Claims Update

Attachments and Acknowledgments

Kepa Zubeldia, M.D.
April 7, 2005
Topics

• Transactions Latest Update
• Claims Attachments
  ◦ Attachments Concepts
  ◦ Future HIPAA Standard Transaction
  ◦ The WEDI/CMS Attachments Pilot
  ◦ Lessons Learned
  ◦ How electronic attachments work
  ◦ Generic Attachments
  ◦ Attachments as infrastructure for NHII
• Transactions Acknowledgments
  ◦ Concepts of transaction acknowledgments
  ◦ Closing the loop, avoiding/detecting the “black hole” effect
  ◦ Options considered by WEDI’s Policy Advisory Group
  ◦ Work in progress
Transactions Update (Yesterday’s NCVHS)

• Tony Trenkle new director of OHS
• New NPRM on Attachments to be published this summer.
  ◦ Currently in the clearance process
• Health Plan ID NPRM to be published in the Fall
• Second round of modifications to the Transactions and Code Sets to be published around the end of the year
  ◦ Draft of Version 5010 of the Implementation Guides just finished open comment period
  ◦ Much better defined requirements
• Enforcement procedures were published last week
• Enforcement Proposed Rule to be published later this spring for comment. Will have details on penalties
• CMS is 99.32% HIPAA compliant for the claims
  ◦ Tony did not know about Contingency Plan termination
• TCS complaints to date: 325
  ◦ 78% against private sector, 16% against Medicaid, 6% Medicare
Health Care Claim Attachments
Attachments Today

• Payer receives a claim or a request for referral, and needs more information…
  ◦ Prescription for DME (e.g. wheelchair)
  ◦ Consent form signed by patient
  ◦ Rehabilitation Treatment Plan information
  ◦ Copy of the EOB on primary payer’s letterhead
  ◦ X-rays (dental, spinal, etc.)
  ◦ Laboratory reports and/or results
  ◦ Any other piece(s) of clinical information

• Additional information does not belong in the claim form or 837. Sent as “attachment” to it.
Attachments Problems

• Provider does not understand the specific question from the payer or the additional information needed
  ◦ Send as much as possible and let the payer figure out what is it that they need
• Payer request is not specific enough
  ◦ Send as much as possible…
• Expensive to handle for payers and providers
  ◦ Cost estimates from $15 to $50 per attachment
• How do you comply with “Minimum Necessary”?  
• Between 3 and 50% of the claims (depending on the payer, the provider and the specialty) are sent with attachments or need attachments later
Attachments Problems (cont.)

• Some payers: One strike and you are out
  ◦ If you don’t send ALL the additional information required by the payer, the claim is denied.
  ◦ Because of the high cost of processing attachments, there is no “interaction” between provider and payer “until you get it right”

• High claim denial rate

• Clinical data is normally not kept in the “administrative” system that generates claims
  ◦ Expensive manual process
Attachment Nirvana

• Provider understands what to send as “attachment” to the claim or referral
  ◦ Because it is predictable
    ▪ E.g., State Law requires signed consent form
    ▪ Payers publish their attachment requirements
      ▫ Better: Industry consensus on attachment requirements
  ◦ Because the payer requests are clear to the provider
    ▪ Standard definitions. Codified requests.

• Provider only sends the required data as attachment
  ◦ Better: The attachment is in a standard format and codified by provider

• Payer automatically processes codified attachments
  ◦ Human intervention required only for non-codified attachments
Standard Electronic Attachments

• Standards:
  ◦ Standard codified questions in the requests from the payers to the providers
  ◦ Standard attachment format for:
    ▪ Structured and codified attachments
    ▪ Structured, non-codified attachments
    ▪ Not structured attachments

• Benefits:
  ◦ Provider knows what the payer wants
  ◦ Payer gets it electronically
    ▪ If codified, it could be processed automatically
  ◦ Cost reduction for both providers and payers
  ◦ Predictability of reimbursement cycle
The HIPAA Attachments

• Electronic attachment standard
  ◦ Familiar X12 transaction sets
    ▪ Request for attachment: 277 (new IG)
    ▪ Response with attachment: 275 (new IG)
    ▪ Unsolicited attachment with claim: 275 (new IG)
  ◦ Clinical Document in HL7/CDA encapsulated inside the X12 “attachment” transaction
    ▪ Bridge between clinical and administrative

