200D | DTP03 | - | 1251 ..... **89**

Claim Transaction Batch Number

This field corresponds to the BHT03 data element from the submitted claim transaction.

D | 2200B | TRN02 | - | 127 ..... **49**

Clearinghouse Trace Number

Unique tracking number for the transaction assigned by a clearinghouse.

D | 2200D | REF02 | - | 127 ..... **86**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format.

D | 2200A | DTP02 | - | 1250 ..... **41**
D | 2200A | DTP02 | - | 1250 ..... **42**
D | 2200D | DTP02 | - | 1250 ..... **89**
D | 2220D | DTP02 | - | 1250 ..... **101**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D | 2200A | DTP01 | - | 374 ..... **41**
D | 2200A | DTP01 | - | 374 ..... **42**
D | 2200D | DTP01 | - | 374 ..... **89**
D | 2220D | DTP01 | - | 374 ..... **101**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual.

D	2100A	NM101	-	98		**38**
D	2100B	NM101	-	98		**47**
D	2200B	STC01	C043-3	98		**51**
D	2200B	STC10	C043-3	98		**53**
D	2200B	STC11	C043-3	98		**54**
D	2100C	NM101	-	98		**61**
D	2200C	STC01	C043-3	98		**66**
D	2200C	STC10	C043-3	98		**68**
D	2200C	STC11	C043-3	98		**68**
D	2100D	NM101	-	98		**77**
D	2200D	STC01	C043-3	98		**81**
D	2200D	STC10	C043-3	98		**83**
D	2200D	STC11	C043-3	98		**84**
D	2220D	STC01	C043-3	98		**95**
D	2220D	STC10	C043-3	98		**97**
D	2220D	STC11	C043-3	98		**97**

Entity Type Qualifier

Code qualifying the type of entity.

D	2100A	NM102	-	1065		**38**
D	2100B	NM102	-	1065		**47**
D	2100C	NM102	-	1065		**61**
D	2100D	NM102	-	1065		**77**

Free Form Message Text

Text used to convey information related to the transaction.

D	2200D	STC12	-	933		**84**
D	2220D	STC12	-	933		**98**

Health Care Claim Status Category Code

Code indicating the category of the associated claim status code.

D	2200B	STC01	C043-1	1271		**50**
D	2200B	STC10	C043-1	1271		**52**
D	2200B	STC11	C043-1	1271		**53**
D	2200C	STC01	C043-1	1271		**65**
D	2200C	STC10	C043-1	1271		**67**
D	2200C	STC11	C043-1	1271		**68**
D	2200D	STC01	C043-1	1271		**80**
D	2200D	STC10	C043-1	1271		**82**
D	2200D	STC11	C043-1	1271		**83**
D	2220D	STC01	C043-1	1271		**94**
D	2220D	STC10	C043-1	1271		**96**
D	2220D	STC11	C043-1	1271		**97**

Health Care Claim Status Code

Code conveying the status of a health care claim.

D	2200B	STC01	C043-2	1271		**51**
D	2200B	STC10	C043-2	1271		**53**
D	2200B	STC11	C043-2	1271		**53**
D	2200C	STC01	C043-2	1271		**66**
D	2200C	STC10	C043-2	1271		**67**
D	2200C	STC11	C043-2	1271		**68**
D	2200D	STC01	C043-2	1271		**81**
D	2200D	STC10	C043-2	1271		**83**
D	2200D	STC11	C043-2	1271		**83**
D	2220D	STC01	C043-2	1271		**95**
D	2220D	STC10	C043-2	1271		**96**
D	2220D	STC11	C043-2	1271		**97**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

D	2000A	HL04	-	736		**36**
D	2000B	HL04	-	736		**45**
D	2000C	HL04	-	736		**60**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

D	2000A	HL01	-	628		**35**
D	2000B	HL01	-	628		**44**
D	2000C	HL01	-	628		**59**
D	2000D	HL01	-	628		**75**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D	2000A	HL03	-	735		**36**
D	2000B	HL03	-	735		**45**
D	2000C	HL03	-	735		**60**
D	2000D	HL03	-	735		**76**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

D	2000B	HL02	-	734		**44**
D	2000C	HL02	-	734		**59**
D	2000D	HL02	-	734		**75**

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

H		BHT01	-	1005		**33**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67).

