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MEMORANDUM
On
HIPAA STANDARD TRANSACTIONS
IMPLEMENTATION GUIDE LEGAL REQUIREMENTS

June 26, 2003

This is a compilation of excerpts from the HIPAA Implementation Guides (IGs) for the Health Care Claim Status Request and Response (276/277), Health Care Claim Payment/Advice (835), Health Care Claim: Institutional (837 I), and Health Care Eligibility Benefit Inquiry and Response (270/271).

The Implementation Guides are incorporated by reference into the rules for HIPAA Transactions and Code Sets. Therefore, the instructions and specifications in the Implementation Guides are regulatory requirements for processing HIPAA standard transactions.

These particular excerpts are complied and annotated by Claredi Corporation to demonstrate that payers must identify errors on a claim-by-claim (or, for non-claims, on a transaction-by-transaction) basis. The information about errors must then be sent to submitters so that they can correct the errors and re-submit as appropriate.

These excerpts conclusively demonstrate that:

1. A transaction using the HIPAA-presecribed format and code sets does not lose its character as a HIPAA "standard transaction" if it contains an error or errors.
2. The IGs contemplate that standard transactions will have errors, and set out how payers are to deal with the errors – by identifying material errors and notifying submitters, so that the submitters can correct and resubmit the affected transactions. For these purposes, a material error is one that would prevent the payer from adjudicating the transaction or otherwise processing it to completion. (Payers may issue "Companion Guides" to explain what errors are material. Materiality of errors may also be dealt with in trading partner agreements. In both cases, the Companion Guides or trading partner agreements must be consistent with the detailed requirements of the IGs and the transactions rules.)
3. HIPAA rules do not require payers to reject single or batched transactions because of an error or errors.
4. If a payer rejects batched transactions because of errors in a small number of transactions in the batch, the payer is violating requirements in the IGs – and is acting illegally.

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim Status Request and Response

276/277

ASC X12N 276/277 (004010X093)

May 2000

X12N guide for this business function of these transaction sets. Previous documentation for these transaction sets includes tutorials based upon Version 3, Release 7, Sub-release 0 (003070) of the 276 and 277.

1.3 Business Use

The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following:

- a solicited response to a health care claim status request (276)
- a notification about health care claim(s) status, including front end acknowledgments
- a request for additional information about a health care claim(s)

One of the uses of the 277 is to respond to inquiries about the status of the front end acknowledgment of the claim(s).

The 276 is used only in conjunction with the 277 Health Care Claim Status Response. Therefore, this implementation guide addresses the paired usage of the 276 as a **request for claim status** and the 277 as a **response to that request.**

There are other guides that are NOT Standards under HIPAA, but may be used voluntarily.

Separate implementation guides were developed to detail using the 277 Health Care Payer Unsolicited Claim Status and the 277 Health Care Claim Request for Additional Information.

It is the intent of the authors that claim status requests processed in a realtime mode will only provide a status of a claim that has been accepted by the payers' adjudication system within 90 days from the date of the inquiry.

Claim status requests that are processed in a batch mode, will return claim status information that is available on the payers' adjudication system that has not been purged.

1.3.1 Health Care Claim Status Request

The 276 is used to transmit request(s) for status of specific health care claim(s).

Authorized entities involved with processing the claim need to track the claim's current status through the adjudication process. The purpose of generating a 276 is to obtain the current status of the claim within the adjudication process. Status information can be requested at the claim and/or line level.

The 276 includes information that is necessary for the payer to identify the specific claim in question. The primary, or unique, identifying element(s) may be supplied to obtain an exact match. However, when the requester does not know the unique element(s), the claim generally is located by supplying several parameters including the provider number, patient identifier, date(s) of service, and submitted charge(s) from the original claim.

1.3.2 Health Care Claim Status Response

The payer uses the 277 Health Care Claim Status Response to transmit the current status within the adjudication process to the requester. When the 276 does not uniquely identify the claim within the payer's system, the response may include multiple claims that meet the identification parameters supplied by the requester.

Examples of status locations within a payer's adjudication process, which vary from payer to payer, may include the following:

These are the three typical uses of the claim status response transaction. They contemplate iterative response cycles.

- pre-adjudication (accepted/rejected claim status)
- claim pended for development (incorrect/incomplete claim(s) within adjudication process) or suspended claim(s) requesting additional information
- finalized claims

Further defined, finalized claims may have outcomes that include the following:

- finalized rejected claim(s)
- finalized denied claim(s)
- finalized approved claim(s) pre-payment
- finalized approved claim(s) post-payment

The status locations are described briefly to convey a cohesive understanding of the use of the 277 Health Care Claim Status Response.

1.3.2.1 Pre-Adjudication System Status

Some claims may reject during the pre-process prior to entering the adjudication system.

Payers may pre-process claims to determine whether or not to introduce them to their adjudication system. This process is performed so that incorrectly formatted claims or those that are missing information can be returned to the provider for correction. Returned claims may not have claim numbers assigned by the payer. For additional information see the 277 Health Care Payer Unsolicited Claim Status Implementation Guide.

1.3.2.2 Claim(s) Pended for Development or Suspended for Additional Information

Another choice is to validate inside the adjudication system.

"Payer may ... accept, but pend, erroneous claims."

Payer is not required to reject the claim in the pre-process nor in the adjudication system. If corrective action is possible, the payer may pend or suspend a claim for correction.

Payers may perform validation editing within their adjudication system and accept, but pend, erroneous claims. Generally, the payer assigns a claim number to the pended claim, notifies the provider of the reason(s) why the claim is pended, requests corrective action, and continues the adjudication process when the corrected information is received.

Similar to a pended claim, a suspended claim requires additional information to complete the adjudication process. Generally, this information is not billing information but rather supplemental information that supports or explains the rendered health care services. This information may be required according to the insurer's medical or utilization policy to monitor the provider's health care delivery patterns, or to manage and coordinate the health care delivered to the individual.

The payer uses the 277 Health Care Claim Request for Additional Information to notify the provider of claims that are pended or suspended and of the specific, additional information requested to release each claim for continued adjudication processing. This guide does not detail the actual request for additional information.

1.3.2.3 Finalized Claim(s)

Claims that complete the adjudication process are referred to as "finalized claims." These claims are returned to the provider/submitter by way of the Health Care Claim Payment/Advice (835). The adjudication determination is concluded. Subsequent business events (e.g., an adjustment or an appeal) may occur, but the claim would be given additional identification. Claims may be finalized and rejected, denied, approved for payment, or paid.

1.3.2.4 Finalized Rejected Claim(s)

Some of the incorrect or incomplete claims may reject and finalize in the adjudication system

Pended claims (i.e., incorrect or incomplete claims within the payer's adjudication system) that exceed the response time frame are finalized and rejected. Generally, the payer removes the claim(s) from his or her pended workload and retains this information in history files.

1.3.2.5 Finalized Denied Claim(s)

Claims may reach final adjudication status and not result in a claim payment. One reason is that the claim services billed on the claim are denied. Reasons why services may be denied include the following: no contract is in effect for the patient, the contract does not cover the services billed, and prior claims were paid to the maximum allowed covered benefit for the currently billed services.

1.3.2.6 Finalized Approved Claim(s) Pre-Payment

Claims may be in final adjudication status but have not yet resulted in a check (electronic or paper) being issued. Due to processing requirements within payment systems, claims may be in this status for specific time intervals. For example, some payers create checks for disbursement on a weekly basis while other payers issue checks no more frequently than fourteen days from receipt. Generally, the amount to be paid is available for claims in this status; however, it is typical that the check number is unknown.

1.3.2.7 Finalized Approved Claim(s) Post-Payment

When claims reach final adjudication status and are paid, complete information is available for inquiry. In some situations the claims approved for payment may not have a check issued. Two examples of this include penalty withholdings and recoveries from erroneously made prior payments.