• Standard data content
  ◦ Certain attachments standard data content adopted by HIPAA
The HIPAA initial set

The upcoming NPRM with propose the adoption of attachment standards for:

1. Ambulance
2. Emergency Department
3. Rehabilitative Services
4. Lab Results
5. Medications
6. Clinical Notes
The HIPAA Law (1996)

“SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—
“(1) IN GENERAL.—If a person desires to conduct a transaction
referred to in section 1173(a)(1) with a health plan as a standard
transaction—
“(A) the health plan may not refuse to conduct such transaction
as a standard transaction;
“(B) the insurance plan may not delay such transaction, or
otherwise adversely affect, or attempt to adversely affect, the
person or the transaction on the ground that the transaction is a
standard transaction; and
“(C) the information transmitted and received in connection with
the transaction shall be in the form of standard data elements of
health information.
Keeping the focus on the goal

- The goal is not HIPAA compliance
- The goal is to reduce the administrative cost, fewer rejections and to simplify the process
- The initial 6 HIPAA attachments are only a step in the right direction
- Other attachment standards are in the works:
  - Home Health claim and pre-certification
  - Medicaid: Consent forms, CPHS
  - Periodontal Charts (HL7 working with ADA)
  - DME
  - Unspecified Content “generic” attachment
    - A standard for “Non-standard attachments”
The attachments bigger picture

• A mechanism to transmit clinical information in support of the administrative process
  ◦ Not just in support of a “claim”

• The standardization of the data content by HIPAA is a good step in the right direction
  ◦ The attachment mechanism, even with non-standard data content, still has very positive ROI

• Same infrastructure can be used to support generic clinical data transfers
The Attachments Pilot

- Coordinated by WEDI, X12, HL7 and CMS
- Funded by CMS
- Prove the feasibility and interoperability of attachments independently implemented by a Medicare contractor and several providers
  - Empire Medicare
  - Memorial Sloan Kettering
  - Montefiore
  - NextGen brings several smaller providers
- Measure the ROI of standard electronic attachments
- Attachment Industry Survey
  - WEDI, HL7, X12, AFEHCT
  - Separate surveys for Providers, Payers, Vendors
Lessons Learned (by Kepa)

• It is important to read the Implementation Guides
  ◦ Don’t try this without reading the instructions
• Start with one attachment type
  ◦ You can get the others on an “as needed” basis
  ◦ Most providers will not implement all 6 of them at the same time
• Walk before you run
  ◦ Start with simple scanned images in attachments
  ◦ Advance to structured attachments later
  ◦ Graduate to codified attachments when you can
• Here is why…
ROI
A range of possibilities

• Attachments can be simple
  ◦ Paper records → Scanned image → Attachment
  ◦ Technologically simple
    ▪ Replaces fax or paper mailings
    ▪ Document “indexing” provided by healthcare provider
      ▫ E.g. “The attached image is the lab report you requested on 2/28/05 for claim #1234567890”
      ▫ No more paper attachments getting lost
  ◦ Inexpensive
  ◦ Substantial ROI
    ▪ For both providers and payers
Getting to Nirvana

- Codified structured attachments require the existence of an EMR system that can produce the information codified in HL7
- Codified attachments can be automatically processed by the payer
- Highest ROI and fastest payment of claims
- More complex implementation than the simpler “scanned paper” option
  - Higher investment
  - Higher return on your investment
Electronic Attachments 101

- Three types of attachments:
  - Structured and codified attachments
  - Structured, non-codified attachments
  - Not structured attachments

- One code set
  - LOINC
  - Codified request for additional information
    - E.g. “I need the patient’s weight”
  - Codified response
    - E.g. “Here is the patient’s stated weight”
Non-Structured Attachment

Submitter (Provider) Information (Name, ID)
Receiver (Payer) Information (Name, ID)
Patient Information (Name, ID)
Claim Information (Date, type, reference, control number)
Attachment type
Question that was asked by payer (LOINC)
Response from provider (LOINC)

Scanned image (fax, pdf, rtf, html, or jpeg)
Non-codified, Structured Attachment

Submitter (Provider) Information (Name, ID)
Receiver (Payer) Information (Name, ID)
Patient Information (Name, ID)
Claim Information (Date, type, reference, control number)
Attachment type
Question that was asked by payer (LOINC)
Response from provider (LOINC)