D	2100A	NM108	-	66		**38**
D	2100B	NM108	-	66		**48**
D	2100C	NM108	-	66		**62**
D	2100D	NM108	-	66		**78**

Information Receiver First Name

The first name of the individual or organization who expects to receive information in response to a query.

D	2100B	NM104	-	1036		**47**

Information Receiver Last or Organization Name

The name of the organization or last name of the individual that expects to receive information or is receiving information.

D	2100B	NM103	-	1035		**47**

Information Receiver Middle Name

The middle name of the individual or organization who expects to receive information in response to a query.

D | 2100B | NM105 | - | 1037 ..... **47**

Information Receiver Primary Identifier

The Identification number of the individual or organization who expects to receive the information in response to a claim submission.

D | 2100B | NM109 | - | 67 ..... **48**

Information Source Application Trace Identifier

This is a unique trace number that identifies a specific transaction.

D | 2200A | TRN02 | - | 127 ..... **40**

Information Source Identifier

The Identification number of the individual or organization who provides the information in this transaction.

D | 2100A | NM109 | - | 67 ..... **39**

Information Source Name

The name of the organization who provides the information in this transaction.

D | 2100A | NM103 | - | 1035 ..... **38**

Information Source Process Date

The date the information request was processed by the Information Source's adjudication system.

D | 2200A | DTP03 | - | 1251 ..... **43**

Information Source Receipt Date

This is the receipt date of the 837 by the entity creating the 277 acknowledgment.

D | 2200A | DTP03 | - | 1251 ..... **41**

Line Item Charge Amount

Charges related to this service.

D | 2220D | SVC02 | - | 782 ..... **92**

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

D | 2220D | REF02 | - | 127 ..... **99**

Original Units of Service Count

Original units of service that were submitted by the provider (in days or units).

D | 2220D | SVC07 | - | 380 ..... **93**

Patient Control Number

Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment.

D | 2200D | TRN02 | - | 127 ..... **79**

Patient First Name

The first name of the individual to whom the services were provided.

D | 2100D | NM104 | - | 1036 ..... **78**

Patient Identification Number

The Identification number of the individual who is the patient in a claim within this transaction.

D | 2100D | NM109 | - | 67 ..... **78**

Patient Last Name

The last name of the individual to whom the services were provided.

D | 2100D | NM103 | - | 1035 ..... **77**

Patient Middle Name or Initial

The middle name or initial of the individual to whom the services were provided.

D | 2100D | NM105 | - | 1037 ..... **78**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D | 2100D | NM107 | - | 1039 ..... **78**

Payer Claim Control Number

A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN).

D | 2200D | REF02 | - | 127 ..... **85**

Pharmacy Prescription Number

A unique identification number assigned to the prescription claim for the purpose of identification.

D | 2220D | REF02 | - | 127 ..... **100**

Procedure Code

Code identifying the procedure, product or service.

D | 2220D | SVC01 | C003-1 | 235 ..... **90**
D | 2220D | SVC01 | C003-2 | 234 ..... **91**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D | 2220D | SVC01 | C003-3 | 1339 ..... **91**
D | 2220D | SVC01 | C003-4 | 1339 ..... **92**
D | 2220D | SVC01 | C003-5 | 1339 ..... **92**
D | 2220D | SVC01 | C003-6 | 1339 ..... **92**

Provider First Name

The first name of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

D | 2100C | NM104 | - | 1036 ..... **62**

Provider Last or Organization Name

The last name of the provider of care or name of the provider organization submitting a transaction or related to the information provided in or request by the transaction.