A payer can expect to receive inquiries for claims that complete the adjudication process. Examples of reasons for post-payment claim status inquiries include the following: coordination of benefits, appeal of adjudication results, and adjustment billing.

So, the HIPAA Standard 277 Response transaction notifies the provider of the status of the claim. The payer has the freedom to accept, reject, pend, suspend, approve, deny, pay or finalize the claim according to its business needs. The status "location" of each claim is communicated to the provider in the 277 Response. If the payer is capable of resolving a claim problem through a "pend" or "suspend" process, the payer may do so. Pended and suspended claims are not required to be rejected by the payer and may finalize. Nothing in this guide requires the payor to conduct all the validation before the claim enters the adjudication system. To the contrary, the guide recognizes that validation may happen as part of the adjudication process.

1.4 Information Flow

Figure 1, General Claim Status Information Flow, illustrates the flow of information related to the 276 and all uses of the 277 Health Care Claim Status Response.

It is recognized from this overview that the provider needs to differentiate between the multiple uses of the 277 claim status. See 2.2.2.1, 276 Table 1 — Header Level, for details. For additional information, see the *277 Health Care Payer Unsolicited Claim Status Implementation Guide (X070)* and the *277 Health Care Claim Request for Additional Information Implementation Guide (X104).*

The 837, 835, and the 276 / 277 pair are "HIPAA Standard Transactions". The 997 and other variations of the 277 are not HIPAA Standard Transactions.

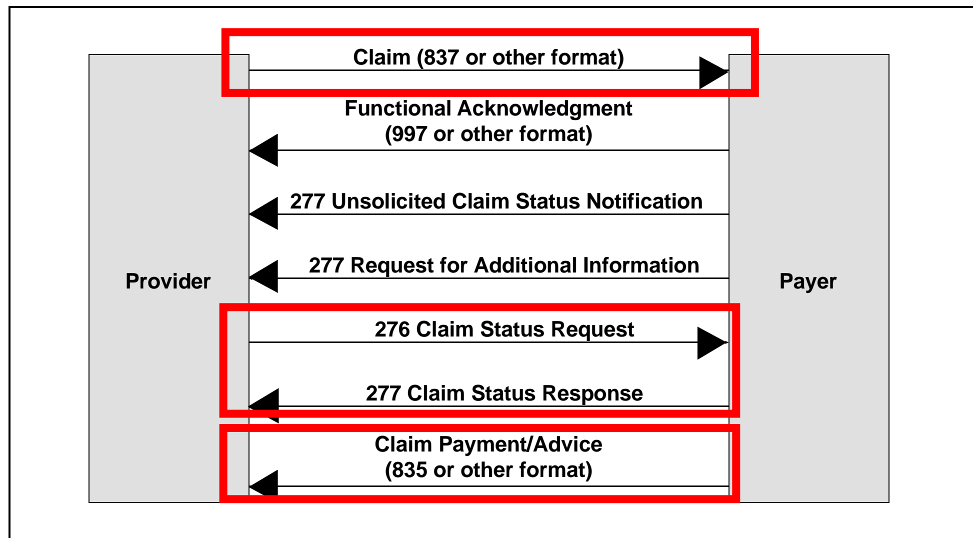


Figure 1. General Claim Status Information Flow

Figure 2, Information Flow for Claim Status Request/Response, illustrates the flow of information for the 276 Health Care Claim Status Request and the 277 Health Care Claim Status Response.

The 997 may be included as part of all implementations. This inclusion in the I.G. validates its use in connection with standard transactions. But the 997 is not required by HIPAA. Another transaction of equivalent functionality could be used instead of the 997.

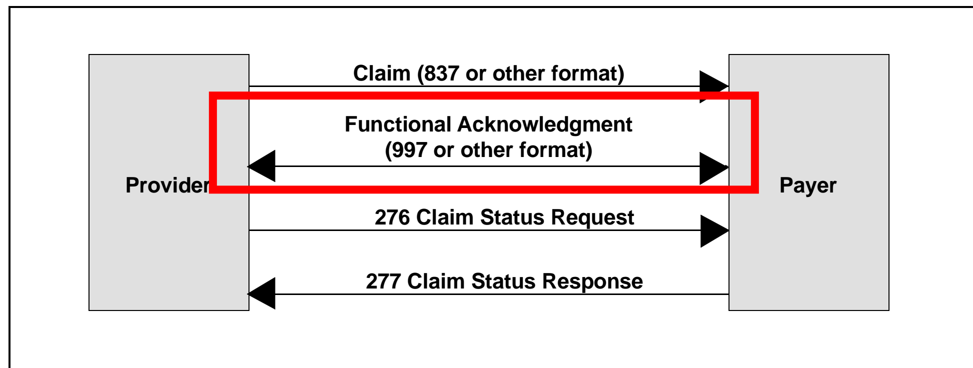


Figure 2. Claim Status Request/Response

1.5 Batch and Real Time Definitions

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time.

Batch – When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. In a batch mode, the sender sends multiple transactions to the receiver, either directly or through a switch (clearinghouse), and does not remain connected while the receiver processes the transactions. If there is an associated business response transaction (such as a 271 response to a 270 for eligibility), the receiver creates the response transaction for the sender off-line. The original sender typically reconnects at a later time (the amount of time is determined by the original receiver or switch) and picks up the response transaction. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

The definitions of "Batch" and "Real Time", including the "Important" notes on the use of the 997 and TA1, are part of all the HIPAA Implementation Guides except for the 835.

Important: When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see section A.1.5.1 for details).

Real Time – Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the response transaction, a 997 Functional Acknowledgment, or a TA1 segment (for details on the TA1 segment, see section A.1.5.1).

Acknowledgement and error responses are a required part of the process. It is understood by the authors that it is the receiver's choice to respond with the TA1+997 (or equivalent) and/or a response transaction. The choice of the 277 as response depends on the ability of the 277 response transaction to convey error information describing the reason for rejection.

IMPLEMENTATION

CLAIM LEVEL STATUS INFORMATION

Loop: 2200D — CLAIM SUBMITTER TRACE NUMBER

Usage: REQUIRED

Repeat: 1

Notes:
1. This is required if the subscriber is the patient.
2. Claim Status information in response to solicited inquiry.

Example: STC*A1:21*19960501**50*0~ or
STC*FI:65*19960511**50*40*19960515*CHK*19960510*50321~

STANDARD

STC Status Information

Level: Detail

Position: 100

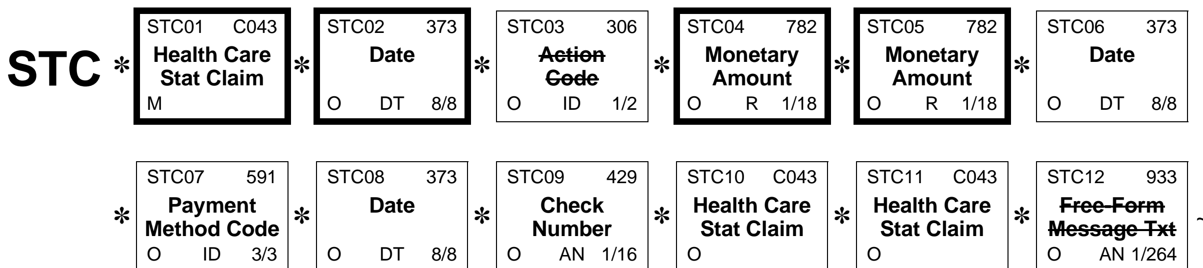
Loop: 2200

Requirement: Mandatory

Max Use: >1

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

DIAGRAM



ELEMENT SUMMARY

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		
REQUIRED	STC01 - 1	1271	**Industry Code** Code indicating a code from a specific industry code list INDUSTRY: *Health Care Claim Status Category Code* This is the Category code. Use code source 507.	M	AN	1/30
REQUIRED	STC01 - 2	1271	**Industry Code** Code indicating a code from a specific industry code list	M	AN	1/30

The combination of the "Status Category" and the "Status Code" describes the status of the claim.