<section>
    <caption>History of Present Illness</caption>
    <paragraph>
        <content>
            Henry Levin, the 7th is a 67 year old male referred for further asthma management. Onset of asthma in his teens. He was hospitalised twice last year, and already twice this year. He has not been weaned off steroids for the past several months.
        </content>
    </paragraph>
</section>

Marked-up Text
(ML7 v3 XML CDA mark-up)
Codified, Structured Attachment

Submitter (Provider) Information (Name, ID)
Receiver (Payer) Information (Name, ID)
Patient Information (Name, ID)
Claim Information (Date, type, reference, control number)
Attachment type
Question that was asked by payer (LOINC)
Response from provider (LOINC)

<section>
<caption>EMS TRANSPORT, DESTINATION SITE INFORMATION</caption>
<caption_cd V="15512-7"/>
<caption>
<paragraph>
<caption>EMS TRANSPORT DESTINATION SITE NAME</caption>
<caption_cd V="18582-7"/>
<caption>
<content>Alfred Newman Neurological Institute</content>
<caption>
<paragraph>
<caption>EMS TRANSPORT, DESTINATION SITE ADDRESS</caption>
<caption_cd V="18583-8"/>
<caption>
<content>123 Main St; Anytown, UT 85912</content>
<local_markup descriptor="AD">
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<local_attr name="CTY" value="Anytown"/>
<local_attr name="STA" value="UT"/>
<local_attr name="ZIP" value="85912"/>
</local_markup>
</content>
</paragraph>
</section>

HL7 CDA codified
(ML7 v3 XML CDA mark-up)
XML Stylesheets

XSL Style Sheet:
Mapping rules in a standard language

Style Sheet Processor

Birthdate: September 24, 1932

History of Present Illness

Henry Levin, the 7th is a 67 year old male referred for further asthma management. Onset of asthma in his teens. He was hospitalized twice last year, and already twice this year. He has not been weaned off steroids for the past several months.

Past Medical History

- Asthma

HTML, PDF, Word-Processing, XML, Data File...
Attachment Models

• Unsolicited attachment sent with the claim
  ◦ Provider knows the attachment will be required
    ▪ E.g., consent form signed by patient
• Attachment sent to payer as response to a payer’s request for additional information
  ◦ HIPAA Standard request for information – 277
    ▪ LOINC-codified request
  ◦ Attachment response – 275
    ▪ Non-structured, structured, codified
    ▪ LOINC matches answer to the question
• Entity to entity exchange of patient information
Linking the Transactions separate transmission

Attachment **Request** from the Payer

ISA Interchange Control Header
GS Functional Group Header
**ST 277** Transaction Set Header: Request
...TRN contains *payer’s control number*

**STC** specific data requested

SE Transaction Set Trailer
GE Functional Group Trailer
IEA Interchange Control Trailer

Attachment **Response** from the Provider

ISA Interchange Control Header
GS Functional Group Header
**ST 275** Transaction Set Header: Response
...TRN contains *payer’s control number*

**STC** specific data requested

...**BIN** specific data response

SE Transaction Set Trailer
GE Functional Group Trailer
IEA Interchange Control Trailer
### Too Many LOINC Codes?
Not Very Many for the HDV

<table>
<thead>
<tr>
<th>Booklet</th>
<th>Questions</th>
<th>Answers (HDV)</th>
<th>Answers (CDV)</th>
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<tr>
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<tr>
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<td>18</td>
<td>18</td>
<td>&gt; 20,000</td>
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<td>Medications</td>
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<td>22</td>
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<tr>
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<td>18</td>
<td>18</td>
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<tr>
<td><strong>Total</strong></td>
<td>444</td>
<td>310</td>
<td>&gt; 20,800</td>
</tr>
</tbody>
</table>

Codes Needed to Prepare 277
Codes Needed to Prepare Human-Decision Variant
Codes Needed to Prepare Computer-Decision Variant
Unspecified Content (generic) Attachment

- Request for Additional Information - 277
  - LOINC-codified request
- Standard response - 275
  - Echo LOINC code from request
  - Include the requested data
    - Not structured (scanned, text, pdf, etc.)
    - Structured, non-codified (HL7 CDA XML mark-up)
    - Structured and codified (HL7 CDA codified)
- Entity to entity exchange of patient information
  - Not a HIPAA attachment. Voluntary adoption
  - Transmission mechanism for EMR or anything else
Non-Structured Attachment