D | 2100C | NM103 | - | 1035 ..... **62**

Provider Middle Name

The middle name of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

D | 2100C | NM105 | - | 1037 ..... **62**

Provider Name Suffix

The name suffix of the provider of care submitting a transaction or related to the information provided in or request by the transaction.

D | 2100C | NM107 | - | 1039 ..... **62**

Provider of Service Information Trace Identifier

A placeholder number used to complete ASC X12 Syntax Loop requirements when providing status for a specific provider's group of claims.

D | 2200C | TRN02 | - | 127 ..... **64**

Quantity Qualifier

Code specifying the type of quantity.

D | 2200B | QTY01 | - | 673 ..... **55**
D | 2200B | QTY01 | - | 673 ..... **56**
D | 2200C | QTY01 | - | 673 ..... **71**
D | 2200C | QTY01 | - | 673 ..... **72**

Reference Identification

The identification value assigned by the sender for this particular transaction.

H | | BHT03 | - | 127 ..... **33**

Reference Identification Qualifier

Code qualifying the reference identification.

D | 2200C | REF01 | - | 128 ..... **70**
D | 2200D | REF01 | - | 128 ..... **85**
D | 2200D | REF01 | - | 128 ..... **86**
D | 2200D | REF01 | - | 128 ..... **87**
D | 2220D | REF01 | - | 128 ..... **99**
D | 2220D | REF01 | - | 128 ..... **100**

Revenue Code

A code that identifies a specific accommodation, ancillary service or billing calculation.

D | 2220D | SVC04 | - | 234 ..... **92**

Service Line Date

Date of service of the identified service line on the claim.

D | 2220D | DTP03 | - | 1251 ..... **101**

Status Information Action Code

Code indicating type of action taken for this data.

D | 2200D | STC03 | - | 306 ..... **82**

Status Information Effective Date

The date that the status information provided is effective.

D | 2200B | STC02 | - | 373 ..... **51**
D | 2200D | STC02 | - | 373 ..... **82**

Total Accepted Amount

Total dollar amount of the accepted claims.

D | 2200B | AMT02 | - | 782 ..... **57**
D | 2200C | AMT02 | - | 782 ..... **73**

Total Accepted Quantity

Total number of accepted claims.

D | 2200B | QTY02 | - | 380 ..... **55**
D | 2200C | QTY02 | - | 380 ..... **71**

Total Claim Charge Amount

The sum of all charges included within this claim.

D | 2200D | STC04 | - | 782 ..... **82**

Total Rejected Amount

Total dollar amount of the rejected claims.

D | 2200B | AMT02 | - | 782 ..... **58**
D | 2200C | AMT02 | - | 782 ..... **74**

Total Rejected Quantity

Total number of rejected claims.

D | 2200B | QTY02 | - | 380 ..... **56**
D | 2200C | QTY02 | - | 380 ..... **72**

Total Submitted Charges for Unit Work

Sum of the dollar amount for the claims being reported for an entity.

D	2200B	STC04	-	782	.....	**52**
D	2200C	STC04	-	782	.....	**67**

Trace Type Code

Code identifying the type of re-association which needs to be performed.

D	2200A	TRN01	-	481	.....	**40**
D	2200B	TRN01	-	481	.....	**49**
D	2200C	TRN01	-	481	.....	**64**
D	2200D	TRN01	-	481	.....	**79**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D		SE01	-	96	.....	**102**

Transaction Set Control Number

The unique identification number within a transaction set.

H		ST02	-	329	.....	**32**
D		SE02	-	329	.....	**102**

Transaction Set Creation Date

Identifies the date the submitter created the transaction.

H		BHT04	-	373	.....	**33**

Transaction Set Creation Time

Time file is created for transmission.

H		BHT05	-	337	.....	**34**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H		ST01	-	143	.....	**32**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H		BHT02	-	353	.....	**33**

Transaction Type Code

Code specifying the type of transaction.

H		BHT06	-	640	.....	**34**

Version, Release, or Industry Identifier

Code indicating the version, release, sub-release and industry identification of the EDI standard being used.

H		ST03	-	1705	.....	**32**