INDUSTRY: ***Health Care Claim Status Code***

This is the Status code. Use code source 508.

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O** **ID** **2/3**

Code identifying an organizational entity, a physical location, property or an individual

STC01-3 further modifies the status code in STC01-2. Required if additional detail applicable to claim status is needed to clarify the status and the payer's system supports this level of detail.

CODE	DEFINITION
13	Contracted Service Provider
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1G	Oncology Center
1H	Kidney Dialysis Unit
1I	Preferred Provider Organization (PPO)
1O	Acute Care Hospital
1P	Provider
1Q	Military Facility
1R	University, College or School
1S	Outpatient Surgicenter
1T	Physician, Clinic or Group Practice
1U	Long Term Care Facility
1V	Extended Care Facility
1W	Psychiatric Health Facility
1X	Laboratory
1Y	Retail Pharmacy
1Z	Home Health Care
28	Subcontractor
2A	Federal, State, County or City Facility
2B	Third-Party Administrator
2E	Non-Health Care Miscellaneous Facility
2I	Church Operated Facility
2K	Partnership
2P	Public Health Service Facility

Code Source 507.

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Code Lists
Provider Taxonomy
Claim Adjustment Reason Codes
Claim Status Codes
Claim Status Category Codes
Health Care Services Decision Reason Codes
Remittance Advice Remark Codes
Property & Casualty
CEO Message
On-Line Conference
Life & Annuity

Health Care Claim Status Category Codes

List Maintenance   List Description

Code	Description	Notes
	Supplemental	
X0	Supplemental Messages	Inactive for 003070, since 2/98.
	Acknowledgments	
A0	Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.	
A1	Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.	
A2	Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.	
A3	Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.	
A4	Acknowledgement/Not Found-The claim/encounter can not be found in the adjudication system.	
A5	Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.	New as of 2/02
A6	Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.	New as of 10/02
A7	Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.	New as of 10/02
P0	Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.	
P1	Pending/In Process-The claim or encounter is in the adjudication system.	
P2	Pending/In Review-The claim/encounter is suspended pending review.	
P3	Pending/Requested	

Status Categories:
Ax - Acknowledgement
Px - Pending
Fx - Finalized
Rx - Request for additional information
Ex - Error in request/system
Dx - Entity not found

	Information-The claim or encounter is waiting for information that has already been requested.	
P4	Pending/Patient Requested Information	
F0	Finalized-The claim/encounter has completed the adjudication cycle and no more action will be taken.	
F1	Finalized/Payment-The claim/line has been paid.	
F2	Finalized/Denial-The claim/line has been denied.	
F3	Finalized/Revised - Adjudication information has been changed	New as of 2/01
F3F	Finalized/Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records.	
F3N	Finalized/Not Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made. The claim/encounter has NOT been forwarded to any subsequent entity identified on the original claim.	
F4	Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.	
F5	Finalized/Cannot Process	Inactive for 003070, since 2/98.
R0	Requests for additional Information/General Requests-Requests that don't fall into other R-type categories.	
R1	Requests for additional Information/Entity Requests-Requests for information about specific entities (subscribers, patients, various providers).	
R3	Requests for additional Information/Claim/Line-Requests for information that could normally be submitted on a claim.	Definition added 2/98
R4	Requests for additional Information/Documentation-Requests for additional supporting documentation. Examples: certification, x-ray, notes.	Definition added 2/98
R5	Request for additional information/more specific detail-Additional information as a follow up to a previous request is needed. The original information was received but is inadequate. More specific/detailed information is requested.	Definition added 6/98
RQ	General Questions (Yes/No Responses)-Questions that may be answered by a simple 'yes' or 'no'.	

All of the green highlights are referring to conditions with the claim itself, and are reported in response to a claim status inquiry.

This E0 code corresponds to an error in the 276 Request rather than an error in the claim data.

Code	Description	Note
E0	Response not possible - error on submitted request data	Changed as of 2/02
E1	Response not possible - System Status	New as of 2/00
D0	Entity not found - change search criteria	Changed as of 2/02

Note that none of the status category codes represent a condition with "another claim" or with the X12 envelope. The problems with the X12 envelope are addressed by the TA1+997. The concept of a correct claim being affected by an incorrect claim in the same batch is not expressible through the 277 or any other X12 transaction.

Code Source 508.

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Health Care Services Decision Reason Codes
Remittance Advice Remark Codes
Property & Casualty
CEO Message
On-Line Conference
Life & Annuity

Health Care Claim Status Codes

List Maintenance   List Description

Code	Description	Notes
0	Cannot provide further status electronically.	
1	For more detailed information, see remittance advice.	
2	More detailed information in letter.	
3	Claim has been adjudicated and is awaiting payment cycle.	
4	This is a subsequent request for information from the original request.	
5	This is a final request for information.	
6	Balance due from the subscriber.	
7	Claim may be reconsidered at a future date.	
8	No payment due to contract/plan provisions.	Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
9	No payment will be made for this claim.	
10	All originally submitted procedure codes have been combined.	Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage.
11	Some originally submitted procedure codes have been combined.	Inactive as of ASC X12 Version 4020. Refer to 12 for new verbiage.
12	One or more originally submitted procedure codes have been combined.	Changed as of 6/01
13	All originally submitted procedure codes have been modified.	Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage.
14	Some all originally submitted procedure codes have been modified.	Inactive as of ASC X12 Version 4020. Refer to 15 for new verbiage.
15	One or more originally submitted procedure code have been modified.	Changed as of 6/01
16	Claim/encounter has been forwarded to entity.	
17	Claim/encounter has been forwarded by third party entity to entity.	
18	Entity received claim/encounter, but returned invalid status.	
19	Entity acknowledges receipt of claim/encounter.	Changed as of 6/01
20	Accepted for processing.	Changed as of

These two codes reflect the payer's choice to edit the claims either before entering the adjudication system or inside it.

Code	Description	Notes
		6/01
21	Missing or invalid information.	Changed as of 6/01
22	... before entering the adjudication system.	Changed as of 6/01
23	Returned to Entity.	Changed as of 6/01
24	Entity not approved as an electronic submitter.	Changed as of 6/01
25	Entity not approved.	Changed as of 6/01
26	Entity not found.	Changed as of 6/01
27	Policy canceled.	Changed as of 6/01
28	Claim submitted to wrong payer.	Inactive as of ASC X12 Version 4020. Refer to 116 for new verbiage.
29	Subscriber and policy number/contract number mismatched.	
30	Subscriber and subscriber id mismatched.	
31	Subscriber and policyholder name mismatched.	
32	Subscriber and policy number/contract number not found.	
33	Subscriber and subscriber id not found.	
34	Subscriber and policyholder name not found.	
35	Claim/encounter not found.	
37	Predetermination is on file, awaiting completion of services.	
38	Awaiting next periodic adjudication cycle.	
39	Charges for pregnancy deferred until delivery.	
40	Waiting for final approval.	
41	Special handling required at payer site.	
42	Awaiting related charges.	
44	Charges pending provider audit.	
45	Awaiting benefit determination.	
46	Internal review/audit.	
47	Internal review/audit - partial payment made.	
48	Referral/authorization.	Changed as of 2/01
49	Pending provider accreditation review.	
50	Claim waiting for internal provider verification.	
51	Investigating occupational illness/accident.	
52	Investigating existence of other insurance coverage.	
53	Claim being researched for Insured ID/Group Policy Number error.	
54	Duplicate of a previously processed claim/line.	
55	Claim assigned to an approver/analyst.	