Submitter (Provider) Information (Name, ID)
Receiver (Payer) Information (Name, ID)
Patient Information (Name, ID)
Claim Information (Date, type, reference, control number)
Attachment type
Question that was asked by payer (LOINC)
Response from provider (LOINC)

Scanned image (fax, pdf, rtf, html, or jpeg)
Non-Structured Attachment

Submitter (Provider) Information (Name, ID)
Receiver (Payer) (Provider) Information (Name, ID)
Patient Information (Name, ID)
Claim Encounter Information (Date, type, reference, control number)
Attachment type
Question Document that was requested asked by payer (LOINC)
Response from provider (LOINC)

Scanned image (fax, pdf, rtf, html, or jpeg)
Summary

• Claim attachments are a bridge between administrative and clinical data
• Can be implemented as simple image or text data transfer. Later migrate to codified HL7
• Low startup cost. Low technology impact
• Impact on cash flow today. Very high ROI
• Can be leveraged for clinical data transfer
• Full functionality available today. The HIPAA will only standardize a small part. Catalyst.
Making Sense of Transaction Acknowledgments for HIPAA Transactions
Topics

• Transaction Acknowledgement Options
  ◦ Generic Acknowledgements
  ◦ Transaction Specific Acknowledgements

• The details of the Acknowledgement transactions
  ◦ TA1, 997, 999, 277, 824
  ◦ Similarities, differences, advantages, disadvantages
The Ack/Nak family scope

- Scope of acceptance or rejection
  - X12 interchange
  - Functional Group
  - Transaction Set
  - Part of a transaction set
    - Claim
    - Eligibility Inquiry
    - Claim Status Inquiry
    - Enrollment
    - Claim payment
    - CDA attachment
    - Etc.
The claim transaction lifetime

Prepare X12 transaction → Validate → Transmit to Trading Partner

Translate to internal format → Validate → Receive from Trading Partner

Meets business needs? → Go → Adjudicate or process → Response to Submitter → Transmit to Trading Partner

Process Response → Validate → Transmit to Trading Partner
Ack/Nak Concepts

- Multiple validation points through lifetime
- Success at one point does not guarantee ultimate success
- Failure at any one point means failure
- As transaction progresses, the granularity of the rejection becomes smaller
- Expect multiple notifications of partial results
Standard Acknowledgments

- The beauty of standards is that there are so many to choose from!
  - TA1
  - 997
  - 999
  - 277
  - 824
  - 102
  - 864
  - 271
  - 278
Ack/Nak transactions

• X12 EDI syntax
  ◦ EDI Interchange, File level
    ▪ TA1
  ◦ Functional Group, Transaction Set
    ▪ 997

• Implementation Guide requirements
  ◦ Functional Group, Transaction Set
    ▪ 999
Ack/Nak transactions

• Application Level
  ◦ Transaction specific
    ▪ 271 Eligibility Response (AAA)
    ▪ 277 Claim Status Response (STC)
    ▪ 278 Healthcare Services Review Response (AAA)
    ▪ 102 for HL7 CDA part of Attachments
  ◦ Claim acknowledgment
    ▪ 277 Health Care Claim Acknowledgement
  ◦ All transactions (including claims)
    ▪ 824 Application Acknowledgement

• Proprietary
  ◦ Text report (encapsulated inside 864 or 102?)
TA1

- Identifies ISA/IEA problems
- If something fails the entire *interchange* (ISA to IEA) is rejected
- If you get one of these rejections you have a translator issue
  - Typically easy to fix
  - Caught early on in the development / test cycle
TA1 Codes

000 No error
001 The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002 This Standard as Noted in the Control Standards Identifier is Not Supported.
003 This Version of the Controls is Not Supported
004 The Segment Terminator is Invalid
005 Invalid Interchange ID Qualifier for Sender
006 Invalid Interchange Sender ID
007 Invalid Interchange ID Qualifier for Receiver
008 Invalid Interchange Receiver ID
009 Unknown Interchange Receiver ID
010 Invalid Authorization Information Qualifier Value
011 Invalid Authorization Information Value
012 Invalid Security Information Qualifier Value
013 Invalid Security Information Value
014 Invalid Interchange Date Value
015 Invalid Interchange Time Value
016 Invalid Interchange Standards Identifier Value
017 Invalid Interchange Version ID Value
018 Invalid Interchange Control Number Value
019 Invalid Acknowledgment Requested Value
020 Invalid Test Indicator Value
021 Invalid Number of Included Groups Value
022 Invalid Control Structure
023 Improper (Premature) End-of-File (Transmission)
024 Invalid Interchange Content (e.g., Invalid GS Segment)
025 Duplicate Interchange Control Number
026 Invalid Data Element Separator
027 Invalid Component Element Separator
028 Invalid Delivery Date in Deferred Delivery Request
029 Invalid Delivery Time in Deferred Delivery Request
030 Invalid Delivery Time Code in Deferred Delivery Request
031 Invalid Grade of Service Code
997 Functional Acknowledgment

**FUNCTIONAL GROUP=FA**

This X12 Transaction Set contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

### Table 1

<table>
<thead>
<tr>
<th>pos.no</th>
<th>seg.id</th>
<th>name</th>
<th>req.des</th>
<th>max</th>
<th>loop.rep</th>
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<tbody>
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<td>SE</td>
<td>Transaction Set Trailer</td>
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<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

1/0100 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments.

Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/0100 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.
997

- Detects Functional Group (GS – GE) or Transaction Set (ST- SE) problems
- Reports ONLY problems concerning X12 syntax
- Finest granularity of rejection is at the ST-SE level
- Cannot report on a specific “claim”
- Cannot report on Implementation Guide errors
  - Attempts to report IG errors with 997 result in very obscure reports due to the scarcity of error codes (22)
- Error location referred as segment count (ST = 1)
- Error report only makes sense if you have access to the original X12 file that was transmitted
  - Most providers cannot use the 997
997 Codes

Loop/Segment Errors
1. Unrecognized segment ID
2. Unexpected segment
3. Mandatory segment missing
4. Loop Occurs Over Maximum Times
5. Segment Exceeds Maximum Use
6. Segment Not in Defined Transaction Set
7. Segment Not in Proper Sequence
8. Segment Has Data Element Errors
9. Required Segment Missing

Element Errors
1. Mandatory Data Element Missing
2. Conditional required data element missing
3. Too many data elements
4. Data element too short
5. Data element too long
6. Invalid character in data element
7. Invalid code value
8. Invalid Date
9. Invalid Time
10. Exclusion Condition Violated
11. Too Many Repetitions
12. Too Many Components
999 Implementation Acknowledgment

FUNCTIONAL GROUP=FA

This X12 Transaction Set contains the format and establishes the data contents of the Implementation Acknowledgment Transaction Set (999) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical and relational analysis of the electronically encoded documents, based upon a full or implemented subset of X12 transaction sets. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

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<td>Transaction Set Trailer</td>
<td>M</td>
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</tr>
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</table>
999

• Detects Functional Group (GS – GE) or Transaction Set (ST- SE) problems
• Reports problems concerning X12 syntax and also IG requirements
• Finest granularity of rejection is at the ST-SE level
• Cannot report on a specific claim
• Can report on Implementation Guide errors
  ◦ In addition to the 22 error codes for the 997, the 999 has 22 new codes specific for IG error reporting.
  ◦ Can report the “error context” for situational errors
• Error location referred as segment count (ST = 1)
• Error report only makes sense if you have access to the original X12 file that was transmitted
  ◦ Most providers cannot use the 999
999 Codes

All of the same codes of the 997, plus:

Segment Errors

1. Implementation Required Segment Missing
2. Implementation Loop Occurs Over Maximum Times
3. Implementation Segment Exceeds Maximum Use
4. Implementation "Not Used" Segment Present
5. Segment Has Implementation Data Element Errors
6. Implementation Dependent Segment Missing
7. Implementation Loop Occurs Under Minimum Times
8. Implementation Segment Below Minimum Use
9. Implementation Dependent "Not Used" Segment Present

Element Errors

1. Implementation Required Data Element Missing
2. Implementation Conditional Data Element Missing
3. Implementation Data Element too Short
4. Implementation Data Element too Long
5. Implementation Invalid Character in Data Element
6. Code Value Not Used in Implementation
7. Implementation Exclusion Condition Violated
8. Implementation Too Many Repetitions
9. Implementation Dependent Data Element Missing
10. Implementation "Not Used" Data Element Present
11. Implementation Too Few Repetitions
12. Implementation Pattern Match Failure
13. Implementation Dependent "Not Used" Data Element Present
### Table 2 - Detail, Information Source Level