56	Awaiting eligibility determination.	
57	Pending COBRA information requested.	
59	Non-electronic request for information.	
60	Electronic request for information.	
61	Eligibility for extended benefits.	
64	Re-pricing information.	
65	Claim/line has been paid.	
66	Payment reflects usual and customary charges.	
67	Payment made in full.	
68	Partial payment made for this claim.	
69	Payment reflects plan provisions.	Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
70	Payment reflects contract provisions.	Inactive as of ASC X12 Version 4020. Refer to 107 for new verbiage.
71	Periodic installment released.	
72	Claim contains split payment.	
73	Payment made to entity, assignment of benefits not on file.	
78	Duplicate of an existing claim/line, awaiting processing.	
81	Contract/plan does not cover pre-existing conditions.	
83	No coverage for newborns.	
84	Service not authorized.	
85	Entity not primary.	
86	Diagnosis and patient gender mismatch.	Changed as of 2/00
87	Denied: Entity not found.	
88	Entity not eligible for benefits for submitted dates of service.	
89	Entity not eligible for dental benefits for submitted dates of service.	
90	Entity not eligible for medical benefits for submitted dates of service.	
91	Entity not eligible/not approved for dates of service.	
92	Entity does not meet dependent or student qualification.	
93	Entity is not selected primary care provider.	
94	Entity not referred by selected primary care provider.	
95	Requested additional information not received.	
96	No agreement with entity.	
97	Patient eligibility not found with entity.	
98	Charges applied to deductible.	
99	Pre-treatment review.	
100	Pre-certification penalty taken.	
101	Claim was processed as adjustment to previous claim.	
102	Newborn's charges processed on mother's claim.	

Some Status Codes are used to report on missing or invalid information. Some of these codes (highlighted) refer to information that is REQUIRED in the 837 claim.

Code	Description	Note
	on mother's claim.	
103	Claim combined with other claim(s).	
104	Processed according to plan provisions.	
105	Claim/line is capitated.	
106	This amount is not entity's responsibility.	
107	Processed according to contract/plan provisions.	Changed as of 6/01
108	Coverage has been canceled for this entity.	
109	Entity not eligible.	
110	Claim requires pricing information.	
111	At the policyholder's request these claims cannot be submitted electronically.	
112	Policyholder processes their own claims.	
113	Cannot process individual insurance policy claims.	
114	Should be handled by entity.	
115	Cannot process HMO claims	
116	Claim submitted to incorrect payer.	
117	Claim requires signature-on-file indicator.	
118	TPO rejected claim/line because payer name is missing.	
119	TPO rejected claim/line because certification information is missing	
120	TPO rejected claim/line because claim does not contain enough information	
121	Service line number greater than maximum allowable for payer.	
122	Missing/invalid data prevents payer from processing claim.	
123	Additional information requested from entity.	
124	Entity's name, address, phone and id number.	
125	Entity's name.	
126	Entity's address.	
127	Entity's phone number.	
128	Entity's tax id.	
129	Entity's Blue Cross provider id	
130	Entity's Blue Shield provider id	
131	Entity's Medicare provider id.	
132	Entity's Medicaid provider id.	
133	Entity's UPIN	
134	Entity's CHAMPUS provider id.	
135	Entity's commercial provider id.	
136	Entity's health industry id number.	
137	Entity's plan network id.	
138	Entity's site id .	
139	Entity's health maintenance provider id (HMO).	
140	Entity's preferred provider organization id (PPO).	Changed as of 6/01
141	Entity's administrative services organization id (ASO).	
142	Entity's license/certification number.	
143	Entity's state license number	

143	Entity's state license number.	
144	Entity's specialty license number.	
145	Entity's specialty code.	
146	Entity's anesthesia license number.	
147	Entity's qualification degree/designation (e.g. RN,PhD,MD)	New as of 2/97
148	Entity's social security number.	
149	Entity's employer id.	
150	Entity's drug enforcement agency (DEA) number.	
152	Pharmacy processor number.	
153	Entity's id number.	
154	Relationship of surgeon & assistant surgeon.	
155	Entity's relationship to patient	
156	Patient relationship to subscriber	
157	Entity's Gender	
158	Entity's date of birth	
159	Entity's date of death	
160	Entity's marital status	
161	Entity's employment status	
162	Entity's health insurance claim number (HICN).	
163	Entity's policy number.	
164	Entity's contract/member number.	
165	Entity's employer name, address and phone.	
166	Entity's employer name.	
167	Entity's employer address.	
168	Entity's employer phone number.	
169	Entity's employer id.	
170	Entity's employee id.	
171	Other insurance coverage information (health, liability, auto, etc.).	
172	Other employer name, address and telephone number.	
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.	Changed as of 2/00
174	Entity's student status.	
175	Entity's school name.	
176	Entity's school address.	
177	Transplant recipient's name, date of birth, gender, relationship to insured.	Changed as of 2/00
178	Submitted charges.	
179	Outside lab charges.	
180	Hospital s semi-private room rate.	
181	Hospital s room rate.	
182	Allowable/paid from primary coverage.	
183	Amount entity has paid.	
184	Purchase price for the rented durable medical equipment.	
185	Rental price for durable medical equipment.	
186	Purchase and rental price of durable medical equipment.	
187	Date(s) of service.	

188	Statement from-through dates.	
189	Hospital admission date.	
190	Hospital discharge date.	
191	Date of Last Menstrual Period (LMP)	New as of 2/97
192	Date of first service for current series/symptom/illness.	
193	First consultation/evaluation date.	New as of 2/97
194	Confinement dates.	
195	Unable to work dates.	
196	Return to work dates.	
197	Effective coverage date(s).	
198	Medicare effective date.	
199	Date of conception and expected date of delivery.	
200	Date of equipment return.	
201	Date of dental appliance prior placement.	
202	Date of dental prior replacement/reason for replacement.	
203	Date of dental appliance placed.	
204	Date dental canal(s) opened and date service completed.	
205	Date(s) dental root canal therapy previously performed.	
206	Most recent date of curettage, root planing, or periodontal surgery.	
207	Dental impression and seating date.	
208	Most recent date pacemaker was implanted.	
209	Most recent pacemaker battery change date.	
210	Date of the last x-ray.	
211	Date(s) of dialysis training provided to patient.	
212	Date of last routine dialysis.	
213	Date of first routine dialysis.	
214	Original date of prescription/orders/referral.	New as of 2/97
215	Date of tooth extraction/evolution.	
216	Drug information.	
217	Drug name, strength and dosage form.	
218	NDC number.	
219	Prescription number.	
220	Drug product id number.	
221	Drug days supply and dosage.	
222	Drug dispensing units and average wholesale price (AWP).	
223	Route of drug/myelogram administration.	
224	Anatomical location for joint injection.	
225	Anatomical location.	
226	Joint injection site.	
227	Hospital information.	
228	Type of bill for UB-92 claim.	Changed as of 6/01
229	Hospital admission source.	
230	Hospital admission hour.	
231	Hospital admission type.	

232	Admitting diagnosis.	
233	Hospital discharge hour.	
234	Patient discharge status.	
235	Units of blood furnished.	
236	Units of blood replaced.	
237	Units of deductible blood.	
238	Separate claim for mother/baby charges.	
239	Dental information.	
240	Tooth surface(s) involved.	
241	List of all missing teeth (upper and lower).	
242	Tooth numbers, surfaces, and/or quadrants involved.	
243	Months of dental treatment remaining.	
244	Tooth number or letter.	
245	Dental quadrant/arch.	
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.	
247	Line information.	
248	Accident date, state, description and cause.	
249	Place of service.	
250	Type of service.	
251	Total anesthesia minutes.	
252	Authorization/certification number.	
253	Procedure/revenue code for service(s) rendered. Please use codes 454 or 455.	Deleted as of 2/97
254	Primary diagnosis code.	
255	Diagnosis code.	
256	DRG code(s).	
257	ADSM-III-R code for services rendered.	
258	Days/units for procedure/revenue code.	
259	Frequency of service.	
260	Length of medical necessity, including begin date.	New as of 2/97
261	Obesity measurements.	
262	Type of surgery/service for which anesthesia was administered.	
263	Length of time for services rendered.	
264	Number of liters/minute & total hours/day for respiratory support.	
265	Number of lesions excised.	
266	Facility point of origin and destination - ambulance.	
267	Number of miles patient was transported.	
268	Location of durable medical equipment use.	
269	Length/size of laceration/tumor.	
270	Subluxation location.	
271	Number of spine segments.	
272	Oxygen contents for oxygen system rental.	
273	Weight.	
274	Height.	
275	Claim.	