<table>
<thead>
<tr>
<th>PAGE #</th>
<th>POS. #</th>
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<tr>
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<td>025</td>
<td>AAA</td>
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<td>9</td>
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<tr>
<td>163</td>
<td>030</td>
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### Table 2 - Detail, Information Receiver Level

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<th>LOOP REPEAT</th>
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<td>9</td>
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<td>184</td>
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<td>AAA</td>
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### Table 2 - Detail, Subscriber Level

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### Table 2 - Detail, Dependent Level

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<th>LOOP REPEAT</th>
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<tr>
<td></td>
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</table>

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271

• Reports errors encountered during the 270 Eligibility Inquiry processing
  ◦ Host not available
  ◦ Data elements missing or invalid in 270 Request
  ◦ Incomplete eligibility search criteria
  ◦ Patient/subscriber not found

• Error codes are sent in AAA segment
• Transaction Accepted/Rejected indicator
• Recommended follow-up action
271 AAA Codes

Information Source 2000A (4 codes)
- Authorized Quantity Exceeded
- Authorization/Access Restrictions
- Unable to Respond at Current Time
- Invalid Participant Identification

Information Source 2100A (6 codes)
- Authorized Quantity Exceeded
- Authorization/Access Restrictions
- Unable to Respond at Current Time
- Invalid Participant Identification
- No response received – Transaction terminated
- Payer Name or Identifier Missing

Information Receiver 2100B (13 codes)
- Required Application Data Missing
- Authorization/Access Restrictions
- Invalid/Missing Provider Identification
- Invalid/Missing Provider Name
- Invalid/Missing Provider Specialty
- Invalid/Missing Provider Phone Number
- Invalid/Missing Provider State
- Invalid/Missing Referring Provider Identification Number
- Provider Ineligible for Inquiries
- Provider Not on File
- Invalid Participant Identification
- Invalid or Missing Provider Address
- Payer Name or Identifier Missing

Subscriber 2100C (29 codes)
- Required Application Data Missing
- Unable to Respond at Current Time
- Invalid/Missing Provider Identification
- Invalid/Missing Provider Specialty
- Invalid/Missing Provider State
- Invalid/Missing Referring Provider Identification Number
- Provider Is not Primary Care Physician
- Provider Not on File
- Service Dates not Within Provider Plan Enrollment
- Inappropriate Date
- Invalid/Missing Date(s) of Service
- Invalid/Missing Date-of-Birth
- Date of Birth Follows Date(s) of Service
- Date of Birth Precedes Date(s) of Service
- Date of Service not within allowable inquiry period
- Date of Service in Future
- Invalid/Missing Patient ID
- Invalid/Missing Patient Name
- Invalid/Missing Patient Gender Code
- Patient Not Found
- Duplicate Patient ID Number
- Patient Birth Date Does Not Match That for the Patient in the Database
- Invalid/Missing Subscriber/Insured ID
- Invalid/Missing Subscriber/Insured Name
- Invalid/Missing Subscriber/Insured Gender Code
National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Claim Status Request and Response

276/277

ASC X12N 276/277 (004010X093)
National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim Request for Additional Information

277

ASC X12N 277 (004050X150)
National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Payer
Unsolicited Claim Status

277

ASC X12N 277 (003070X070)
National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Claim Acknowledgement

277

ASC X12N 277 (004040X167)
## 277 Health Care Information Status Notification

### Table 1 - Header

<table>
<thead>
<tr>
<th>PAGE #</th>
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<td>32</td>
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<td>ST</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>34</td>
<td>0200</td>
<td>BHT</td>
<td>Beginning of Hierarchical Transaction</td>
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### Table 2 - Information Source Detail

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<tr>
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<td>0500</td>
<td>NMH</td>
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### Table 2 - Information Receiver Detail

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<td>49</td>
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<td>NMH</td>
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<td>55</td>
<td>1000</td>
<td>STC</td>
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<td>&gt;1</td>
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### Table 2 - Billing/Pay-To Provider of Service Detail

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### Table 2 - Patient Detail

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</table>
The 277 transactions IGs

• Four DIFFERENT Implementation Guides
  ◦ 277 Health Care Claim Status Response (4010)
    ▪ The 277 is a response to a request for claim status information. It can also respond to errors in the request, much like the 271 does. It uses the STC segment instead of AAA.
  ◦ 277 Health Care Claim Request for Additional Information (4050)
    ▪ A payer’s request for additional information to support a healthcare claim. Part of the Attachment request/response. Uses LOINC codes. Does not use Claim Status codes.
  ◦ 277 Health Care Payer Unsolicited Claim Status (3070)
    ▪ An unsolicited listing of claims pending adjudication in a payer’s system. Sometimes used as front-end acknowledgment.
  ◦ 277 Health Care Claim Acknowledgement (4040)
    ▪ An application acknowledgement response to the 837 claim/encounter transactions. Mandated by NJ DOBI.

• Differences are significant enough to require separate implementation guides for the 277
  ◦ Additional Utah UHIN guide for front-end acknowledgment (4020)
  ◦ The Claim Status Codes are the same in all four cases.
277 Front-end Claim Acknowledgment

- Standard Implementation Guide 004040X167
- Reports front-end claim validation errors or acknowledgement of receipt of claim
- Reports claim by claim instead of segment by segment or loop by loop.
- Includes batch summary counts and dollars
- Can include the payer’s internal claim control number
- Exactly the same claim status codes as the other 277
  - Codes are not yet very specific for acknowledgement
- Allows for free-form error message text
- Relatively easy to produce by application, even after the 837 has been translated to a flat file
Claim Status Codes

• Total of 464 Codes
  ◦ Request for Additional Information
  ◦ Claim Status
  ◦ Error type

• Only about 105 codes usable for front-end acknowledgment

  Generic (dump) codes
  ▪ 21 - Missing or Invalid Information
  ▪ 23 - Returned to Entity
  ▪ 122 - Missing/invalid data prevents payer from processing claim.
ASC X12N/005010X186

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Implementation Guide and Application Reporting (824)

MAY 2004
# Application Advice

## Table 1 - Header

<table>
<thead>
<tr>
<th>PAGE #</th>
<th>POS. #</th>
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<th>REPEAT</th>
<th>LOOP REPEAT</th>
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## Table 2 - Detail

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<th>REPEAT</th>
<th>LOOP REPEAT</th>
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<td>Individual or Organizational Name</td>
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**Note:**

- Loop ID - 1000A SUBMITTER NAME
- Loop ID - 1000B RECEIVER NAME
- Loop ID - 2000 ORIGINAL TRANSACTION IDENTIFICATION
- Loop ID - 2100 ERROR OR INFORMATIONAL MESSAGE LOCATION
824 Application Acknowledgment

- X12 Standard Technical Report Type 3 Draft 005010X186
- Simple, easy to use transaction set
- Can report at the X12 segment or loop number
- Can also report claim by claim or “item by item” or by batch
- Reports error in the context of a claim and in X12 context
- Includes the “error context” for situational errors (as in 999)
- Very flexible reporting, serves as transaction acknowledgement for all healthcare transactions
- Has been in use by the banking industry to report errors in the 835 and 820 for over 10 years
- Insurance-specific Implementation Guide available in 2003
  - New draft available as TR3 in 2005
- Error codes specific to transaction front-end validation
- Error codes still under development
  - Allows the use of proprietary error codes if no standard code is available
  - Allows for a free-form error message in addition to the error code
  - Facilitates transition to standard codes
  - Expect to see proprietary error codes for some time
### 824 Codes (available as “E” and “W”)

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<th>Code</th>
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<th>Code</th>
<th>Description</th>
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<td>Missing/Invalid receiver identifier</td>
<td>E031</td>
<td>Required segment missing</td>
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<tr>
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<td>Missing/Invalid member identifier</td>
<td>E032</td>
<td>Required element missing</td>
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<td>Missing/Invalid subscriber identifier</td>
<td>E033</td>
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<td>Missing/Invalid patient identifier</td>
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<td>Situational segment missing</td>
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<td>E006</td>
<td>Missing/Invalid plan sponsor identifier</td>
<td>E035</td>
<td>Situational element missing</td>
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<td>Missing/invalid payee identifier</td>
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<td>&quot;&quot;&quot;Not Used&quot;&quot; data element present&quot;</td>
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<td>E028</td>
<td>Sender not authorized for this transaction</td>
<td>E059</td>
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</table>
Which one to use?