276	UB-92/HCFA-1450/HCFA-1500 claim form.	Changed as of 6/01
277	Paper claim.	
278	Signed claim form.	
279	Itemized claim.	
280	Itemized claim by provider.	
281	Related confinement claim.	
282	Copy of prescription.	
283	Medicare worksheet.	
284	Copy of Medicare ID card.	
285	Vouchers/explanation of benefits (EOB).	
286	Other payer's Explanation of Benefits/payment information.	
287	Medical necessity for service.	
288	Reason for late hospital charges.	
289	Reason for late discharge.	
290	Pre-existing information.	
291	Reason for termination of pregnancy.	
292	Purpose of family conference/therapy.	
293	Reason for physical therapy.	
294	Supporting documentation.	
295	Attending physician report.	
296	Nurse's notes.	
297	Medical notes/report.	New as of 2/97
298	Operative report.	
299	Emergency room notes/report.	
300	Lab/test report/notes/results.	New as of 2/97
301	MRI report.	
302	Refer to codes 300 for lab notes and 311 for pathology notes	Removed prior to 2/97
303	Physical therapy notes. Please use code 297:6O (6 'OH' - not zero)	Deleted as of 2/97
304	Reports for service.	
305	X-ray reports/interpretation.	
306	Detailed description of service.	
307	Narrative with pocket depth chart.	
308	Discharge summary.	
309	Code was duplicate of code 299	Removed prior to 2/97
310	Progress notes for the six months prior to statement date.	
311	Pathology notes/report.	
312	Dental charting.	
313	Bridgework information.	
314	Dental records for this service.	
315	Past perio treatment history.	
316	Complete medical history.	
317	Patient's medical records.	
318	X-rays.	
319	Pre/post-operative x-rays/photographs.	New as of 2/97
320	Study models.	
321	Radiographs or models.	
322	Recent fm x-rays.	
323	Study models, x-rays, and/or narrative.	
324	Recent x-ray of treatment area and/or narrative.	

Code	Description	Notes
325	Recent fm x-rays and/or narrative.	
326	Copy of transplant acquisition invoice.	
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.	
328	Speech therapy notes. Please use code 297:6R	Deleted as of 2/97
329	Exercise notes.	
330	Occupational notes.	
331	History and physical.	
332	Authorization/certification (include period covered).	New as of 2/97
333	Patient release of information authorization.	
334	Oxygen certification.	
335	Durable medical equipment certification.	
336	Chiropractic certification.	
337	Ambulance certification/documentation.	
338	Home health certification. Please use code 332:4Y	Deleted as of 2/97
339	Enteral/parenteral certification.	
340	Pacemaker certification.	
341	Private duty nursing certification.	
342	Podiatric certification.	
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.	
344	Documentation that provider of physical therapy is Medicare Part B approved.	
345	Treatment plan for service/diagnosis	
346	Proposed treatment plan for next 6 months.	
347	Refer to code 345 for treatment plan and code 282 for prescription	Removed prior to 2/97
348	Chiropractic treatment plan.	
349	Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P	Deleted as of 2/97
350	Speech pathology treatment plan. Please use code 345:6R	Deleted as of 2/97
351	Physical/occupational therapy treatment plan. Please use codes 345:6O (6 'OH' - not zero), 6N	Deleted as of 2/97
352	Duration of treatment plan.	
353	Orthodontics treatment plan.	
354	Treatment plan for replacement of remaining missing teeth.	
355	Has claim been paid?	
356	Was blood furnished?	
357	Has or will blood be replaced?	
358	Does provider accept assignment of benefits?	
359	Is there a release of information signature on file?	
360	Is there an assignment of benefits signature on file?	
361	Is there other insurance?	
362	Is the dental patient covered by medical insurance?	

Many of these requests for additional information refer to information that could be submitted in the claim itself, and most of the time would be submitted if the "situationally required" requirements of the Implementation Guide are satisfied.

363	Will worker's compensation cover submitted charges?	
364	Is accident/illness/condition employment related?	
365	Is service the result of an accident?	
366	Is injury due to auto accident?	
367	Is service performed for a recurring condition or new condition?	
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?	
369	Does patient condition preclude use of ordinary bed?	
370	Can patient operate controls of bed?	
371	Is patient confined to room?	
372	Is patient confined to bed?	
373	Is patient an insulin diabetic?	
374	Is prescribed lenses a result of cataract surgery?	
375	Was refraction performed?	
376	Was charge for ambulance for a round-trip?	
377	Was durable medical equipment purchased new or used?	
378	Is pacemaker temporary or permanent?	
379	Were services performed supervised by a physician?	
380	Were services performed by a CRNA under appropriate medical direction?	Changed as of 10/99
381	Is drug generic?	
382	Did provider authorize generic or brand name dispensing?	
383	Was nerve block used for surgical procedure or pain management?	
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?	
385	Is appliance upper or lower arch & is appliance fixed or removable?	
386	Is service for orthodontic purposes?	
387	Date patient last examined by entity	New as of 2/97
388	Date post-operative care assumed	New as of 2/97
389	Date post-operative care relinquished	New as of 2/97
390	Date of most recent medical event necessitating service(s)	New as of 2/97
391	Date(s) dialysis conducted	New as of 2/97
392	Date(s) of blood transfusion(s)	New as of 2/97
393	Date of previous pacemaker check	New as of 2/97
394	Date(s) of most recent hospitalization related to service	New as of 2/97
395	Date entity signed certification/recertification	New as of 2/97
396	Date home dialysis began	New as of 2/97
397	Date of onset/exacerbation of illness/condition	New as of 2/97

398	Visual field test results	New as of 2/97
399	Report of prior testing related to this service, including dates	New as of 2/97
400	Claim is out of balance	New as of 2/97
401	Source of payment is not valid	New as of 2/97
402	Amount must be greater than zero	New as of 2/97
403	Entity referral notes/orders/prescription	New as of 2/97
404	Specific findings, complaints, or symptoms necessitating service	New as of 2/97
405	Summary of services	New as of 2/97
406	Brief medical history as related to service(s)	New as of 2/97
407	Complications/mitigating circumstances	New as of 2/97
408	Initial certification	New as of 2/97
409	Medication logs/records (including medication therapy)	New as of 2/97
410	Explain differences between treatment plan and patient's condition	New as of 2/97
411	Medical necessity for non-routine service(s)	New as of 2/97
412	Medical records to substantiate decision of non-coverage	New as of 2/97
413	Explain/justify differences between treatment plan and services rendered.	New as of 2/97
414	Need for more than one physician to treat patient	New as of 2/97
415	Justify services outside composite rate	New as of 2/97
416	Verification of patient's ability to retain and use information	New as of 2/97
417	Prior testing, including result(s) and date(s) as related to service(s)	New as of 2/97
418	Indicating why medications cannot be taken orally	New as of 2/97
419	Individual test(s) comprising the panel and the charges for each test	New as of 2/97
420	Name, dosage and medical justification of contrast material used for radiology procedure	New as of 2/97
421	Medical review attachment/information for service(s)	New as of 2/97
422	Homebound status	New as of 2/97
423	Prognosis	Inactive for 004030, since 10/99. LOINC codes have the ability to ask for prognosis.
424	Statement of non-coverage including itemized bill	New as of 2/97
425	Itemize non-covered services	New as of 2/97
426	All current diagnoses	New as of 2/97
427	Emergency care provided during transport	New as of 2/97
428	Reason for transport by ambulance	New as of 2/97
429	Loaded miles and charges for transport to nearest facility with appropriate services	New as of 2/97
430	Nearest appropriate facility	New as of 2/97
431	Provide condition/functional status at time of service	New as of 2/97