• Consider your audience
  ◦ Who gets the acknowledgment report/transaction?
  ◦ What are they going to do with it?
    ▪ Rejected claims (or equivalent “unit of work”) only
    ▪ Accepted claims / acknowledgment of receipt

• Need more than one Ack transaction?
  ◦ TA1 and 997 or 999 for EDI / IG errors
    ▪ Loops, Segments, Elements
    ▪ Error reporting only
  ◦ 277 or 824 for claims / units reporting
    ▪ Business application reporting
    ▪ Both, error reporting and acknowledgment of receipt for valid units of work
Transactions vs. human readable

• Codified transactions
  ◦ Easily automated
    ▪ Clearinghouse, Vendor
  ◦ Error codes issues
    ▪ Standard codes lose specificity
    ▪ Proprietary codes difficult to automate

• Human readable
  ◦ Should be understandable by providers
  ◦ Reporting granularity
    ▪ Report each “unit of work”, rejected, accepted
    ▪ EDI segment reports vs. claim by claim reports
Examples

• Transactions
  ◦ 824 Transaction Set + Batch levels only
  ◦ 824 Rejected and accepted claims, no warnings
  ◦ 824 All claims acknowledged, include warnings
  ◦ 277 Acknowledgment
  ◦ 277 Utah UHIN version
Sample 824 – No accepted claims detail

Transaction Set Summary

Batch Summary

<table>
<thead>
<tr>
<th>Transaction Set</th>
<th>Batch Summary</th>
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<tbody>
<tr>
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</tbody>
</table>

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Sample 824 – Claim by claim + Warnings

### Transaction Set Summary

- **Claim by claim detail**
  - (including errors/warnings on accepted claims)

### Batch Summary

- **Transaction Set**
- **Summary**

---

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<table>
<thead>
<tr>
<th>Claim</th>
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| HL | 3/2/19/1 |
| NM1 | 85/2/GOOD AND ASSOCIATES |
| TRN | 1/1 |
| STC | A1/19:65/WQ/16970.33 |
| QTY | QA/5 |
| QTY | QC/0 |
| AMT | YU/16970.33 |
| AMT | YY/0 |

| HL | 4/3/PT |
| NM1 | 5/1/SMITH/TED |
| TRN | 22646296 |
| STC | A1/21:65/WQ/16970.33 |
| QTY | QA/5 |
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| AMT | YU/16970.33 |
| AMT | YY/0 |

| HL | 5/3/PT |
| NM1 | 5/1/BROWN/ROBERT/W|JR/MI/886553737 |
| TRN | 278945639637 |
| STC | A1/126:65/20040913/WQ/1100.67 |
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| AMT | YY/0 |

| HL | 6/3/PT |
| NM1 | 5/1/JAMES/JIM/DD/MI/011332211 |
| TRN | 289437450584598 |
| STC | A1/126:65/20040913/WQ/12642.16 |
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| HL | 7/3/PT |
| NM1 | 5/1/MAE/SALLIE/MM/987656321 |
| TRN | 2984576898 |
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| HL | 8/3/PT |
| NM1 | 5/1/DOE/JANE/MM/777553333 |
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| SE | 52/0001 |
Sample 277 004020X070 UHIN

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BHT*0010*06*0.1*20040913*200256*TH~
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NM1*AY2*CONSOLIDATED INSURANCE CO*****46*00000~
PER*IC*CUSTOMER SUPPORT*TE*8005551212~
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DTP*050*D8*20040913~
DTP*009*D8*20040913~

HL*2*1*21*1~
NM1*41*2*PHIL GOOD, M.D.****46*TXX23~
HL*3*2*19*1~
NM1*85*2*GOOD AND ASSOCIATES*****24*555677777~
TRN*1*1~
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REF*1C*99983000~

HL*4*3*PT:0~
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TRN*2*26462967~
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REF*D9*2004091498765432100003~

HL*7*3*PT:0~
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TRN*2*984576898~
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HL*8*3*PT:0~
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TRN*2*8767657645765~
REF*D9*2004091498765432100005~

SE*47*0001~
Questions

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Kepa.Zubeldia@claredi.com