432	Date benefits exhausted	New as of 2/97
433	Copy of patient revocation of hospice benefits	New as of 2/97
434	Reasons for more than one transfer per entitlement period	New as of 2/97
435	Notice of Admission	New as of 2/97
436	Short term goals	New as of 2/97
437	Long term goals	New as of 2/97
438	Number of patients attending session	New as of 2/97
439	Size, depth, amount, and type of drainage wounds	New as of 2/97
440	why non-skilled caregiver has not been taught procedure	New as of 2/97
441	Entity professional qualification for service(s)	New as of 2/97
442	Modalities of service	New as of 2/97
443	Initial evaluation report	New as of 2/97
444	Method used to obtain test sample	New as of 2/97
445	Explain why hearing loss not correctable by hearing aid	New as of 2/97
446	Documentation from prior claim (s) related to service(s)	New as of 2/97
447	Plan of teaching	New as of 2/97
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.	New as of 2/97
449	Projected date to discontinue service(s)	New as of 2/97
450	Awaiting spend down determination	New as of 2/97
451	Preoperative and post-operative diagnosis	New as of 2/97
452	Total visits in total number of hours/day and total number of hours/week	New as of 2/97
453	Procedure Code Modifier(s) for Service(s) Rendered	New as of 2/97
454	Procedure code for services rendered.	New as of 2/97
455	Revenue code for services rendered.	New as of 2/97
456	Covered Day(s)	New as of 2/97
457	Non-Covered Day(s)	New as of 2/97
458	Coinsurance Day(s)	New as of 2/97
459	Lifetime Reserve Day(s)	New as of 2/97
460	NUBC Condition Code(s)	New as of 2/97
461	NUBC Occurrence Code(s) and Date(s)	New as of 2/97
462	NUBC Occurrence Span Code(s) and Date(s)	New as of 2/97
463	NUBC Value Code(s) and/or Amount(s)	New as of 2/97
464	Payer Assigned Control Number	New as of 2/97
465	Principal Procedure Code for Service(s) Rendered	New as of 2/97
466	Entities Original Signature	New as of 2/97
467	Entity Signature Date	New as of 2/97
468	Patient Signature Source	New as of 2/97
469	Purchase Service Charge	New as of 2/97
470	Was service purchased from another entity?	New as of 2/97

471	Were services related to an emergency?	New as of 2/97
472	Ambulance Run Sheet	New as of 2/97
473	Missing or invalid lab indicator	New as of 6/98
474	Procedure code and patient gender mismatch	Changed as of 2/00
475	Procedure code not valid for patient age	Changed as of 2/00
476	Missing or invalid units of service	New as of 6/98
477	Diagnosis code pointer is missing or invalid	New as of 6/98
478	Claim submitter's identifier (patient account number) is missing	New as of 6/98
479	Other Carrier payer ID is missing or invalid	New as of 6/98
480	Other Carrier Claim filing indicator is missing or invalid	New as of 6/98
481	Claim/submission format is invalid.	New as of 10/98
482	Date Error, Century Missing	New as of 2/99
483	Maximum coverage amount met or exceeded for benefit period.	New as of 6/99
484	Business Application Currently Not Available	New as of 2/00
485	More information available than can be returned in real time mode. Narrow your current search criteria.	New as of 2/01
486	Principle Procedure Date	New as of 10/01
487	Claim not found, claim should have been submitted to/through 'entity'	New as of 2/02
488	Diagnosis code(s) for the services rendered.	New as of 6/02
489	Attachment Control Number	New as of 10/02
490	Other Procedure Code for Service(s) Rendered	New as of 2/03
491	Entity not eligible for encounter submission	New as of 2/03
492	Other Procedure Date	New as of 2/03
493	Version/Release/Industry ID code not currently supported by information holder	New as of 2/03
494	Real-Time requests not supported by the information holder, resubmit as batch request	New as of 2/03

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The "envelope" is the ISA and IEA segments that surround the "Functional Group(s)".

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. 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 sending 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.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The 997 can report "X12 syntax" errors only. The errors may be in the Functional Group, transaction set, segments or elements.

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. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

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

Implementation of the 997 is not required under HIPAA, but it is "recommended."

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

The 997 Transaction Set cannot accommodate responses to errors beyond X12 syntactical errors. Errors caused by deviations from the HIPAA Implementation Guide requirements, errors caused by not meeting the "situational" requirements, errors caused by not sending an X12-optional but HIPAA-required element, errors caused by sending an X12-optional but HIPAA-not-used element, and many other data content errors cannot be reported with the 997. Using the 997 to report these other errors would cause at least these effects:

- Inability to properly represent the cause of the error in the 997
- Inability to represent the claim in which the error occurred
- The entire transaction set must be handled as a unit, regardless of the number of claims that it may contain.

Current industry practice is to represent these other errors with a transaction different from the 997, generally a proprietary report.

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**

The TA1 may acknowledge the envelope as valid even though the transaction set inside the envelope may be invalid.

2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in the Appendix.**

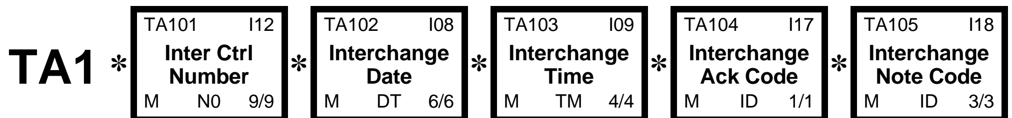
Example: **TA1✻000000905✻940101✻0100✻A✻001~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.			
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.			
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)			
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			This is the time of the original interchange being acknowledged. (HHMM)			

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M** **ID** **1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	**The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.**
E	**The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.**
R	**The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.**

It is possible to accept an X12 envelope even when it has errors, as long as the errors are not relevant to the receiver of the X12 interchange.
Example: invalid date or time information.

REQUIRED **TA105** **I18** **Interchange Note Code** **M** **ID** **3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
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

STANDARD

997 Functional Acknowledgment

The 997 can only address syntactical analysis of the data, per X12 syntax. Other errors (semantic) cannot be reported with the 997.

Functional Group ID: FA

This Draft Standard for Trial Use 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 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 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.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

The finest granularity of a 997 response is at the Transaction Set level

TRANSACTION SET RESPONSE TRAILER

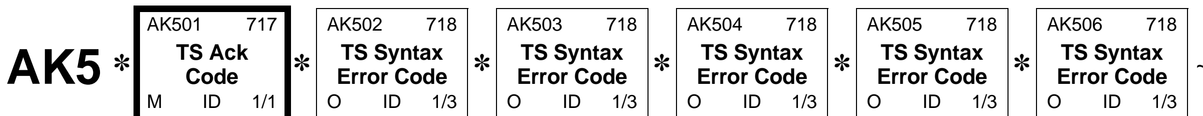
Loop: AK2/AK3 — DATA SEGMENT NOTE
Usage: REQUIRED
Repeat: 1
Example: AK5✻E✻5~

STANDARD

AK5 Transaction Set Response Trailer

Level: Header
Position: 060
Loop: AK2
Requirement: Mandatory
Max Use: 1
Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AK501	717	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	M ID 1/1

CODE	DEFINITION
A	Accepted ADVISED
E	Accepted But Errors Were Noted
M	Rejected, Message Authentication Code (MAC) Failed
R	Rejected ADVISED
W	Rejected, Assurance Failed Validity Tests
X	Rejected, Content After Decryption Could Not Be Analyzed

Only the three highlighted error codes are normally used. The other codes are only used to report on encryption and authentication problems.

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9✻A✻1✻1✻1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

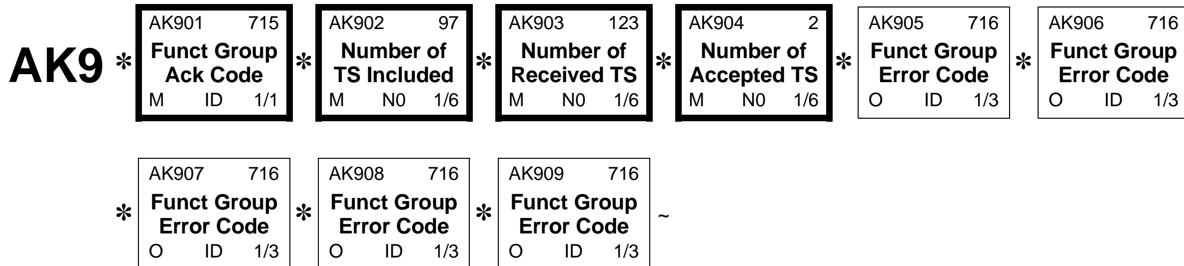
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code**	**M ID 1/1**

Code indicating accept or reject condition based on the syntax editing of the functional group

COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.

CODE	DEFINITION
A	**Accepted**
	ADVISED
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

Same error codes exist at the "Functional Group" level.

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim Payment/Advice

835

ASC X12N 835 (004010X091)

May 2000

2.2.4.1 Institutional-Specific Use

Within the institutional environment, certain circumstances require special handling. Although it is customary in the non-institutional and outpatient environment to provide adjustments and full service line detail with the remittance advice, this situation is unusual for inpatient claims. There are circumstances when there is a need to provide service-specific adjustments, but it is not desirable to provide all service information. When working with room rate adjustments, administrative days, or non-covered days, it may be appropriate to provide these adjustments at the claim level and not provide service level detail. Claim Adjustment Reason Code 78, Non-covered Days/Room Charge Adjustment, is used in the claim level Claim Adjustment Segment to report an adjustment in the room rate or in the number of days covered. The associated adjustment amount provides the total dollar adjustment related to reductions in the number of covered days and the per day rate. The associated adjustment quantity is used to report the actual number of non-covered days.

2.2.5 Data Relationship with Other Transactions (837, 277, NCPDP 3.2)

A one-for-one relationship does not exist among the Health Care Claim Transaction Set (837), the Health Care Claim Status Notification Transaction Set (277), and the 835. One 835 transaction set can account for claims submitted using multiple 837 transactions. The Claim Submitter's Identifier reported in the claim within the 837 is returned in the 835 transaction for tracking purposes. The Claim Submitter's Identifier is located in the 837 in CLM01. In the 835, the Claim Submitter's Identifier, for example, a patient control number, is in CLP01.

Relationship among the 837, 277 and 835 transaction sets.

The 277's primary use is to convey status information on non-adjudicated claims; the 835 is used to transmit data needed for posting subsequent to the adjudication of a claim. The 277 also can account for claims already paid by an 835. In this case, a one-for-one relationship does not exist between the transactions.

The Claim Submitter's Identifier, reported in the claim within the 837 always is returned in the 835 and frequently is returned in the 277 transaction for tracking purposes. When used in the 277, the Claim Submitter's Identifier is located in TRN02.

There is also a Prescription Drug Claim Transaction (NCPDP 3.2). (NCPDP is the acronym for National Council for Prescription Drug Programs.) Similar to the 837 transaction, a one-for-one relationship does not exist between the NCPDP 3.2 and the 835. One 835 transaction can account for claims submitted using multiple NCPDP 3.2 transactions. The Claim Submitter's Identifier is located in the NCPDP 3.2 Claim Information Section, field 402-D2, Prescription Number.

2.2.6 Procedure Code Bundling and Unbundling

Procedure code bundling or unbundling occurs when a **payer** believes that the actual services performed and reported for a claim payment can be represented by a different group of procedure codes. Grouping usually results in a lower payment from the payer. Bundling occurs when two or more reported procedures are going to be paid under only one procedure code. Unbundling occurs when one submitted procedure code is to be paid and reported back as two or more procedure codes.

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Institutional

837

ASC X12N 837 (004010X096)

May 2000

1.1.2 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Health Claims Payment Advice. Should the Secretary adopt the X12N 837 Health Care Claim: Institutional transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA. If adopted under HIPAA, the X12N 837 Health Care Claim: Institutional transaction cannot be implemented except as described in this Implementation Guide.

1.2 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010).

1.3 Business Use and Definition

The ASC X12N standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

The sender may send more data than is necessary for the receiver. The receiver can ignore it. The receiver is not required to use all the data sent or to reject the transaction because it contains unnecessary data.

This implementation guide is intended to provide assistance in developing and executing the electronic transfer of health encounter and health claim data. With a few exceptions, this implementation guide does not contain payer-specific instructions. Trading partners agreements are not allowed to set data specifications that conflict with the HIPAA implementations. Payers are required by law to have the capability to send/receive all HIPAA transactions. For example, a payer who does not pay claims with certain home health information must still be able to electronically accept on their front end an 837 with all the home health data. The payer cannot up-front reject such a claim. However, that does not mean that the payer is required to bring that data into their adjudication system. The payer, acting in accordance with policy and contractual agreements, can ignore data within the 837 data set. In light of this, it is permissible for trading partners to specify a subset of an implementation guide as data they are able to *process* or act upon

most efficiently. A provider who sends the payer in the example above home health data has just wasted their resources and the resources of the payer. Thus, it behooves trading partners to be clear about the specific data within the 837 (i.e., a subset of the HIPAA implementation guide data) they require or would prefer to have in order to efficiently adjudicate a claim. The subset implementation guide must not contain any loops, segments, elements or codes that are not included in the HIPAA implementation guide. In addition, the order of data must not be changed. Trading partners cannot up-front, reject a claim based on the standard HIPAA transaction.

1.3.1 Terminology

Certain terms have been defined to have a specific meaning within this guide. The following terms are particularly key to understanding and using this guide.

Dependent
In the hierarchical loop coding, the Dependent code indicates the use of the patient hierarchical loop (Loop ID-2000C).

Destination Payer
The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB).

Patient
The term “patient” is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber’s insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1, HL Segment, for further details. Every effort has been made to ensure that the meaning of the word “patient” is clear in its specific context.

Provider
In a generic sense, the provider is the entity that originally submitted the claim/encounter. A provider may also have provided or participated in some aspect of the health care service described in the transaction. Specific types of providers are identified in this implementation guide (e.g., billing provider, referring provider).

Secondary Payer
The term “secondary payer” indicates any payer who is not the primary payer. The secondary payer may be the secondary, tertiary, or even quaternary payer.

Subscriber
The subscriber is the person whose name is listed in the health insurance policy. Other synonymous terms include “member” and/or “insured.” In some cases the subscriber is the same person as the patient. See the definition of patient, and see Section 2.3.2.1, HL Segment, for further details.

Transmission Intermediary
A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term “intermediary” is not used to convey a specific Medicare contractor type.

1.3.2 Batch and Real Time Definitions

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time. This guide is intended for use in a Batch only environment.

Batch — When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. In a batch mode, the sender sends multiple transactions to the receiver, either directly or through a switch (clearinghouse), and does not remain connected while the receiver processes the transactions. If there is an associated business response transaction (such as a 271 response to a 270 for eligibility), the receiver creates the response transaction for the sender off-line. The original sender typically reconnects at a later time (the amount of time is determined by the original receiver or switch) and picks up the response transaction. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

Same language as in other guides.

Important: When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see section A.1.5.1 for details).

Real Time — Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the response transaction, a 997 Functional Acknowledgment, or a TA1 segment (for details on the TA1 segment, see section A.1.5.1).

1.4 Information Flows

The Health Care Claim Transaction for Institutional Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). See Section 2.6, Interactions with Other Transactions, for a summary description of these interactions.

Relationship to other transactions.

To ensure timely processing, specific information needs to be included when submitting bills to Property and Casualty payers (e.g. Automobile, Homeowner's, or Workers' Compensation insurers and related entities). Section 4.2, Property and Casualty, of this Implementation Guide explains these requirements.

2 Data Overview

The data overview introduces the 837 transaction set structure and describes the positioning of business data within the structure. The implementation guide developers recommend familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure. For a review, see Appendix A, ASC X12 Nomenclature, and Appendix B, EDI Control Directory.

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set — the implementation view and the standard view. The implementation view of the transaction set is presented in Section 2.1, Overall Data Architecture. See figure 3, 837 Transaction Set Listing, for the implementation view. Figure 3 displays only the segments described in this implementation guide and their designated health care names. The standard view, which is presented in Section 3, Transaction Set, displays all segments available within the transaction set and their assigned ASC X12 names.

The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transmission Type Identification	R	1	
	...				

Table 2 - Detail, Billing/Pay-To Provider Hierarchical Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
001	HL	Billing/Pay-To Provider Hierarchical Level	R	1	
003	PRV	Billing/Pay-To Provider Specialty Information	S	1	
010	CUR	Foreign Currency Information	S	1	
		LOOP ID - 2010A BILLING PROVIDER NAME			1
015	NM1	Billing Provider Name	R	1	
025	N3	Billing Provider Address	S	1	
	...				

Figure 3. 837 Transaction Set Listing

2.2 Loop Labeling and Use

For the user's convenience, the 837 transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-2000A BILLING/PAY-TO PROVIDER LEVEL contains information about the billing and pay-to providers. The descriptive name - BILLING/PAY-TO PROVIDER LEVEL - informs the user of the overall focus of the loop. The shorthand name -2000A - gives, at a glance, the position of the loop within the overall transaction. Billing and pay-to providers have their own subloops labeled Loop ID-

What does the word "should" mean in this sentence? Is it a requirement, or a permission?

There is an "unofficial" letter from one of the X12N workgroups that states that, even in the case of the situation being defined, the sender has the option of sending the data if the data is available and the sender desires to send it.

This is a very important issue but it is not addressed by this document. It is only mentioned here for reference.

Industry Usages:

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

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

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

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

Loop Usages:
Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Eligibility Benefit Inquiry and Response

270/271

ASC X12N 270/271 (004010X092)

May 2000

Required Search Options

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are:

Patient's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option.

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are:

Loop 2100C

Subscriber's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)

Loop 2100D

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option if their system does not have unique Member Identifiers assigned to dependents.

Alternate Search Options

In the absence of all of the above pieces of information, such as in an emergency situation or if the patient has forgotten to bring their identification card, a 270 may be sent with as many of the above pieces of data that are available as well as any of the other items identified in the transaction (such as Social Security Number, subscriber's name when the patient is not the subscriber, relationship to insured). The information source should attempt to look up the patient if there is a reasonable amount of information present. An information source may outline additional search options available in their trading partner agreement, however under no circumstances may they require the use of a search option that differs from the ones outlined above.

Insufficient Identifying Elements

In the event that insufficient identifying elements are sent to the information source, the information source will return a 271 identifying the missing data elements in a AAA segment.

It is possible to have an incomplete 270 transaction set, and the only appropriate response to such transaction set is a 271 response. This means that the incomplete 270 inquiry MUST be processed by the receiver. Rejection of the 270 at the front-end may not be appropriate in that case.

Multiple Matches

In the event that multiple matches are found in the information source's database (this should be due only to utilizing a search option other than the required search option), it is recommended that the information source should not return all the matches found. In this case, the information source should return a 271 identifying duplicates found in a AAA segment and if possible in another AAA segment , identifying the missing data elements necessary to provide an exact match.

1.3.9 Rejected Transactions

As long as the 270 Inquiry passes syntax validation, the 271 response is required.

A 271 Eligibility, Coverage or Benefit Information response transaction must contain at least one EB (Eligibility or Benefit Information) segment or one AAA (Request Validation) segment. This is assuming that the 270 Eligibility, Coverage or Benefit Inquiry has passed syntax error checking without any errors and has not been identified as rejected in a 997 Functional Acknowledgment.

The AAA Request Validation segment is used to identify why an EB Eligibility or Benefit Information segment has not been generated or in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically an AAA segment is generated as a result of either an error in the data being detected (e.g. Missing Subscriber ID) or no matching information in the database (e.g. Subscriber Not Found). The difference is subtle, but they generate different types of messages. If data is missing or invalid, it must be corrected and a new transaction must be generated. If an entity is not found in the database however, it could mean one of two things. The first would be that the Information Receiver should review what was submitted to verify that it was correct and if it was incorrect take the necessary steps to correct and resubmit the transactions. The second would be, if it is determined that the data was correct, the entity is not associated with the Information Source or switch processing the transaction and a definitive answer has been generated. One other use of the AAA segment is to identify a problem with the processing system itself (e.g. the Information Source's system is down). In this case, validation of data may or may not have taken place, so the assumption is made that the data is correct (AAA01 would be "Y" since it cannot point out where the error is), but the transaction will likely have to be resent (as determined by AAA04).

There are three elements that are used in the AAA segment. AAA01 is a Yes/No indicator (identifies if the data content was valid). AAA02 is not used. AAA03 is a Reject Reason Code (identifies why the transaction did not generate an EB segment). AAA04 is a Follow-up Action Code (identifies what further action should be taken).

The I.G. process expects errors and explains how to deal with them.

AAA01 is used to indicate if errors were detected with the data or the transaction as a whole. A "Y" indicates that no data errors were detected and the transaction was processed as far as it could go. An "N" indicates that errors were detected in the data and corrective action is needed. The reason AAA01 would have a "Y" in the event there is a system problem is because no errors were detected in the transaction itself.

AAA03 is used to indicate why an EB segment was not generated. This is in essence an error code.

AAA04 is used to indicate what action, if any, the Information Receiver should take.

IMPLEMENTATION

SUBSCRIBER REQUEST VALIDATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**
2. **Use this segment to indicate problems in processing the transaction specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's subscriber eligibility/benefit inquiry information loop (Loop 2110C).**

The syntax errors were reported by the 997. The data errors are reported with the AAA segment in the 271 response.

Example: **AAA✻N✻✻70✻C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 160

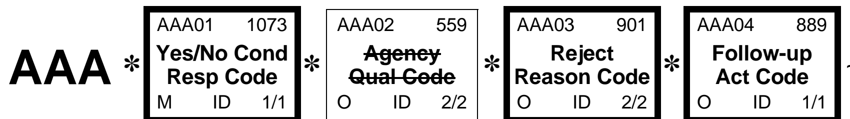
Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code**	**M ID 1/1**

Code indicating a Yes or No condition or response

INDUSTRY: ***Valid Request Indicator***

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**

See rejection codes below.

CODE	DEFINITION
Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**

Usage	Ref.	Elem.	Name	Req.	Type	Length
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	**O**	**ID**	**2/2**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

CODE	DEFINITION
15	Required application data missing
52	Service Dates Not Within Provider Plan Enrollment
53	Inquired Benefit Inconsistent with Provider Type
54	Inappropriate Product/Service ID Qualifier
55	Inappropriate Product/Service ID
56	Inappropriate Date
57	Invalid/Missing Date(s) of Service
60	Date of Birth Follows Date(s) of Service
61	Date of Death Precedes Date(s) of Service
62	Date of Service Not Within Allowable Inquiry Period
63	Date of Service in Future
69	Inconsistent with Patient's Age
70	Inconsistent with Patient's Gender

The highlighted elements may be verifiable during data validation in the "front-end", or in the eligibility application. As in other HIPAA transactions, error handling is an integral part of the transaction processing.

Usage	Ref.	Elem.	Name	Req.	Type	Length
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed	**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	Please Correct and Resubmit
N	Resubmission Not Allowed
R	Resubmission Allowed
W	Please Wait 30 Days and Resubmit
X	Please Wait 10 Days and Resubmit
Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly