

# Introduction to the Companion Guide

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## Overview

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### Purpose

This Companion Guide provides PARTNERS Blue Medicare trading partners with guidelines for submitting electronic batch transactions. The guide uses 'PNHP' and 'PARTNERS' to refer to PARTNERS Blue Medicare Products.

Blue Medicare HMO and Blue Medicare PPO plans are offered by PARTNERS National Health Plans of North Carolina, Inc., a subsidiary of Blue Cross and Blue Shield of North Carolina (BCBSNC). PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. Plans are administered by BCBSNC. BCBSNC and PARTNERS do not discriminate based on color, gender, religion, national origin, age, race, disability, handicap, sexual orientation, genetic information, source of payment or health status as defined by the Centers for Medicare & Medicaid Services (CMS). All qualified Medicare beneficiaries may apply. You must be entitled to Medicare Part A and enrolled in Medicare Part B and must reside in the CMS-approved service area. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or another third party. BCBSNC and PARTNERS are independent licensees of the Blue Cross and Blue Shield Association.

The Companion Guide documents, any assumptions, conventions, or data issues that may be specific to PNHP business processes when implementing the HIPAA ASC X12N Implementation Guides. As such, this Companion Guide is unique to PNHP.

This document does NOT replace the HIPAA ASC X12N Implementation Guides for EDI transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of PNHP. This document provides information on PNHP specific code handling and situation handling that is within the parameters of the HIPAA Administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure and content. Information contained within the HIPAA Implementation Guides (IGs) has not been repeated here although the IGs have been referenced when necessary.

This Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between PNHP and its trading partners. Refer to the TPA for guidelines pertaining to PNHP legal conditions surrounding the implementation of the EDI transactions and code sets. Refer to the Companion Guide for information on PNHP business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. **If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.**

### Content

The PNHP Companion Guide to HIPAA Transactions contains an Introduction chapter, and a chapter for each ASC X12N transaction used by PNHP. Each of the transaction chapters in this document contains one or more tables that explain PNHP business rules within the context of the HIPAA ASC X12N Implementation Guides. The tables reference the Loop, Segment, and Element designations of the Implementation Guides so that users can easily access the relevant sections of the guides as needed.

## ***Document Structure***

The Companion Guide contains the following major components:

- Introductory chapter includes information relevant to the implementation of HIPAA regulations for PNHP processes generally, and connectivity information for Asynchronous data transmissions.
- Appendix A contains Health Care Claims Adjustment Reason Codes as published by Washington Publishing Company online at [http://www.wpcdi.com/Organizations\\_40.asp](http://www.wpcdi.com/Organizations_40.asp)
- A glossary of terms specific to PNHP business rules within the context of implementing the ANSI transactions. Note that this glossary does not include the HIPAA glossary of terms, which is freely available to the public at [http://www.wedi.org/public/articles/HIPAA\\_GLOSSARY.pdf](http://www.wedi.org/public/articles/HIPAA_GLOSSARY.pdf)
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## ***Term Usage***

The Companion Guide's usage of ASC X12N Transaction terms complies with the description of terms as presented in *Appendix A (ASC X12N Nomenclature)* of each ASC X12N Implementation Guide for Transaction and Code Set rules. Definitions are also given in *Section 3 (Transaction Set)* of each ASC X12N Implementation Guide. Please refer to the HIPAA Implementation Guides for definitions of terms.

Terms used in this Companion Guide that are specific to PNHP will be defined as presented within each transaction chapter or included in the Glossary section.

## Contact Information

### Electronic Data Interchange (EDI Services)

EDI Services supports applications for the electronic exchange of health care claims, remittance, enrollment, and inquiries and responses. EDI Services also provides support for health care providers and clearinghouses that conduct business electronically. If you are already submitting electronically, and need assistance, contact EDI Services at 1-888-310-4110.

#### *Requests for Service*

Health care providers or clearinghouses wishing to transmit electronic transactions directly with PNHP must sign a Trading Partner Agreement and submit the original copy to EDI Services. The Trading Partner Agreement establishes the legal relationship between PNHP and the trading partner. Health care providers who submit their transmissions indirectly to PNHP, via a clearinghouse, do not need to complete the Trading Partner Agreement, but are required to fill out an Electronic Connectivity Form.

The following procedures should be followed to obtain the Electronic Connectivity Form:

1. The Health care provider calls PNHP Customer Services at 1-888-310-4110 and makes the request to be set up for electronic submission. The health care provider will need to supply a contact name, phone number, email address and Tax-ID.
2. An E-mail containing an electronic form will then be E-mailed or faxed to the health care provider, which can be filled out electronically. The form will then need to be printed, must be signed, and the hard copy returned to PNHP EDI Services by mail.
3. Once the form is received containing all the required information, the health care provider will be set up in the PNHP System to submit electronically.
4. After successful set up, the Provider will be emailed or faxed a confirmation letter.

The health care provider should allow 8-10 business days to complete the set up process.

#### *Companion Guide*

The companion guide is available for all PNHP trading partners via the BCBSNC Web site, <http://www.bcbsnc.com/providers/blue-medicare-providers> or by calling EDI Services at 1-888-310-4110.

# Rules of Exchange

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The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving EDI transactions with PNHP.

## Trading Partner Requirements

### *Testing*

Testing for transaction compliance and connectivity is required with each vendor or health care provider that directly sends/receives electronic transaction to/from PNHP. Testing is performed for each type of ASC X12N transaction sent.

PNHP EDI Services provides trading partners with support and information throughout the testing process to ensure a smooth transition to production.

## Frequency of Data Exchange

Response turn-around time for transactions can vary, depending upon the sender's hardware and the transaction in question. Confirmations of transmissions should be received within one hour of batch submissions, and often sooner. See chapters on the individual transactions for time ranges for transaction exchanges.

## Transmission Confirmation

Trading partners are responsible for the timely retrieval and verification of the file transmission reports and transaction responses. This includes retrieval of the Claims Status Detail and Summary Reports, as well as the 997. PNHP recommends that trading partners review the transmission confirmations the first business day after transactions have been submitted.

### *Batch Matching*

Senders of batch transmissions should note that transactions are unbundled during processing and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing. More detailed information is contained within each transaction chapter of the Companion Guide about batch matching transmissions with returns.

### *Batch File Acceptance*

Batch files are accepted for processing upon verification of the sender's interchange control information. When rejected batch transactions occur due to invalid sender identifiers and/or other invalid sender interchange information, the Trading Partner will be contacted directly by PNHP EDI Services.

### *Acknowledgements*

Acknowledgements are performed at the GS (Functional Group) level via a 997 transaction acknowledgement transaction. Senders should expect to receive a 997 confirmation of receipt within an hour of submitting a transaction.

TA1 acknowledgement at the IS (Interchange) level are not used. See Batch File Acceptance.

## Error Reporting

Error reporting occurs through one or more of the following:

1. Transaction Reports
2. 997 acknowledgement transaction
3. Direct contact via PNHP EDI Services

Paired transactions, such as the 270/271 and the 276/277, contain error-reporting capabilities in the responding transactions for business errors. Claims transactions receive business edit error information via the Claims Status Detail and Summary Report. Senders should retrieve Audit reports via PNHP's bulletin board.

Submitted Transaction	Transaction Structure Level of Error	Type of Error	Transaction Returned
270, 276, 278, 837-I, 837-P, 820, 834	ISA/IEA Interchange Control	<ul style="list-style-type: none"> <li>• Invalid Identifiers</li> <li>• Improper Batch Structure</li> </ul>	<p>Submitter will be contacted by PNHP EDI Services.</p> <p>997 will not be returned. TA1 is not used</p>
270, 276, 278, 837-I, 837-P, 820, 834	<ul style="list-style-type: none"> <li>• GS/GE Segment</li> <li>• ST/SE Segment</li> <li>• Detail Segments</li> </ul>	HIPAA Implementation Guide Violations	997
837 Institutional 837 Professional	Detail Segments	PNHP Claim Adjudication Errors	Claims Detail and Summary Report

**Table 1: Error Reporting for Various Transactions**

**Important Notice:** For Implementation Guide violations, PNHP returns the 997 Transaction ONLY. Trading partners who are unable to accept a 997 transaction are not provided with alternative Implementation Guide error reporting mechanisms.

### Stakeholder Validation Messages

Where applicable, each transaction chapter contains a table that lists these messages with suggested actions to rectify the transmission problem. Consult the relevant transaction chapter for more information about the message you have received.

## Identifiers

### Sender Identifier

The Sender Identifier is used at the Interchange Control, or ISA06, of a transmission. PNHP accepts a "Mutually Defined" (ZZ) value. PNHP EDI Services will assign the Trading Partner sender identifier.

### ***Information Receiver Identifier***

The Information Receiver Identifier is used for the 270/271 and 276/277 Transactions to identify the entity that is receiving the information of the inquiry. For trading partners of PNHP, this is the PNHP Provider Identifier, the Social Security Number, or the Federal Tax ID.

### ***Provider Identifiers***

Until such time as the implementation of the National Provider Identifier, PNHP requires the use of the PNHP Provider Identifier for Rendering Provider (837 Professional) and Service Facility (837 Institutional) Health Care Claim transactions.

Please see the Data Element Tables within each transaction chapter for guidance on placement and code identifiers regarding the provider identifiers.

### ***Subscriber Identifiers***

Submitters should be careful to use the full member's identification number as it appears on the PNHP Member ID card.

### ***Claim Identifiers***

PNHP issues a claim identification number upon receipt of any accepted claim. The ASC X12N Implementation Guide refers to this number as Payer Claim Control Number, which is returned using the CLP segment on the 835 Remittance transaction.

## **Data Formats**

### ***Character Set Restrictions***

Within a data string, PNHP accepts any characters within the Basic Character Sets outlined in Appendix A.1.2 of each transaction ASC X12N Implementation Guide. PNHP returns only the tilde (~) from the Extended Character Set. Other characters that are acceptable within proper names are dashes, apostrophes, spaces, and periods.

### ***Delimiters***

Delimiters are characters used to separate data elements within a data string. Examples of standard delimiters used in ASC X12N transactions include the asterisk (\*), colon (:), and the tilde (~). Delimiters used by PNHP are specified in the Interchange Header segment (the ISA level) of a transaction.

Transmission Senders must identify the delimiters they are using in the ISA16 element of any transaction. PNHP will accept all delimiters within the Basic and Extended Character Sets, listed in Section A.1.2.3 of each Implementation Guide. In responding transactions, PNHP uses most characters from the Basic Character Set, but only the tilde (~) from the Extended Character Set.

### ***Dates (Format and Content)***

The following statements apply to dates contained in any of the transactions:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.

- The only values acceptable for “CC” (century) are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use military format, or numbers from 00 to 23, to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15 p.m.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after a patient’s service date.

### ***Percentages***

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

### ***File Format (Record Lengths)***

PNHP accepts the Implementation Guide standards for variable record lengths and file formats. PNHP returns a streamed format record – a record that is not broken by spaces or delimiters.

## **Control Segments**

The Control Segments section applies to all transactions as it includes the ISA and GS Segments, which are part of every transaction structure.

### **ISA Segment**

The Interchange Control Segment (ISA/IEA) provides essential information to the receiver of the transaction. The ISA Segment identifies both the sender and receiver’s identifiers, the time of the file transfer, and the segment terminators/delimiters used by the sender.

Senders should note that if Implementation Guide errors are found at the ISA Segment, the entire ISA/IEA segment is rejected.

## Interchange Control: Data Elements Table\*

\*Note that this table reflects the PNHP business rules for both incoming and outgoing ISA/IE Segments.

Segment Type		Element ID		
ISA	Interchange Control Header			
		ISA01	Authorization Information Qualifier	PNHP expects a value of "00"
		ISA02	Authorization Information	Use 10 blank spaces
		ISA03	Security Information Qualifier	PNHP expects a value of "00"
		ISA04	Security Information	Use 10 blank spaces
		ISA05	Interchange ID Qualifier	<ul style="list-style-type: none"> <li>For inbound ISA, PNHP expects to see a value of "ZZ"</li> <li>For outbound, PNHP returns a value of "ZZ"</li> </ul>
		ISA06	Interchange Sender ID	<ul style="list-style-type: none"> <li>For inbound, use the identifier established with PNHP EDI Services</li> <li>For outbound, PNHP uses 'PNHP'</li> </ul>
		ISA07	Interchange ID Qualifier	<ul style="list-style-type: none"> <li>For inbound ISA, PNHP expects to see a value of "ZZ"</li> <li>For outbound, PNHP returns a value of "ZZ"</li> </ul>
		ISA08	Interchange Receiver ID	<ul style="list-style-type: none"> <li>For inbound ISA use 'PNHP'</li> <li>For outbound ISA, PNHP returns the trading partner's identifier, established with PNHP EDI Services</li> </ul>
		ISA14	Acknowledgement Requested	PNHP strongly recommends a value of "1" (acknowledgement requested)
		ISA15	Usage Indicator	Stakeholders should indicate whether the batch transmission is a test ("T") or production ("P") file.
IEA	Interchange Control Trailer			
		IEA01	Number of Included Functional Groups	PNHP prefers only one functional group per transmission
		IEA02	Interchange Control Number	This value must match ISA13

## Functional Group Segment

The Functional Group Segment identifies the type of transaction being sent, identifiers for the sender and receiver of the transactions, as well as the sender's Group Control Number. PNHP recommends that only one Functional Group be sent per transmission.

Any Implementation Guide errors found within the Functional Group Segment are reported via a 997 Transaction. Senders should note that if Implementation Guide errors are found in the Functional Group Segment Header or Footer, the entire GS/GE Functional Group is rejected.

## Functional Group: Data Elements Table

Segment Type		Element ID		
GS	Functional Group Header			
		GS02	Application Sender's Code	<ul style="list-style-type: none"> <li>For inbound GS segments, PNHP recommends that this number is consistent with the ISA06</li> <li>For outbound GS segments, PNHP returns the same value as ISA06, the trading partner's identifier as established with PNHP EDI Services</li> </ul>
		GS03	Application Receiver's Code	<ul style="list-style-type: none"> <li>For inbound GS segments, use a value consistent with ISA08</li> <li>For outbound GS segments, PNHP returns the same value as ISA08, the trading partner's identifier as established with PNHP EDI Services</li> </ul>
		GS06	Group Control Number	Group control number should match GE02
GE	Functional Group Trailer			
		GE02	Group Control Number	Group control number should match GE06

## Connectivity Media for Batch Transactions

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### Synchronous File Communication

#### *Environment*

PNHP uses Internet FTP to control and manage all trading partners file exchanges.

#### *Transmission Security*

Transmission security is based upon utilizing PGP encryption technology where all OpenPGP key formats are supported and used for all electronic file exchanges.

#### *Batch Retrieval*

Batch files, such as 997 acknowledgements and/or reports including claims status reports, will be removed from the trading partner FTP account folder after successful download.

### ***Communication Protocols***

PNHP supports synchronous file communication via FTP Internet protocol.

File transmissions are sent and received within secure envelopes protected by PGP technology using public/private key encryption.

### ***User Responsibility***

It is the trading partner or sender's responsibility to obtain the required pgp encryption software. PNHP accepts all OpenPGP public key formats.

### ***File Format (Record Length)***

For HIPAA-compliant transactions, file formats are presented in contiguous strings. Delimiters, identified in the ISA segment of the transaction, differentiate the various data elements within the string. PNHP returns a streamed format record – a record that is not broken by spaces or delimiters.

### ***Availability***

PNHP FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

# Chapter 1

## 837 – Institutional Health Care Claim

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### Overview

This chapter of the PNHP Companion Guide identifies processing or adjudication particular to PNHP in its implementation of the 837 Institutional Health Care Claim Transaction. The chapter contains two sections:

- A general section with material applicable to the processing of claims and business edits performed by PNHP
- A table outlining specific requests for data format or content within the transaction, or describing PNHP handling of specific data types

While all ASC X12N compliant transactions are accepted by PNHP, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices. Understanding PNHP business procedures may expedite claims processing for trading partners as they exchange EDI transactions with PNHP.

### Claims Processing

#### *Submitting Claims*

#### **Important Notice:**

PNHP does not accept electronic secondary coverage claims. Clearinghouses submitting claims on behalf of service providers must reject secondary claims and prevent electronic submission to PNHP.

#### *Time Frames for Processing*

#### **Batch**

PNHP FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Claim files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' claims adjudication processes.

Electronically submitted claims files received on weekends and holidays will be processed on the next business day.

#### **Batch Volume**

While the HIPAA Implementation Guides allow up to 5000 claims per ST/SE Segment of a transmission, PNHP strongly recommends limiting the number of claims per batch to 1000 ST/SE Segments. The HIPAA Implementation Guides mandate that if any claim contains an IG error, the entire ST/SE segment containing that claim shall be rejected.

#### **Code Sets**

PNHP does not accept National Drug Codes (NDC) by non-retail pharmacies. J-code submissions are acceptable.

PNHP prefers that no decimal point be used when sending Diagnosis codes within the HI levels of the transaction. This is consistent with the specifications of the 837 Professional Implementation Guide.

## **Identification Codes and Numbers**

### **Provider Identifiers**

Until such time as the National Provider Identification Numbers are assigned, PNHP uses the PNHP assigned Provider Number in the 2010AA REF segment (Billing Provider Secondary Identification). All Billing Providers who have been assigned a PNHP Provider ID must enter this secondary information for proper claims processing.

### **Subscriber Identifiers**

Submitters must use the member's complete alphanumeric or numeric identification code as it appears on the subscriber's card for X12 subscriber and patient identifiers.

### **Claim Identifiers**

PNHP issues a claim identification number upon receipt of any submitted claim. It is provided to senders in the Claims Detail and Summary Audit Report.

## **Data Retention of Denied Claims**

Data from claims that are denied is retained for a minimum of three years before archiving. This data is available electronically for eighteen months before archiving. After eighteen months, inquiries should be restricted to telephone inquiries only.

## **Business Edits**

### **Reporting on Problem Data**

The following table indicates which transaction or report is used for problems found within the 837 Institutional Claim Transaction.

<b>Transaction Structure Level of Error</b>	<b>Type of Error</b>	<b>Transaction Returned</b>
ISA/IEA Interchange Control	<ul style="list-style-type: none"><li>• Invalid Identifiers</li><li>• Improper Batch Structure</li></ul>	Submitter will be contacted by PNHP EDI Services  997 will not be returned TA1 is not used
<ul style="list-style-type: none"><li>• GS/GE Segment</li><li>• ST/SE Segment</li><li>• Detail Segments</li></ul>	HIPAA Implementation Guide violations	997
Detail Segments		Claims Detail and Summary Audit Report

### **Stakeholder Validation Messages**

Claims failing adjudication edits are grouped into two processing categories: Pre-adjudication and Adjudication. Errors for both of these categories are reported on the Claims Detail and Summary Audit Report.

Claims reported as 'DENIED' are entered into the PNHP adjudication system.

Claims reported as 'POST' are *not* entered into the PNHP adjudication system. Note: The PNHP claim  
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number listed for a 'POST' error line is for information only. Due to the severity of a 'POST' error, further claims processing is halted, which prevents the claim number from entering the adjudication system.

The table below provides a list of the messages stakeholders may receive if a 'POST' edit error is encountered during claims pre-adjudication edit processing.

<b>Message</b>	<b>Action</b>
Practice has not been approved for EDI billing	Correct. Resubmit affected claims
Provider number submitted is invalid for your practice	Correct. Resubmit affected claims
Member not on file	Correct. Resubmit affected claims

### ***Field Length***

HIPAA regulations specify field lengths for many of the data elements of the 837 Institutional Health Care Claim transaction. PNHP accepts all compliant data elements on the 837 Institutional Claim; however, monetary values that are in negative numbers will invoke special handling. Special handling can sometimes extend the normal processing time for transactions. The listing presented below identifies PNHP field length specifications for dates.

### ***Dates (Format and Content)***

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance: CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) are 18, 19 or 20
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use military format: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (E.g. 20011301) are rejected
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after a patient's service date; a patient's "Admission Date" must not be after the "Statement Covers From Date"

Transaction: 837 Institutional						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
	Beginning of Hierarchal Transaction					
		BHT: Beginning of Hierarchal				
			04	Transaction creation date		
			06	Use 'CH' Chargeable		
1000A	Submitter Information				Loop Required	
		NM1:Submitter Name				
			09	Submitter's Federal Tax ID		
1000B	Receiver Information				Loop Required	
		NM1:Receiver Name				
			09	561520001 – PNHP's Federal Tax ID		
2000A	Billing/Pay-To Provider Information				Loop Required	
2010AA	Billing Provider Information				Loop Required	
		NM1:Billing Provider Name				
			08	Use 'XX' – NPI Identifier	Required	
			09	NPI information	Required	
		REF: Secondary ID				
			01	Use 'EI' Tax ID. Identifier	Required	
			02	Tax ID information	Required	
2010AB	Pay-To Provider Information				Loop Required if PRV01=PT	
		Not Used				
2000B	Subscriber Hierarchal Level				Loop Required	
		SBR: Subscriber Info.				
			01	'P' - Primary Claims	Required. Only Primary Claims Accepted via EDI. ***** Send Secondary claims via paper	

			02	'18' - Self	<b>Required for Subscriber claims</b>
			09	'16' - Medicare Risk	Required
2010BA	Subscriber Information				Loop Required.
		NM1:Subscriber Name			
			02	'1' Person entity	'2' Not Allowed
			08	'MI'	Required.
			09	PNHP's Member ID	Required.
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	<b>Required if SBR02=18</b>
			03	Subscriber/Patient Gender	<b>Required if SBR02=18</b>
2010BC	Payer Information				Loop Required
		NM1:Payer Name	08	'PI' - Payer Identification	
2000C	Patient Hierarchal Level				HL Situational. Dependent Claims Only
		PAT: Patient Info.			
			01	Patient's relationship to insured	<b>Required for dependent claims</b>
2010CA	Patient Information				Loop Situational. Dependent Claims Only
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required.
			03	Subscriber/Patient Gender	Required.
2300	Claim Information				Loop Required. Maximum 100 Claims.
		CLM: Claim Info.			Required.
			01	Claim submitters identifier	This is used as Patient control number for return on 835 claim payment advice.
			02		File paper claim if amount exceeds maximum 9,999,999.00.
		DTP: Statement Dates			Required.
			01	'434'	
			02	Statement From/Thru Dates	- From date must not exceed Thru date. - From/Thru date cannot be greater than today's date. - Admission date cannot be greater than From date.
		DTP: Admission Date/Hour			Situational
			01	'435'	

			02	Admission Date/Hour	- Admission date cannot be greater than statement From date.
		CL1:Institutional Claim Code			Situational
			01	Admission Code	
			02	Admission Source Code	
			03	Patient Status Code	
		REF: Clearinghouse Claim ID			Recommended
			01	'D9'	
			02	Clearinghouse Claim ID	
		REF: Document ID Code			
			01	'DD'	
			02	Document ID Code	Optional
		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
					<b>Do not send decimals in any Diagnosis code.</b>
					<b>PNHP uses first 5 Diag. codes.</b>
		HI: Principal Diag. Code			
			01-1	'BK'	
			01-2	Principal Diag. Code	
		HI: Admitting Diag. Code			
			02:1	'BJ'	
			02:2	Admitting Diag. Code	
		HI: Other Diag. Code			
			01-06:1	'BF'	PNHP uses first 3 Other Diag. codes.
			01-06:2	Other Diag. Code	
		HI:DRG			
			01:1	'DR'	
			02:1	DRG	
					<b>PNHP uses first 5 proc. codes.</b>
		HI: Principal procedure code			
			01:1	'BP' - HCPCS or 'BR' - ICD-9-CM	
			01:2	HCPCS or ICD-9-CM	
		HI: Other procedure code			PNHP uses up to 4 Other proc. codes
			01-12:1	'BO' - HCFA or BQ' - ICD-9-CM	
			01-12:2	HCFA or BQ- ICD-9-CM	
		QTY: Covered days			
			01	'CA'	
			02	Covered days	
		QTY: Non-covered days			

			01	'NA'	
			02	Non-covered days	
		QTY: Lifetime reserve days			
			01	'LA'	
			02	Lifetime reserve days	
2310A	Attending Physician Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310B	Operating Physician Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310C	Other Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310D	Referring Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310E	Service Facility Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2400	Service Line Info				Loop Required
		LX: Service Line	01	Service line control number	This is used by provider as control number used for claim tracking purposes and returned on 835 claim payment advice.
		SV2:Institutional Service			

			01	Revenue code	- An inpatient claim must contain one accommodation code
			02:1	<b>Identifiers</b> 'HC' - HCPCS 'IV' - Home Infusion codes 'ZZ' – HIPPS Codes	<b>CPT codes are also Level 1 HCPCS codes, use 'HC'.</b>
			02:2	HCPCS, Home Infusion code, HIPPS information.	
		DTP: Service Line Date			Date must be contained within the 'Statement dates'
			02	Use 'D8' format (CCYYMMDD)	
			03	Service Line Date	
2420A	Attending Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2420B	Operating Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2420C	Other Physician Info. Service level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required

## Chapter 2

# 837 – Professional Health Care Claim

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### Overview

This chapter of the PNHP Companion Guide identifies processing or adjudication particular to PNHP in its implementation of the 837 Professional Health Care Claim Transaction. The chapter contains two sections:

- A general section with the material applicable to the processing of claims and business edits performed by PNHP
- A table outlining specific requests for data format or content within the transaction, or describing PNHP handling of specific data types

While all ASC X12N compliant transactions are accepted by PNHP, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices. Understanding PNHP business procedures may expedite claims processing for trading partners as they exchange EDI transactions with PNHP.

### Claims Processing

#### *Submitting Claims*

##### **Important Notice:**

PNHP does not accept electronic secondary coverage claims. Clearinghouses submitting claims on behalf of service providers must reject secondary claims and prevent electronic submission to PNHP.

#### *Time Frames for Processing*

##### **Batch**

PNHP FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Claim files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' claims adjudication processes.

Electronically submitted claims files received on weekends and holidays will be processed on the next business day.

##### **Batch Volume**

While the HIPAA Implementation Guides allow up to 5000 claims per ST/SE Segment of a transmission, PNHP strongly recommends limiting the number of claims per batch to 1000 ST/SE Segments. The HIPAA Implementation Guides mandate that if any claim contains an IG error, the entire ST/SE segment containing that claim shall be rejected.

## Code Sets

PNHP does not accept National Drug Codes (NDC) by non-retail pharmacies. J-code submissions are acceptable.

PNHP prefers that no decimal point be used when sending Diagnosis codes within the HI levels of the transaction. This is consistent with the specifications of the 837 Professional Implementation Guide.

## Identification Codes and Numbers

### Provider Identifiers

Until such time as the National Provider Identification Numbers are assigned, PNHP uses the PNHP assigned Provider number in the 2010AA REF segment (Billing Provider Secondary Identification). All Billing Providers who have been assigned a PNHP Provider ID must enter this secondary information for proper claims processing.

### Subscriber and Patient Identifiers

Submitters must use the member's complete alphanumeric or numeric identification code as it appears on the subscriber's card for X12 subscriber and patient identifiers.

### Claim Identifiers

PNHP issues a claim identification number upon receipt of any submitted claim. It is provided to senders in the Claim Detail and Summary Audit Report.

## Data Retention of Denied Claims

Data from claims that are denied is retained for a minimum of three years before archiving. This data is available electronically for eighteen months before archiving. After eighteen months, inquiries should be restricted to telephone inquiries only.

## Business Edits

### Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 837 Professional Claim Transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
ISA/IEA Interchange Control	<ul style="list-style-type: none"><li>Invalid Identifiers</li><li>Improper Batch Structure</li></ul>	Submitter will be contacted by PNHP EDI Services.  997 will not be returned TA1 not used
<ul style="list-style-type: none"><li>GS/GE Segment</li><li>ST/SE Segment</li><li>Detail Segments</li></ul>	HIPAA Implementation Guide Violations	997
Detail Segments		Claims Detail and Summary Audit Report

### Stakeholder Validation Messages

Claims failing adjudication edits are grouped into two processing categories: Pre-adjudication and Adjudication. Errors for both of these categories are reported on the Claims Detail and Summary Audit Report.

Claims reported as 'DENIED' are entered into the PNHP adjudication systems.

Claims reported as 'POST' are *not* entered into the PNHP adjudication system. Note: The PNHP claim number listed for a 'POST' error line is for information only. Due to the severity of a 'POST' error, further claims processing is halted which prevents the claim number from entering the adjudication system.

Message	Action
Practice has not been approved for EDI billing	Correct. Resubmit affected claims
Provider number submitter is invalid for your practice	Correct. Resubmit affected claims
Member not on file	Correct. Resubmit affected claims

### Field Length

HIPAA regulations specify field lengths for many of the data elements of the 837Institutional Health Care Claim transaction. PNHP accepts all compliant data elements on the 837Institutional Claim; however, monetary values that are in negative numbers will invoke special handling. Special handling can sometimes extend the normal processing time for transactions. The listing presented below identifies PNHP field length specifications for dates.

### Dates (Format and Content)

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance – CCYYMMDD, except for ISA segments where the date format is YYMMDD
- The only values acceptable for “CC” (century) are 18, 19 or 20
- Dates that include ours should use the following format: CCYYMMDDHHMM
- Use military format: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- No spaces or character delimiters should be used in presenting dates or times
- Dates that are logically invalid (e.g. 20011301) are rejected
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after a patient’s service date; a patient’s “Admission Date” must not be after the “Statement Covers From Date.”

Transaction: 837 Professional						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
	Beginning of Hierarchal Transaction					
		BHT: Beginning of Hierarchal				
			04	Transaction creation date		
			06	Use 'CH' Chargeable		
1000A	Submitter Information				Loop Required	
		NM1:Submitter Name				
			09	Submitter's Federal Tax ID		
1000B	Receiver Information				Loop Required	
		NM1:Receiver Name				
			09	561520001 – PNHP's Federal Tax ID		
2000A	Billing/Pay-To Provider Information				Loop Required	
		PRV: Provider Specialty Info				
			01	Use 'BI' when 2010AA Billing Provider Loop is used to send Rendering Facility Provider Use 'PT' when 2010AB Pay-To Provider Loop is used to send Rendering Facility Provider		
			03		Use 'Unknown' if not available	
2010AA	Billing Provider Information				Loop Required	
		NM1:Billing Provider Name				
			08	Use 'XX' – NPI Identifier	Required	
			09	NPI information	Required	
		REF: Secondary ID				
			01	Use 'EI' Tax ID. Identifier	Required	
			02	Tax ID information	Required	
2010AB	Pay-To Provider Information				Loop Required if PRV01=PT	
		Not Used				
2000B	Subscriber Hierarchal Level				Loop Required	
		SBR: Subscriber Info.				

			01	'P' - Primary Claims	<b>Required. Only Primary Claims Accepted via EDI. ***** Send Secondary claims via paper</b>
			02	'18' - Self	<b>Required for Subscriber claims</b>
			09	'16' - Medicare Risk	Required
2010BA	Subscriber Information				Loop Required.
		NM1:Subscriber Name			
			02	'1' Person entity	'2' Not Allowed
			08	'MI'	Required.
			09	PNHP Member ID	Required.
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	<b>Required if SBR02=18</b>
			03	Subscriber/Patient Gender	<b>Required if SBR02=18</b>
2010BC	Payer Information				Loop Required
		NM1:Payer Name	08	'PI' - Payer Identification	
2000C	Patient Hierarchal Level				HL Situational. Dependent Claims Only
		PAT: Patient Info.			
			01	Patient's relationship to insured	<b>Required for dependant claims</b>
2010CA	Patient Information				Loop Situational. Dependent Claims Only
		DMG: Demographic Info.			
			02	Subscriber/Patient Birthdate	Required.
			03	Subscriber/Patient Gender	Required.
2300	Claim Information				Loop Required. Maximum 100 Claims.
		CLM: Claim Info.			Required.
			01	Claim submitters identifier	This is used as Patient control number for return on 835 claim payment advice.
			02	Claim Amount	File paper claim if amount exceeds maximum 9,999,999.00.
			05	Place of service	Required.
		DTP: Date onset of current illness			Situational
			01	'431'	
			02	Date onset of current illness	- cannot exceed current date or patients date of birth
		REF: Clearinghouse Claim ID			Recommended
			01	'D9'	
			02	Clearinghouse Claim ID	

		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
					<b>Do not send decimals in any Diagnosis code.</b>
					<b>PNHP uses first 5 Diag. codes.</b>
		HI: Principal Diag. Code			
			01-1	'BK'	
			01-2	Principal Diag. Code	
		HI: Other Diag. Code			
			02:0 7-1	'BF'	Up to 4 Other Diag.
			02:0 7-2	Other Diag. Code	
2310A	Referring Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
			02	UPIN Number	
2310B	Rendering Provider Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2310D	Service Facility Info. Claim level				Loop Situational
		NM1: Physician Info.			
			08	Use 'XX' – NPI Identifier	Required
			09	NPI information	Required
2400	Service Line Info				Loop Required
		LX: Service Line	01	Service line control number	This is used by provider as control number used for claim tracking purposes and returned on 835 claim payment advice.
		SV1:Professional Service			
			01:1	'HC' - HCPCS or 'IV' - Home Infusion codes	<b>CPT codes are also Level 1 HCPCS codes, use 'HC'.</b>
			02:2	HCPCS or Home Infusion code	
		DTP: Service Date From/To			
			01	'472'	
			02	Use 'D8' format: (CCYYMMDD) or 'RD8' format: (CCYYMMDD-CCYYMMDD)	

			03	Service Line Date	
		REF: Prior Authorization or Referral Number			
			01	'9F' - Referral; 'G1' - Auth#.	
			02	Referral or Auth#	
		REF:CLIA Clinical lab improvement facility amendment			
			01	'X4' - CLIA#	
			02	CLIA#	
2420A	Referring Provider Info. Service level				Loop Situational
		REF: Secondary ID			
			01	Use 'G2' Payer Provider Number	<b>Optional. Preferred</b>
			02	Payer Provider Number	
		REF: Secondary ID			
			01	Use '1G' UPIN Number	Optional .Secondary Preference
			02	UPIN Number	
2420F	Rendering Provider Info. Service level				Loop Situational
		PRV: Specialty Info			
			03	Specialty code	<b>Required if loop sent; Use 'Unknown' if not available</b>
		REF: Secondary ID			
			01	Use 'G2' Payer Provider Number	<b>Required if loop sent</b>
			02	Payer Provider Number	
		REF: Secondary ID			
			01	Use '1G' UPIN Number	Optional
			02	UPIN Number	

## Chapter 3

# 270-271 Health Care Eligibility Benefit Inquiry and Response

## Overview

This chapter of the PNHP Companion Guide identifies processing particular to PNHP in its implementation of the 270-271 Health Care Eligibility Benefit Inquiry and Response Transaction. The chapter contains two sections:

- A general section with material applicable to the processing the of 270/271 transaction pair.
- A table outlining specific data format or content within the transactions, or describing PNHP handling of specific data types

While all ASC X12N compliant transactions are accepted by PNHP, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices.

## Claims Status Processing

### *Submitting Requests*

#### **Important Notice:**

PNHP accepts 270 Health Care Eligibility Benefit Inquiry Transactions in batch mode only. Real-time 270 transactions are not accepted.

### *Response to Requests*

PNHP returns 271 Health Care Eligibility Benefit Response Transactions in batch mode only.

PNHP will return 271 Health Care Eligibility Benefit Response Transactions with table level loops in a form structurally similar to the 270 Health Care Eligibility Benefit Inquiry and include all originally sent 270 segments.

Clearinghouses submitting claim status requests on behalf of service providers may need to restructure PNHP 271 Health Care Eligibility Benefit Response prior to return of information to service provider. PNHP will not create a individual response 271 X12 envelope for each batch of 270 requests submitted via clearinghouse.

### *Time Frames for Processing*

#### **Batch**

PNHP FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' processes.

Electronically submitted files received on weekends and holidays will be processed on the next business day.

270 files received on weekends and holidays will be processed on the next business day.

### **Batch Volume**

Maximum of 1,000 Subscriber/Dependent level requests for each 270 transaction. Use additional 270 transactions if necessary.

### **Code Sets/Identifiers**

PNHP uses HIPAA codes sets and identifiers according to the 270/271 Implementation guide.

### **Subscriber/Dependent Identifiers**

Submitters must use the member's complete alphanumeric or numeric identification code as it appears on the subscriber's card for X12 subscriber and patient identifiers.

## **Business Edits**

### **Reporting on Problem Data**

The following table indicates which transaction or report is used for problems found within the 270-271 Health Care Eligibility Benefit Inquiry and Response Transactions.

<b>Transaction Structure Level of Error</b>	<b>Type of Error</b>	<b>Transaction Returned</b>
ISA/IEA Interchange Control	<ul style="list-style-type: none"><li>Invalid Identifiers</li><li>Improper Batch Structure</li></ul>	Submitter will be contacted by PNHP EDI Services  997 will not be returned TA1 is not used
<ul style="list-style-type: none"><li>GS/GE Segment</li><li>ST/SE Segment</li><li>Detail Segments</li></ul>	HIPAA Implementation Guide violations	997
Detail Segments		HIPAA compliant Inquiry/Response segments accepted/generated according to 270/271 Implementation guides.

### **Field Length**

HIPAA regulations specify field lengths for many of the data elements used in the segments of X12N transactions as defined in the implementation guides.. PNHP accepts all compliant data elements included in X12N transactions. The listing presented below identifies PNHP field length specifications for dates.

### **Dates (Format and Content)**

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance: CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) are 18, 19 or 20
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use military format: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm

- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (E.g. 20011301) are rejected
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after a patient's service date; a patient's "Admission Date" must not be after the "Statement Covers From Date"

Transaction: 270 Health Care Eligibility Benefit Request						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
	Beginning of Hierarchal Transaction				Required	
		BHT: Beginning of Hierarchal				
			04	Transaction creation date		
2000A	Informational Source Hierarchal Level				Loop Required	
		HL: Hierarchal Level				
			03	20 – Information Source		
			04	1 – Subordinate HL's exist		
2100A	Payer Name				Loop Required	
		NM1:Payer Name				
			01	PR – Payer		
			08	PI – Payer Identification		
			09	PNHP		
2000B	Information Receiver Hierarchal Level				Loop Required	
		HL: Hierarchial Level				
			03	19 – Provider of Service		
			04	1 – Subordinate HL's exist		
2100B	Receiver Name				Loop Required	
		NM1:Receiver Name				
			01	41 – Submitter		
			08	46 – Electronic Transmitter ID		
			09	Trading Partner ID		
2000C	Subscriber Hierarchal Level				Loop Required	
		HL: Hierarchial Level				
			03	22 - Subscriber		
			04	1 – Subordinate HL's exist.	Required for Dependent Inquiry – 2110D Loop Id (HL03 = 23) must exist	
				0 – Subordinate HL's do not exist	Required for Subscriber Inquiry 2100C Loop ID. Dependent Inquiry – 2110D Loop Id (HL03 = 23) must not exist.	
				0 – Subordinate HL's do not exist	Required for Subscriber Inquiry 2100C	

					Loop ID. Dependent Inquiry – 2110D Loop Id (HL03 = 23) must not exist.
		TRN: Trace Number			Required
2100C	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	Expected for Dependent Inquiry – 220E Loop Id when Subscriber Inquiry 2200D not present
				QC – Use only when Subscriber is the patient	Expected for Subscriber Inquiry 2200D regardless of presence of Dependent Inquiry
			08	MI – Member ID Number	
			09	PNHP Member ID	
		REF: Subscriber Addl. Info.	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110C	Subscriber Request Parameters				Loop Situational
		EQ: Service Type Code	01	30 - Generic Request for	
		DTP: Subscriber Date	01	307: Eligibility	
2000D	Dependent Hierarchical Level				Loop Required
		HL: Hierarchical Level			
			03	23 – Dependent	
			04	0 – Subordinate HL's do not exist	Required for Dependent Inquiry – 2200E Loop Id must exist.
		TRN: Trace Number			Required
2100D	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	PNHP Member ID	
		REF: Subscriber Addl. Info.	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110D	Dependent Request Parameters				Loop Situational
		EQ: Service Type Code	01	30 – Generic Request for	
		DTP: Subscriber Date	01	307: Eligibility	

Transaction: 271 Health Care Eligibility Benefit Response						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
	Beginning of Hierarchal				Required	
		BHT: Beginning of				
			04	Transaction creation date		
2000A	Information Source Hierarchal Level				Loop Required	
		HL: Hierarchal Level				
			03	20 – Information Source		
			04	1 – Subordinate HL's exist		
2100A	Payer Name				Loop Required	
		NM1:Payer Name				
			01	PR – Payer		
			08	PI – Payer Identification		
			09	PNHP		
2000B	Information Receiver Hierarchal Level				Loop Required	
		HL: Hierarchal Level				
			03	19 – Provider of Service		
			04	1 – Subordinate HL's exist		
2100B	Receiver Name				Loop Required	
		NM1:Receiver Name				
			01	41 – Submitter		
			08	46 – Electronic Transmitter ID		
			09	Trading Partner ID		
2000C	Subscriber Hierarchal Level				Loop Required	
		HL: Hierarchal Level				
			03	22 - Subscriber		
			04	1 – Subordinate HL's exist.		
				0 – Subordinate HL's do not exist		
		TRN: Trace Number			Required	

2100C	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	
				QC – Use only when Subscriber is the patient	
			08	MI – Member ID Number	
			09	PNHP Member ID	
		REF: Subscriber Addl.	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110C	Subscriber Request Parmenters				Loop Situational
		EB: Eligibility Info	01	1 – Active Coverage	
				6 – Inactive	
				V – Cannot Process	
		DTP: subscriber Date	01	307: Eligibility	
		MSG: Message Text	01	Message when applicable	
2000D	Dependent Hierarchial Level				Loop Required
		HL: Hierarchial Level			
			03	23 – Dependent	
			04	0 – Subordinate HL's do not exist	
		TRN: Trace Number			Required
2100D	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	PNHP Member ID	
		REF: Subscriber Addl. Info	01	EJ – Patient Control Number	
		DTP: Subscriber Date	01	307: Eligibility	
2110D	Dependent Request Parmenters				Loop Situational
		EB: Eligibility Info	01	1 – Active Coverage	
				6 – Inactive	
				V – Cannot Process	
		DTP: Subscriber Date	01	307: Eligibility	
		MSG: Message Text	01	Message when applicable	

## Chapter 4

# 835 – Claim Payment/Advice

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### Overview

This chapter of the PNHP Companion Guide identifies processing or adjudication particular to PNHP in its implementation of the 835 Health Care Claim Transaction.

The 835 Transaction, Health Care Claim Advice, provides an electronic verification of the payment of electronic and/or paper claims submitted to PNHP for processing. The 835 Transaction is returned for both the Professional and Institutional 837 claim submission.

The 835 EOP advice will be sent electronically. If requested, submitters may receive it in paper form as well.

### Time Frames for Processing

PNHP sends 835 batch transactions weekly immediately following check creation. Response time to 837 claim submissions varies, and may be longer than one week.

PNHP will anticipate an acknowledgement response to the 835 from submitters in the form of a 997.

### Electronic Funds Transfer (EFT)

The PNHP 835 transaction does not include Electronic Funds Transfer, only EOP remittance advice.

### Claims Remittance Processing

1. PNHP generates electronic 835 Transactions only for claims that have a “paid” or “denied” record on file. Claims that are still in the adjudication process or that have been returned with error messages do not receive an 835 response (See 837 Companion Guide for information about status reports).
2. The claims submitted via batch transactions might not be returned together within the original batch or in the original order. Submitters can match checks with remittance advice by using the trace number (TRN segment) or check number. Submitters can match 837 submissions with 835 EOP advice by using the Patient Control Number (CLP01).
3. Payees will see all originally submitted procedure codes broken out on the SVC06 element, with the adjusted dollar amount in the CAS03 segment.
4. Claim adjustments will be reported at the service level.

### 835 Mapping from 837

Payees may need to be aware of values used from the 837 for adjudication or reassociation. Any mapping issues particular to PNHP business rules are identified on the 835 Data Element Table.

### Identification Codes and Numbers

In creating the 835 Transaction, PNHP uses the standard medical and non-medical codes sets prescribed in Appendix C of the 835 Implementation Guide.

**Provider Identifier**

Until such time as the National Provider Identifier is issued, the 835 Transaction returns the PNHP Provider number, PNHP Practice number, and UPIN. Payee IRS number is also included but may not be on an individual provider level.

**Subscriber Identifier**

On the 835, the Insured ID (NM109 of Claim Payment Info Insured Name Segment) represents the subscriber member number.

**Claims Identifier**

The Claims Identifier is the PNHP generated claim number for tracking the claim (CLP07).

**Reason Adjustment Codes**

The 835 Transaction Standard limits the content of the Service Adjustment CAS Segment CAS02 Claim Adjustment Reason Code Element to those codes listed in WPC's Health Care Claim Adjustment Reason Code Guide (see Appendix A for the complete code list).

## 835 Data Element Table

Transaction: 835			
Loop ID	Loop ID Description	Segment/Element	Element Value
	<b>Transaction Set Header</b>		
		ST01: Transaction Set ID	'835'
		ST02: Transaction Set Control Number	Transaction set control number
		<b>BPR Financial Information</b>	
		BPR01: Transaction Handling Code	'1' – remittance only
		BPR02: Provider Payment Amount	Prov payment amount
		BPR03: Credit/Debit flag Code	"C"
		BPR04: Payment Method Code	'CHK'
		BPR05: Payment Format Code	NOT USED
		BPR06: ID Number Qualifier (Originating)	NOT USED
		BPR07: Identification Number (Originating)	NOT USED
		BPR08: Account Number Qualifier (Originating)	NOT USED
		BPR09: Account Number (Originating)	NOT USED
		BPR10: Originating Company Identifier	NOT USED
		BPR11: Originating Company Supplemental Code	NOT USED
		BPR12: ID Number Qualifier (Receiving)	NOT USED
		BPR13: Identification Number (Receiving)	NOT USED
		BPR14: Account Number Qualifier (Receiving)	NOT USED
		BPR15: Account Number (Receiving)	NOT USED
		BPR16: Paid Date	Paid Date
		<b>TRN Reassociation Trace#</b>	
		TRN01: Trace Type Code	'1'
		TRN02: Reference Identification (check or trace#)	Check or Trace#
		TRN03: Originating Company Identifier (Payer IRS)	'1' + IRS number
		<b>CUR Segment Foreign currency information</b>	NOT USED
		<b>REF Segment – EV Clearing House (if applicable)</b>	NOT USED
		<b>REF Segment – F2</b>	NOT USED
		<b>DTM Segment</b>	

		<b>Adjudication Cycle Data</b>	
		DTM01: Adjudication Cycle Date Qual	'405'
		DTM02: Paid Date	
<b>1000A</b>	<b>PAYER IDENTIFICATION</b>		
		<b>N1 Segment Payer Identification</b>	
		N101: Entity Identifier Code	'PR'
		N102: Payer Name	Payer Name
		N103: Identification Code Qualifier	NOT USED
		N104: Identification Code (Payer ID)	NOT USED
		<b>N3 Segment Payer Address</b>	
		N301: Payer Address Line	Address1
		N302: Payer Address Line 2	Address2
		<b>N4 Segment Payer city, street, zip</b>	
		N401: Payer City name	City
		N402: Payer State or Province code	State
		N403: Payer Postal Code	Zip
		<b>REF Segment Additional Payer Information</b>	NOT USED
		REF01: Payer Id Number	
		REF02: Payer Id	
		<b>PER Segment Payer Contact Information</b>	NOT USED
<b>1000B</b>	<b>PAYEE IDENTIFICATION</b>		
		<b>N1 Segment Payee Identification</b>	
		N101: Entity Identifier Code (Payee ID)	'PE'
		N102: Payee Name	Payee Name
		N103: Identification Code Qualifier	'FI'
		N104: Identification Code (Payee IRS)	'1' + IRS number
		<b>N3 Segment Payee Address</b>	NOT USED
		<b>N4 Segment Payee city, state, zip</b>	NOT USED
		<b>REF Segment Payee Additional Information</b>	NOT USED
<b>2000</b>	<b>HEADER NUMBER</b>		
		<b>LX Segment Header Number</b>	
		LX01: LX Counter	Incremented for each line number
		<b>TS3 Segment Provider Summary Information</b>	NOT USED

		TS2 Segment Provider Supplemental Summary Information	NOT USED
2100	CLAIM PAYMENT INFO		
		CLP Segment Claim Payment Information	
		CLP01: Patient Control Number	Patient Control Number
		CLP02: Claim Status Code	Claim Status Code
		CLP03: Total Claim Charge Amt	Total Claim Charge Amt
		CLP04: Claim Payment Amt	Claim Payment Amt
		CLP05: Patient Resp Amt	NOT USED
		CLP06: Claim Filing Ind. Code	Claim Filing Ind. Code
		CLP07: Payer Claim Control Number	PNHP Claim Number
		CLP08: Facility Type Code	Facility Type Code
		CLP09: Claim Frequency Code	Claim Frequency Code
		CLP10: Patient Status Code	
		CLP11: DRG Code	DRG Code
		CLP12: Quantity (DRG Weight)	NOT USED
		CLP13: Percent (Discharge fraction)	NOT USED
		CAS Segment Claim Adjustment	NOT USED
		NM1 Segment Patient Name	
		NM101: Entity ID Code (Patient Name Qual)	'QC'
		NM102: Entity type Qualifier (Insured Name Qual)	'1'
		NM103: Patient Name Last	Patient Name Last
		NM104: Patient Name First	Patient Name First
		NM105: Patient Name Middle	Patient Name Middle
		NM106: Prefix	Prefix
		NM107: Patient Name Suffix	Patient Name Suffix
		NM108: Id Code Qual	'MI'
		NM109: Patient Identifier	Patient Identifier
		NM1Segment Insured Name	
		NM101: Insured or Subscriber	'IL'
		NM102: Insured Type	'1'
		NM103: Insured Name Last	Insured Name Last
		NM104: Insured Name First	Insured Name First
		NM105: Insured Name Middle	Insured Name Middle
		NM106: Insured Name Prefix	Insured Name Prefix
		NM107: Insured Name Suffix	Insured Name Suffix
		NM108: Insured ID Type	'MI'
		NM109: Insured Id	Insured Id
		NM1 Segment Corrected Patient/Insured Name	NOT USED
		NM1 Segment Service Provider Name	
		NM101: Rendering Name Qual	'82'
		NM102: Rendering Name Type	Rendering Name Type
		NM103: Rendering Name Last	Rendering Name Last
		NM104: Rendering Name First	Rendering Name First

		NM105: Rendering Name Middle	NOT USED
		NM106: Rendering Name Prefix	NOT USED
		NM107: Rendering Name Suffix	NOT USED
		NM108: Rendering ID Qual	'BD'
		NM109: Rendering ID (PNHP Provider#)	Rendering ID (PNHP Provider #)
		NM1 Segment Crossover Carrier Name	NOT USED
		NM1 Segment Corrected Priority Payer Name	NOT USED
		MIA Segment Inpatient Adjudication Information	NOT USED
		MOA Segment Outpatient Adjudication Information	NOT USED
		REF Segment Other Claim Related Identification	NOT USED
		REF Segment Rendering Provider Identification	
		REF01: Rendering Prov Id Qual	'G2'
		REF02: Rendering Prov Id (PNHP Practice#)	Rendering Prov Id (PNHP Practice#)
		REF Segment Rendering Provider Identification	
		REF01: Rendering Prov ID Qual	'1G'
		REF02: Rendering Prov Id (UPIN)	Rendering Prov Id (UPIN)
		DTM Segment Claim Date	
		DTM01: Claim Date Qual	'050'
		DTM02: Claim Date Received	
		PER Segment Claim Contact Information	NOT USED
		AMT Segment Claim Supplemental Information	NOT USED
		QTY Segment Claim Supplemental Info Quantity	NOT USED
2110	SERVICE PAYMENT INFO		
		SVC Segment Service Payment Information	
		SVC01-1: Procedure Code Qual	'HC'
		SVC01-2: Adjudicated Procedure Code/ Rev Cd	Adjudicated Procedure Code/ Rev Cd
		SVC01-03: Modifier1	Modifier1
		SVC01-04: Modifier2	Modifier2
		SVC01-05: Modifier3	Modifier3
		SVC01-06: Modifier4	Modifier4
		SVC01-07: Proc description	NOT USED
		SVC02: Charge Amount	Charge Amount
		SVC03: Paid Amount	Paid Amount
		SVC04: Revenue Code	Revenue Code
		SVC05: Units of service PAID	Units of service PAID

	Procedure code submitted (Not Adjudicated)	
	SVC06-1: Procedure Code Qual	'HC'
	SVC06-2: Procedure Code	Procedure Code
	SVC06-3: Modifier1	Modifier1
	SVC06-4: Modifier2	Modifier2
	SVC06-5: Modifier3	Modifier3
	SVC06-6: Modifier4	Modifier4
	SVC06-7: Proc description	NOT USED
	SVC07: Orig. units of service count	Orig. units of service count
	DTM Segment	
	Service Date (From)	
	DTM01: Service Period Start Qual	'150'
	DTM02: Service DATE (effective)	Service DATE (effective)
	CAS Segment 1-6	
	Service Adjustment *See attached Adjustment Code Table	
	CAS01: Claim Adjust Code	Claim Adjust Code
	CAS02: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS03: Monetary Amt	Monetary Amt
	CAS04: Quantity	NOT USED
	CAS05: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS06: Monetary Amt	Monetary Amt
	CAS07: Quantity	NOT USED
	CAS08: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS09: Monetary Amt	Monetary Amt
	CAS10: Quantity	NOT USED
	CAS11: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS12: Monetary Amt	Monetary Amt
	CAS13: Quantity	NOT USED
	CAS14: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS15: Monetary Amt	Monetary Amt
	CAS16: Quantity	NOT USED
	CAS17: Claim Adjust Reason Code	Claim Adjust Reason Code
	CAS18: Monetary Amt	Monetary Amt
	CAS19: Quantity	NOT USED
	REF Segment	NOT USED
	Service Identification (Service Payment info)	
	REF Segment	
	Rendering Prov Info	
	REF01: Id Qual	'1J'
	REF02: Rendering Prov Id (PNHP Prov#)	Rendering Prov Id (PNHP Prov#)
	REF03	NOT USED
	REF04	NOT USED
	REF Segment	
	Rendering Prov Info	
	REF01: Id Qual	'HPI'
	REF02: Rendering Prov Id. (NPI)	Rendering Prov Id. ( <b>Future NPI</b> )
	REF03	NOT USED
	REF04	NOT USED

		REF Segment	REF 2 <sup>nd</sup> occurrence
		Rendering Prov Info	
		REF01: Id Qual	'1G'
		REF02: Rendering Prov Id. (UPIN)	Rendering Prov Id (UPIN)
		REF03	NOT USED
		REF04	NOT USED
		Service Supplemental AMT	NOT USED
		Service Supplemental QUANTITY	NOT USED
		Health Care Remark Codes LQ	
		LQ01: Remittance Remark/EX-Codes Qual	'HE'
		LQ02: Remittance Remark/Ex-Code	Remittance Remark/ Ex-Code
		PLB Segment 1-6	
		Provider Adjustment	
		PLB01: Provider ID	Provider ID
		PLB02: End of Providers Fiscal Year	End of Providers Fiscal Year
		PLB03-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB03-02: Adjustment Identifier	Adjustment Identifier
		PLB04: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB05-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB05-02: Adjustment Identifier	Adjustment Identifier
		PLB06: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB07-01: Adjustment Reason Identifier Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB07-02: Adjustment Identifier	Adjustment Identifier
		PLB08: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB09-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code 'FB' is the only applicable code (forwarding balance)
		PLB09-02: Adjustment Identifier	Adjustment Identifier
		PLB10:: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB11-01: Adjustment Identifier	Adjustment Identifier

		Reason Code	Reason Code
		PLB11-02: Adjustment Identifier	Adjustment Identifier
		PLB12: Amount	Amount (positive value indicates reduction in payment due to past overpayment or other payment recovery)
		PLB13-01: Adjustment Identifier Reason Code	Adjustment Identifier Reason Code
		PLB13-02: Adjustment Identifier	Adjustment Identifier
		PLB14: Amount	Amount (Positive value indicates reduction in payment due to past overpayment or other payment recovery)
		SE Segment	
		Transaction Set Trailer	
		SE01: Total Number of Included Segments	Total Number of Included Segments
		SE02: Transaction Set Control Number	Transaction Set Control Number (Same as ST02)

## Chapter 5

# 276 Health Care Claim Status Request / 277 Health Care Claim Status Response

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## Overview

This chapter of the PNHP Companion Guide identifies processing particular to PNHP in its implementation of the 276 Health Care Claim Status Request and 277 Health Care Claim Status Response Transaction. The chapter contains two sections:

- A general section with material applicable to the processing of the 276/277 transaction pair
- A table outlining specific data format or content within the transactions, or describing PNHP handling of specific data types

While all ASC X12N compliant transactions are accepted by PNHP, the HIPAA Implementation Guides allow for some discretion in applying the regulations to existing business practices.

## Claims Status Processing

### *Submitting Requests*

#### **Important Notice:**

PNHP accepts 276 Health Care Claim Status Request Transactions in batch mode only. Real time 276 transactions are not accepted.

### *Response to Requests*

PNHP returns 277 Health Care Claim Status Response Transactions in batch mode only.

PNHP will return 277 Claim Status Response Transactions with table level loops in a form structurally similar to the 276 Claim Status Request and include all originally sent 276 segments.

Clearinghouses submitting claim status requests on behalf of service providers may need to restructure PNHP 277 Health Care Claims Status Response prior to return of information to service provider. PNHP will not create an individual response 277 X12 envelope for each batch of 276 provider level requests submitted via clearinghouse.

### *Time Frames for Processing*

#### **Batch**

#### **Batch**

PNHP FTP Services supporting file submission and retrieval is available for 7 days a week excluding periodic weekend downtimes for scheduled system maintenance.

Files must be received prior to the 3:00pm EST cutoff time each business day in order to be part of the current days' processes.

Electronically submitted files received on weekends and holidays will be processed on the next business day.

276 files received on weekends and holidays will be processed on the next business day.

### **Batch Volume**

Maximum of 1,000 Subscriber/Dependent level requests for each Service Provider Level. Use additional Service Provider levels if necessary.

### **Code Sets/Identifiers**

PNHP uses HIPAA code sets and identifiers according to the 276/277 Implementation guide. Standard code sets used include Claim Status Category and Claims Status codes.

Subscriber/Dependent identifiers

Submitters must use the member's complete alphanumeric or numeric identification code as it appears on the subscriber's card for X12 subscriber and patient identifiers.

### **Business Edits**

#### **Reporting on Problem Data**

The following table indicates which transaction or report is used for problems found within the 276/277 Transaction.

<b>Transaction Structure Level of Error</b>	<b>Type of Error</b>	<b>Transaction Returned</b>
ISA/IEA Interchange Control	<ul style="list-style-type: none"> <li>Invalid Identifiers</li> <li>Improper Batch Structure</li> </ul>	<p>Submitter will be contacted by PNHP EDI Services</p> <p>997 will not be returned TA1 is not used</p>
<ul style="list-style-type: none"> <li>GS/GE Segment</li> <li>ST/SE Segment</li> <li>Detail Segments</li> </ul>	HIPAA Implementation Guide violations	997
Detail Segments		Format compliant inquiry data supplied within 276 will generate 277response. 277responses may or may not return the expected information depending on the validity of the 277 parameters.

### **Field Length**

HIPAA regulations specify field lengths for many of the data elements used in the segments of X12N transactions as defined in the implementation guides. PNHP accepts all compliant data elements included in the X12N transactions. The listing presented below identifies PNHP field length specifications for dates.

### ***Dates (Format and Content)***

The following statements apply to any dates within a 276/277 Transaction:

- All dates should be formatted according to Year 2000 compliance: CCYYMMDD, except for ISA segments where the date format is YYMMDD
- The only values acceptable for “CC” (century) are 18, 19 or 20
- Dates that include hours should use the following format: CCYYMMDDHHMM
- Use military format: 00 to 23 to indicate hours, and 00 to 59 to indicate minutes. For example, an admission date of 200206262115 defines the date and time of June 26, 2002 at 9:15pm
- No spaces or character delimiters should be used in presenting dates or times
- Dates that are logically invalid (E.g. 20011301) are rejected
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after a patient’s service date; a patient’s “Admission Date” must not be after the “Statement Covers From Date”

### ***Implementation of Claim Level Vs. Service Line Level 276 Inquiries***

PNHP processes Claim Level and Service Line Level Inquiries as separate and unique requests for Claim Status Information.

For example: Both subscriber or dependent level inquiries having segment parameters other than the TRN segment within their respective Claim Submitter Trace and Service Line Information Loops will be treated as one Claim Level Request and one Service Level Request.

Additional: Claim Level parameters will not serve to filter, select or retrieve information when extracting and formatting 277 responses for Service Level Requests.

### ***Multiple TRN 276 Claim Status Inquiries***

- The PNHP Implementation tables below are not intended to be a comprehensive description of each 276/277 segment available. The table identifies all tables and loops. Elements for segments requiring additional explanation listed for certain segments are highlights certain segment table outlining specific data format or content within the transactions, or describing PNHP handling of specific data types.

**Transaction: 276 Health Care Claim Request**

Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				Required
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
2000A	Information Source Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	20 – Information source	
			04	1 – Subordinate HLs exist	
2100A	Payer Name				Loop Required
		NM1: Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	PNHP	
2000B	Information Receiver Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HLs exist	
2100B	Receiver Name				Loop Required
		NM1: Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Service Provider Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	21 – Information Receiver	
			04	1 – Subordinate HLs exist	
2100C	Service Provider Name				Loop Required
		NM1: Subscriber Name			
			01	1P – Service Provider Name	
			08	SV – Service Provider Number	
			09	Partner's assigned provider number	
2000D	Subscriber Hierarchal Level				Loop Required
		HL: Hierarchal Level			

			03	22 – Subscriber	
			04	1 – Subordinate HLs exist	Required for Dependent Inquiry – 2200E Loop ID (HL03=23) must exist
				0 – Subordinate HLs do not exist	Required for Subscriber Inquiry 2200D Loop ID. Dependent Inquiry – 2200E Loop ID (HL03=23) must not exist.
		DMG: Demographic Information			Required for 2100D Subscriber Inquiry – 2200D Loop ID must exist.
2100D	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL – Subscriber	Expected for Dependent Inquiry – 2200E Loop ID when Subscriber Inquiry 2200D not present.
				QC – Use only when Subscriber is the Patient	Expected for Subscriber Inquiry 2200D regardless of presence of Dependent Inquiry 2200E.
			08	MI – Member ID Number	
			09	PNHP Member ID	
2200D	Subscriber Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or PNHP assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only
2210E	Subscriber Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			04	Revenue Code	Not Used
		REF: Service Line Item ID			
			01	FJ – Line Item Control Number	<b>Allowed but not functional.</b> Providers Line Item not saved in Payer system.
2000E	Dependent Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	23 – Dependent	

			04	0 - Subordinate HLs do not exist	Required for Dependent Inquiry – 2200E Loop ID must exist
		DMG: Demographic Information			Required for 2100D Subscriber Inquiry – 2200D Loop ID must exist
2100E	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Patient	
			08	MI – Member ID Number	
			09	PNHP Member ID	
2200E	Dependent Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or PNHP assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only
2210E	Dependent Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			04	Revenue Code	Not Used
		REF: Service Line Item ID			
			01	FJ – Line Item Control Number	<b>Allowed but not functional.</b> Providers Line Item not saved in Payer system.

**Transaction: 277 Health Care Claim Response**

Loop ID	Loop ID Description	Segment	Element	Element Values	Comments
	Beginning of Hierarchal Transaction				Required
		BHT: Beginning of Hierarchal			
			04	Transaction creation date	
2000A	Information Source Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	20 – Information Source	
			04	1 – Subordinate HLs exist	
2100A	Payer Name				Loop Required
		NM1: Payer Name			
			01	PR – Payer	
			08	PI – Payer Identification	
			09	PNHP	
2000B	Information Receiver Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	19 – Provider of Service	
			04	1 – Subordinate HLs exist	
2100B	Receiver Name				Loop Required
		NM1: Receiver Name			
			01	41 – Submitter	
			08	46 – Electronic Transmitter ID	
			09	Trading Partner ID	
2000C	Service Provider Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	21 – Information Receiver	
			04	1 – Subordinate HLs exist	
2100C	Service Provider Name				Loop Required
		NM1: Subscriber Name			
			01	1P – Service Provider Name	
			08	SV – Service Provider Number	

			09	Partner's assigned provider number	
2000D	Subscriber Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	22 – Subscriber	
			04	1 – Subordinate HLs exist	Required for Dependent Inquiry – 2200E Loop ID (HL03 = 23) must exist
				0 – Subordinate HLs do not exist	Required for Subscriber Inquiry 2200D Loop ID. Dependent Inquiry – 2200E Loop ID (HL03 = 23) must not exist.
2100D	Subscriber Name				Loop Required
		NM1: Subscriber Name			
			01	IL - Subscriber	
				QC – Subscriber is the Patient	
			08	MI – Member ID Number	
			09	PNHP Member ID	
2200D	Subscriber Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or PNHP assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only.
2220D	Subscriber Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			03	Payment Amount	
			04	Revenue Code	Not Used
2000E	Dependent Hierarchal Level				Loop Required
		HL: Hierarchal Level			
			03	23 – Dependent	
			04	0 – Subordinate HLs do not exist	
2100E	Dependent Name				Loop Required
		NM1: Subscriber Name			
			01	QC – Pateint	
			08	MI – Member ID Number	
			09	PNHP Member ID	

2200E	Dependent Claim Request Parameters				Loop Situational
		TRN: Trace Number			Required
		REF: Claim Identification Number			
			01	1K – Patient Control Number or PNHP assigned Claim Number	Patient Control Number corresponds to CLM01 originally sent in X12N 837.
		REF: Institutional Bill Type ID		Example: REF*BLT*131	X12N 837I only.
2220E	Dependent Service Line Request Parameters				Loop Situational
		SVC: Service Line Information			Required
			01	HC – HCPCS	
				NU – Revenue Code	
			03	Payment Amount	
			04	Revenue Code	Not used

# Chapter 6

## 278 – Health Care Services Review/Response

### Overview

This chapter of the PNHP Companion Guide identifies processing medical referrals and hospital admissions particular to PNHP in its implementation of the 278 Health Care Services Review/Response Transaction. The chapter contains two sections:

- a general section with material applicable to the processing of Referrals/Admissions and business edits performed by BCBSNC
- a table outlining specific requests for data format or content within the transaction, or describing PNHP handling of specific data types

### Frequency

#### Time Frames for Processing

Admission and referral processing is done in batch after the end of the business day. Batches must have passed through an initial validation process to reach the enrollment process. Senders should allow time for validation and submit transmissions by 5:30 p.m.

#### Batch Volume

There are no standard Batch Volume limitations.

#### Acknowledgements

A 997 will be returned to the submitter upon the receipt of a batch transmission. This is conditional, based upon the integrity of the ISA. If the ISA is in error and/or the submitter's ID is erroneous, no 997 will be sent.

#### Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 834 Benefit Enrollment and Maintenance transaction.

#### Transaction Structure

Level of Error	Type of Error	Transaction Returned
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide Violations	997
Detail Segments	PARTNERS Business Edits (see 278 - Data Element Table for details)	AMISYS Error Report

# Business Edits

## Identification Codes and Numbers

### **Provider Identifiers**

Until such time as the National Provider Identification Numbers are assigned, Partners uses the Partners' Provider Number in the 2310 NM1 segment (Individual or Organizational Name). As outlined in the Data Element Table, this field is not required. Therefore, if the member does not have knowledge of this number, nothing needs to be entered here.

### **Subscriber Identifiers**

Submitters should use the subscriber's SSN until HIPAA legislation requires differently.

### ***Dates (Format and Content)***

The following statements apply to any dates within an 278 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.

# Chapter 8

## 820 – Payroll Deducted

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### Overview

This chapter of the PNHP Companion Guide Identifies processing information for the 820 Premium Payment Order/Advice transaction. The following areas are covered in this chapter:

- Time Frames for Processing
- Business Edits
- Reporting Problems
- Stakeholder Validation Messages

### 820 Transaction Processing

#### *Time Schedules for Processing*

Batch Premium Payment/Advice transactions must be received by 4:00pm EST to be processed that day.

#### *Batch Volume*

There are no standard Batch Volume limitations.

### Acknowledgements

A 997 will be returned to the submitter upon the receipt of a batch transmission. This is conditional, based upon the integrity of the ISA. If the ISA is in error and/or the submitter's ID is erroneous, no 997 will be sent.

### Reporting on Problem Data

The following table indicates which transaction or report is used for communicating problems found within the 820 Payment/Remittance Advice transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
	HIPAA Implementation Guide	997
<ul style="list-style-type: none"> <li>• GS/GE Functional Group</li> <li>• ST/SE Segment</li> </ul>	Violations	
Detail Segments	PNHP Business Edits (See 820 – Data Element Table for details)	Proprietary Error Report

# Business Edits

## Identification Codes and Numbers

### ***Payer Identifiers***

Until such time as the National Employer Identification Numbers are mandated, PNHP uses the PNHP Group Number on the 2310 NM1 segment (Individual or Organizational Name). As outlined in the Data Element Table, this field is not required. Therefore, if the trading partner does not have knowledge of this number, nothing needs to be entered here.

### ***Subscriber Identifiers***

Submitters should use the subscriber's SSN until HIPAA legislation requires differently.

### ***Dates (Formats and Control)***

The following statements apply to any dates within an 820 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD
- The only values acceptable for CC (century) are 18, 19, or 20.

Transaction: 820						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
	ST : 820 Header					
			01	820	Required	
			02	0001	Required. If more than one functional group within the transaction, use the next logical number (0002).	
	BPR : Beginning Segment					
			01	C = Payment Accompanies Remittance D = Payment only I = Remittance information only P = Prenotification of future transfers U = Split payment and remittance X = Handling Party's to split payment and remittance	Required	
			02	XXXX.XX	Required and in this format. Amount of payment.	
			03	C = credit D = debit	Required	
			04	ACH = Automated Clearing House BOP = Financial Institution Option CHK = Check FWT = Federal Reserve Funds/Wire Transfer SWT = Society for Worldwide Interbank Financial Telecommunications	Required	

			05	CCP = Cash Concentration/Disbursement plus Addenda CTX = Corporate Trade Exchange	Required if payment is made using ACH network
		TRN : Reassociation Key			
			01	1 = Current Transaction Trace number 3 = Financial Reassociation Trace number	Required. Trace Type code
			02	Check or Trace number	Required
			16	Date expressed as CCYYMMDD	Required. Date the originating company intends for the transaction to be settled.
		REF : Receivers Identification Key			
			01	14	Required
			02	561520001	Required. PNHP's Federal Tax ID.
		DTM : Date/Time			
			04	RD8	Required if submitting DTM05. Indicates date format of CCYYMMDD – CCYYMMDD.
			05	Coverage period in date format above	Required if submitting DTM04
1000A	Premium Receiver's Name				
		N1 : Name			
			101	PE	Required
			102	PARTNERS National Health Plans of N.C.	Required
			103	F1	Required. Means the number in N104 is a Federal Taxpayer ID.
			104	561520001	Required
1000B	Premium Payer's Name				
		N1 : Name			
			101	PR	Required
			102	Free Form Name	Required
			103	F1	Required. Identifies N104 to be the federal tax id of the payer.
			104	Federal Taxpayer ID number	Required
2000A	Organization Summary Remittance				
		ENT : Entity			
			01	Must be a sequential number within the transaction set, starting with one and incrementing by one.	Required. Generally will be 1.
			02	2L	Required if submitting this segment. Means Corporation.
			03	FI	Required. Means the number in ENT04 is a federal tax id.

			04	Entity's Federal Taxpayer ID Number	Required
2300A	Organization Summary Remittance Detail				
		RMR : Remittance Advice Accounts Receivable Open Item Reference			
			01	1L	Required. Indicates that RMR02 is the PNHP group number assigned to the payer.
			02	Employer PNHP Group Number	Required
			04	Amount of Total Payment	Required
			05	Amount of the billed premium	Required
2310A	Summary Line Item				
		IT1 : Baseline Item Data			
			01	1	Required
2315A	Member Count				
		SLN : Subline Item Detail			
			01	1	Required. Should be same as IT101.
			03	0	Required. Means information only.
			04	Head count	Required. This is the number of contract holders with the type of coverage identified in SLN05-1.
			05-1	10 = Group – family coverage IE = Person – individual coverage PR = Pair – self and spouse coverage	Required. Must be the unit of measure for SLN04 above.
2320A	Organization Summary Remittance Level Adjustment				
		ACX : Adjustment			
			01	Adjustment Amount	Required if paid amount differs from billed amount. If negative use a "-" sign.
			02	20 = Balance Due Declined 52 = Credit for Previous Overpayment 53 = Remittance for previous Overpayment AA = Prepaid Benefit or Advances H1 = Information forthcoming H6 = Partial Payment Remitted IA = Invoice Amount does not Match Account Analysis Statement J3 = Promised Adjustment not Received	Adjustment reason. Required if using ADX01.
2000B	Individual Remittance				
		ENT : Entity			
			01	1	Number to differentiate within transactions. If more than one use 2, 3, etc.

			02	2J	
			03	34 = SSN EI = Employee ID Number ZZ = Mutually Defined	This is what the identification code will be.
2100B	Individual Name				
		NM1 : Individual or Organizational Name			
			01	EY = Employee Name QE = Policyholder	
			02	1	Means person
			03	Last Name	
			04	First Name	
			05	Middle Name	
2300B	Individual Premium Remittance Detail				
		RMR : Remittance Advice Accounts Receivable Open Item Reference			
			01	AZ = PNHP issued Group Number IK – Invoice Number	If this segment is used, this element is Required. Can use either.
			02	Reference Number as identified in RMR01	
			04	Payment amount for this entity	If this segment is used, this element is required.
			05	Invoiced Amount	Required if payment does not equal invoiced amount.
		DTM : Date/Time Reference			
			01	582	Identifies the date/time reference as a report period.
			05	RD8	Format of Date range in DTM06.
			06	CCYYMMDD – CCYYMMDD	Dates of the coverage period.
2320B	Individual Premium Adjustment				
		ADX : Adjustment			
			01	Adjustment Amount	If this segment is used, this element is Required.
			02	20 = Balance Due Declined 52 = Credit for Previous Overpayment 53 = Remittance for Previous Underpayment AA = Prepaid Benefit AX = Person no longer employed H1 = Information Forthcoming H6 = Partial Payment Remitted IA = Invoice Amount does not Match Account Analysis Statement J3 = Promised Adjustment not Received	Reason for adjustment.

## 820 Transaction Balancing

Balancing is performed at two levels:

- The total amount of the payment reported in BPR02 must equal the total of all RMR04's.

$$\text{BPR02} = \text{Total of all RMR04}$$

- If the RMR05 field is present and the value is different than the RMR04, additional ADX segment(s) must be included to document the amount differences between RMR04 and RMR05.

$$\text{RMR04} = \text{RMR05} + \text{ADX01}$$

## Chapter 9

# 834 – Benefit Enrollment and Maintenance

---

## Overview

This chapter of the PNHP Companion guide identifies processing Group Enrollments particular to PNHP in its implementation of the 834 Benefit Enrollment and Maintenance Transaction. The chapter contains two sections:

- A general section with material applicable to the processing of Group Enrollments and business edits performed by PNHP
- A table outlining specific requests for data format or content within the transaction, or describing PNHP handling of specific data types

## Frequency

### *Time Frames for Processing*

Enrollment processing is done in batch after the end of the business day. The batch process starts promptly at 6:30pm EST. Batches must have passed through an initial validation process to reach the enrollment process. Senders should allow time for validation and submit transmissions by 5:30pm EST.

### *Batch Volume*

There are no standard Batch Volume limitations.

## Acknowledgements

A 997 will be returned to the submitter upon the receipt of a batch transmission. This is conditional, based upon the integrity of the ISA. If the ISA is in error and/or the submitter's ID is erroneous, no 997 will be sent.

## Reporting on Problem Data

The following table indicates which transaction or report is used for problems found within the 834 Benefit Enrollment and Maintenance transaction.

Transaction Structure Level of Error	Type of Error	Transaction Returned
<ul style="list-style-type: none"><li>• GS/GE Functional Group</li><li>• ST/SE Segment</li><li>• Detail Segments</li></ul>	HIPAA Implementation Guide Violations	997
Detail Segments	PNHP Business Edits (See 834 – Data Element Table for details)	Proprietary Error Report

# Business Edits

## Identification Codes and Numbers

### **Provider Identifiers**

Until such time as the National Provider Identification Numbers are assigned, PNHP uses the PNHP Provider Number on the 2310 NM1 segment (Individual or Organizational Name). As outlined in the Data Element Table, this field is not required. Therefore, if the member does not have knowledge of this number, nothing needs to be entered here.

### **Subscriber Identifiers**

Submitters should use the subscriber's SSN until HIPAA legislation requires differently.

### **Dates (Format and Control)**

The following statements apply to any dates within an 834 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD
- The only values acceptable for "CC" (century) are 18, 19 or 20.

Transaction: 834						
Loop ID	Loop ID Description	Segment	Element	Element Values	Comments	
1000B	Payer				Loop Required	
		N1: Payer				
			01	Use 'IN'		
			03	561520001	PNHP's Federal TaxID	
2000	Member Level Detail				Loop Required	
		INS: Insured Benefit				
			01	"Y" for Contract Record Otherwise "N"		
			02	"18" for Self "01" for Spouse "19" for Child		
			03	Maintenance Type Code with value of either "A", "C", or "T"	If equal to "T", a termination date must be provided in Segment DTP of Loop 2300.	
			05	"C" if Cobra Member Otherwise "A"		
			10	"Y" if Member is Handicapped	Default "N"	
		REF: Subscriber Number				
			01	"0F"		
			02	Subscriber's SSN		
		REF: Member Policy				

		Number		
			01	"1L"
			02	Member's Division# provided by PNHP
2100A	Member Name			Loop Required
		NM1:Member Name		
			01	"IL"
			02	"1"
			03	Member's Last Name
			04	Member's First Name
			05	Member's Middle Name or Initial
				Optional
			06	Member's Prefix
				Optional
			07	Member's Suffix
				Optional
			08	"34"
				Required if INS01 = "Y" Optional for Members
			09	Member's SSN
				Required if INS01 = "Y" Optional for Members
		PER: Member Communications Numbers		
			01	"IP"
				Required if INS01 = "Y"
			03	"HP"
				Required if INS01 = "Y"
			04	Subscriber's home phone number
				Required if INS01 = "Y"
			05	"WP"
				Optional if INS01 = "Y"
			06	Subscriber's work phone number
				Optional if INS01 = "Y"
		N3: Member Residence Street Address		
			01	Subscriber's street address
				Required if INS01 = "Y"
			02	Subscriber's second street address if it exists
		N4: Member's Residence City, State, Zip Code		
			01	Subscriber's City Name
				Required if INS01 = "Y"
			02	Subscriber's State Name
				Required if INS01 = "Y"
			03	Subscriber's Postal Code
				Required if INS01 = "Y"
		DMG: Member Demographics		
			01	"D8"
			02	Member's Date of Birth
			03	Member's Gender
			04	Member's Marital
				Optional if INS01 = "Y"
2300	Health Coverage			Loop Required x2 if sending termination
		DTP: Health Coverage Dates		

			01	"348" for effective date. "349" for termination date. Only send termination date if Member is truly terminating.	
			02	"D8"	
			03	CCYYMMDD date	
2310	Provider Information				
		NM1:Provider Name			
			01	"P3" Primary Care Provider	
			02	1	
			09	PNHP provided PCP number	
2320	Coordination of Benefits				
		COB: Coordination of Benefits			
			03	"1" if there is a coordination of benefits. Otherwise "6"	

# Glossary

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<b>Term</b>	<b>Definition</b>
<	A symbol to indicate a value is “less than” another. For example, 2 < 3. This symbol is used in some PNHP proprietary error messages.
>	A symbol to indicate a value is “greater than” another. For example, 3 > 2. This symbol is used in some PNHP proprietary error messages.
ANSI	American National Standards Institute; the ANSI defines the stream file format X12N, upon which the HIPAA-compliant electronic transactions are modeled. The ANSI format allows variable record lengths. See the Washington Publishing Company Web site for more information on ANSI formats and HIPAA compliance.
ASC	Accredited Standards Committee
Billing Provider	The entity providing medical services requesting the adjudication of the claim. The Billing Provider is identified in both 837 transactions.
Billing Service	An entity that provides claims services to providers/suppliers. A billing service collects claim information from a provider or supplier electronically or on paper and will bill the insurance payer.
Category Codes	An ANSI code set that indicates claim level status information, particularly in a 277 Transaction. The limited set of ANSI category codes used by PNHP is contained in the Companion Guide Chapter on the 276 and 277 Transactions: Claim Status and Response.
CCN	Claim Control Number. See Claim Identifier
Claim Identifier	The PNHP assigned number for individual claims. In the HIPAA ASC X12 Transaction Implementation Guides, this Identification Number is sometimes described as the Internal Control Number (ICN), the Document Control Number (DCN), or the Claim Control Number (CCN).
Clearinghouse	An entity that transfers or moves EDI transactions for a health care provider or supplier.
COB	Coordination of Benefits
Code Set	A group of codes with pre-defined meanings, either medical or non-medical. A code set may be controlled by X12 or by an independent industry group. Only values from a named code set may be used in specific data elements. Appendix C of every implementation guide contains listings of external code sources used in the IG.

<b>Term</b>	<b>Definition</b>
Delimiters	A delimiter is a character used to separate two data elements (or sub-elements) or to terminate a segment within a data string. Delimiters are specified in the interchange header segment, ISA. Examples of standard delimiters used in ANSI X12 transactions include the asterisk (*), colon (:), and the tilde (~). See Data String Example sections of any of the transaction chapters of this document for further examples.
Dependent	The individual for whom a health insurance claim is being submitted if different from the subscriber.
DOB	Date of Birth
DOS	Date of Service
DX	Diagnosis Code
EDI	Electronic Data Interchange; the EDI Services division of PNHP establishes connectivity arrangements with trading partners for electronic transmission.
EFT	Electronic Funds Transfer is the automatic transfer of payment to a provider or supplier's bank account.
Element	A data component identified in the HIPAA Implementation Guides that collectively comprise the content of a transaction segment. Data elements have identifiers that indicate the segment to which they belong, such as NM1-01, which indicates the NM1 Segment, and the 01 element within that segment.
Element Table	The Companion Guide includes a Transaction Element Table for each transaction to provide PNHP business rule annotations at the segment and element level for that specific transaction.
Envelope	A section of an EDI Transaction that defines some portion of the electronic exchange, such as the Communications Envelope or the Interchange Envelope.
EOP	Explanation of Payment
ERA	Electronic Remittance Advice
File Map	File maps are included in this document to illustrate the sample data strings as they correspond to the HIPAA Implementation Guides (IG) and PNHP processing. IG Loops, Segments, and Elements are identified. The File Maps allow the user to see an entire transaction condensed so that it can be viewed within a couple of pages.

Term	Definition
Functional Acknowledgement (997)	A functional acknowledgement is sent via a 997 Transaction, in response to the receipt of an electronic transaction at the Functional Group (GS/GE) level. A 997 Transaction can also be used to indicate Implementation Guide errors. See the Introduction to the Companion Guide, Reporting, for more information.
HCPCS	HCFA Common Procedural Coding System is a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.
Information Receiver	The information receiver is a new label used in the 270/271 and 276/277 Transactions to identify the entity making the inquiry and therefore receiving the information from the inquiry.
GS/GE	The header and trailer identifiers for the Functional Group portion of an ISA/IEA envelope within an EDI transmission. The Functional Group identifies the type of transaction sent, such as an 837 or a 270.
ID	Identifier
ICN	Internal Control Number. See Claim Identifier.
Interchange Acknowledgement (TA1)	A TA1 transaction provides acknowledgement of receipt of a transmission at the Interchange Control (ISA/IEA) level. A TA1 can also be used to indicate Implementation Guide errors at the ISA/IEA level. See the Introduction to the Companion Guide for more information.
ISA/IEA	The header and trailer identifiers for the Interchange Control envelope. The ISA/IEA header and trailer define the parameters of an Interchange Group envelope within an EDI transmission.
Loop	The largest named unit of information in a transaction set. A loop contains logically related segments in order to group related information. Loops are labeled by a combination of nominative and numeric identifiers, such as <i>2000 Billing/Pay to Provider</i> . The numeric portion of the label indicates its placement within the transaction ( <i>2000</i> ), while the descriptive name identifies its focus ( <i>Billing/Pay to Provider</i> ).
Member ID	Sometimes called the certificate number, this is the PNHP identification number for a subscriber or member of a health care plan. Note that not all members are subscribers. Dependents of subscribers may have their own member identification number.

Term	Definition
National Provider ID (NPI)	A national system for uniquely identifying all providers of health care services, supplies, and equipment. These identifiers have not yet been assigned. PNHP is requesting the use of the PNHP Provider Number until the NPI has been assigned. In some cases where the provider does not have a PNHP Provider Number, the provider's Federal Tax Identifier (or Social Security Number) may be used instead. Use of the Federal Tax Identifier instead of the PNHP Provider Number should be verified with PNHP EDI Services prior to usage.
NOP	Notification of Payment is contained in an 835 Transaction. It contains detailed information, at the line item level, about what claims were paid or denied.
NSF	National Standard Format. The NSF defines standard code sets used universally in business or government. Within the context of HIPAA, the NSF generally refers to a flat text file format used for the HCFA 1500 claim prior to the implementation of the ASC X12N format.
NUBC	The National Uniform Billing Codes define the billing codes used by institutional providers for processing claims.
Patient	The individual for whom a health insurance claim is being submitted.
Pay-to Provider	The Pay-to Provider identifies a loop in both the 837 Institutional and Professional transactions. The Pay-to Provider loop is required if the provider receiving payment is different from the Billing Provider.
Qualifier	A code from an approved code list used to define the data contained in the element following the qualifier.
Receiver Identifier	The Receiver Identifier is used in an 835 Transaction if the recipient of the payment is other than the payee identified in the transaction. It is distinct from the Information Receiver ID used in the 270 and 276 transactions.
Segment	A group of data elements that defines a portion or "level" of a loop. Each segment focuses on a particular subject within a loop, such as <i>Provider Information</i> , and is comprised of any number of elements. Segments are labeled by an alpha or alphanumeric indicator and a descriptive name, such as <i>NM1 Individual or Organizational Name</i> .
Sender	The sender of an electronic transaction may be a clearinghouse, service bureau, health institution, or health provider. The sender must have a unique identifier, entered in the ISA level of the transaction for successful electronic transmission. See the Introduction to the Companion Guide for definitions for all identifiers.

<b>Term</b>	<b>Definition</b>
Special Characters	Generally only those characters contained on a lower-case keyboard are accepted for electronic transmission. Data elements such as names may contain dashes, apostrophes, spaces, or periods. See Character Set Restrictions in the Introduction to the Companion Guide for more information about special characters.
Stakeholder	A stakeholder is any entity with which PNHP has a Trading Partner Agreement and/or a request for electronic connectivity. It can be either a health care provider, that provider's clearinghouse or service bureau, or an employer group.
ST/SE Set	The ST/SE set is a portion of an interchange envelope that contains numerous detail segments of a transaction. Multiple ST/SE segments may be contained within a Functional Group. In an 837 Functional Group, for example, an ST/SE segment contains multiple claims. Each ST/SE segment contains transactions grouped by healthcare provider.
Submitter	The submitter is identified in the ST/SE level of a transaction and is a health care provider or health care institution. PNHP distinguishes between a <i>submitter</i> and the <i>sender</i> of an EDI transaction, which is often a clearinghouse or service bureau.
TOB	An abbreviation for Type of Bill or Bill Type used in some PNHP proprietary error messages.
Trading Partner (TP)	A business entity with which an agreement exists to exchange information, either electronically or on paper.
TPA	Trading Partner Agreement; A Trading Partner Agreement must be completed by an entity wishing to send electronic transactions to PNHP. See the <i>Contact Information: Requests for Service</i> section of the <i>Introduction to the Companion Guide</i> for more information about the TPA.
Transaction	Within the context of HIPAA, PNHP refers to a transaction as that collection of data elements necessary to perform a business function, whether that is the adjudication of a claim or the response to an inquiry.
Transmission	Two possible definitions are used within context of the Companion Guide: the actual electronic send action, or the entire Communications Envelope that includes the ISA or Interchange Envelope/s.
Vendor	An entity that provides hardware, software, and/or ongoing technical support to health care providers or suppliers for their electronic transmissions of transactions.
WPC	Washington Publishing Company (WPC) publishes the ANSI developed HIPAA Transaction Implementation Guides and their accompanying Status, Category, and Adjustment Reason Code lists.

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# Appendix A: Health Care Claims Adjustment Reason Codes\*

	Description	Note
1	Deductible Amount	
2	Coinsurance Amount	
3	Co-payment Amount	
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	
5	The procedure code/bill type is inconsistent with the place of service	
6	The procedure code is inconsistent with the patient's age	
7	The procedure code is inconsistent with the patient's gender	Changed as of 2/00
8	The procedure code is inconsistent with the provider type	
9	The Diagnosis is inconsistent with the patient's age	
10	The Diagnosis is inconsistent with the patient's gender	Changed as of 2/00
11	The Diagnosis is inconsistent with the procedure	
12	The Diagnosis is inconsistent with the provider type	
13	The date of death precedes the date of service	
14	The date of birth follows the date of service	
15	Payment adjusted because the submitted authorization number is missing	Changed as of 2/01
16	Claim/service lacks information that is needed for adjudication	
17	Payment adjusted because requested information was not provided or was insufficient/incomplete	Changed as of 2/01
18	Duplicate claim/service	
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier	
20	Claim denied because this injury/illness is covered by the liability carrier	
21	Claim denied because this injury/illness is the liability of the no-fault carrier	
22	Payment adjusted because this care may be covered by another payer per coordination of benefits	Changed as of 2/01
23	Payment adjusted because charges have been paid by another payer	Changed as of 2/01
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan	Changed as of 6/00
25	Payment denied. Your Stop loss deductible has not been met	
26	Expenses incurred prior to coverage	
27	Expenses incurred after coverage terminated	
28	Coverage not in effect at the time the service was provided.	Inactive for 004010, since 6/98. Redundant to codes 26&27
29	The time limit for filing has expired	
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements	Changed as of 2/01
31	Claim denied as patient cannot be identified as our insured	
32	Our records indicate that this dependent is not an eligible dependent as defined	
33	Claim denied. Insured has no dependent coverage	
34	Claim denied. Insured has no coverage for newborns	
35	Benefit maximum has been reached	
36	Balance does not exceed co-payment amount	Inactive for 003040
37	Balance does not exceed deductible	Inactive for 003040
38	Services not provided or authorized by designated (network) providers	
39	Services denied at the time the authorization/pre-certification was requested	
40	Charges do not meet qualifications for emergent/urgent care	

	Description	Note
41	Discount agreed to in Preferred Provider contract	Inactive for 003040
42	Charges exceed our fee schedule or maximum allowable amount	
43	Gramm-Rudman reduction	
44	Prompt-pay discount	
45	Charges exceed your contracted/legislated fee arrangement	
46	This (these) service(s) is (are) not covered	Inactive for 004010, since 6/00. Use code 96
47	This (these) Diagnosis(es) is (are) not covered, missing or are invalid	Changed as of 6/00
48	This (these) procedure(s) is (are) not covered	Inactive for 004010, since 6/00. Use code 96
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer	
51	These are non-covered services because this is a pre-existing condition	
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed	Changed as of 10/98
53	Services by an immediate relative or a member of the same household are not covered	
54	Multiple physicians/assistants are not covered in this case	
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer	
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer	
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage or this day's supply	Changed as of 2/01
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service	Changed as of 2/01
59	Charges adjusted based on multiple surgery rules or concurrent anesthesia rules	Changed as of 6/00
60	Charges for outpatient services with this proximity to the inpatient services are not covered	
61	Charges adjusted as penalty for failure to obtain second surgical opinion	Changed as of 6/00
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization	Changed as of 2/01
63	Correction to a prior claim	Inactive for 003040
64	Denial reversed per Medical Review	Inactive for 003040
65	Procedure code was incorrect. This payment reflects the correct code	Inactive for 003040
66	Blood deductible	
67	Lifetime reserve days (Handled in QTY, QTY01=LA)	Inactive for 003040
68	DRG weight (Handled in CLP 12)	Inactive for 003040
69	Day outlier amount	
70	Cost outlier –Adjustment to compensate for additional costs	Changed as of 6/01
71	Primary Payer amount	Deleted as of 6/00. Use code 23
72	Coinsurance day (Handled in QTY, QTY01=CD)	Inactive for 003040
73	Administrative days	Inactive for 003050
74	Indirect Medical Education Adjustment	
75	Direct Medical Education Adjustment	
76	Disproportionate Share Adjustment	
77	Covered days (Handled in QTY, QTY01=CA)	Inactive for 003040
78	Non-covered days/Room charge adjustment	
79	Cost Report days (Handled in MIA15)	Inactive for 003050
80	Outlier days (Handled in QTY, QTY01=OU)	Inactive for 003050
81	Discharges	Inactive for 003040
82	PIP days	Inactive for 003040
83	Total visits	Inactive for 003040
84	Capital Adjustment (Handled in MIA)	Inactive for 003050
85	Interest amount	

	Description	Note
86	Statutory Adjustment	Inactive for 004010, since 6/98. Duplicative of code 45
87	Transfer Amount	
88	Adjustment amount represents collection against receivable created in prior overpayment	
89	Professional fees removed from charges	
90	Ingredient cost adjustment	
91	Dispensing fee adjustment	
92	Claim paid in full	Inactive for 003040
93	No claim level adjustments	Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional
94	Processed in Excess of charges	
95	Benefits adjusted. Plan procedures not followed	Changed as of 6/00
96	Non-covered charge(s)	
97	Payment is included in the allowance for another service/procedure	Changed as of 2/99
98	The hospital must file the Medicare claim for this inpatient non-physician service	Inactive for 003040
99	Medicare Secondary Payer Adjustment Amount	Inactive for 003040
100	Payment made to patient/insured/responsible party	
101	Predetermination: anticipated payment upon completion of services or claim adjudication	Changed as of 2/99
102	Major Medical Adjustment	
103	Provider promotional discount (e.g.: Senior Citizen discount)	Changed as of 6/01
104	Managed care withholding	
105	Tax withholding	
106	Patient payment option/election not in effect	
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim	
108	Payment reduced because rent/purchase guidelines were not met	Changed as of 2/01
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor	
110	Billing date predates service date	
111	Not covered unless the provider accepts assignment	
112	Payment adjusted as not furnished directly to the patient and/or not documented	Changed as of 2/01
113	Payment denied because service/procedure was provided outside the United States or as a result of war	Changed as of 2/01
114	Procedure/product not approved by the Food and Drug Administration	
115	Payment adjusted as procedure postponed or canceled	Changed as of 2/01
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements	Changed as of 2/01
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care	Changed as of 2/01
118	Charges reduced for ESRD network support	
119	Benefit maximum for this time period has been reached	
120	Patient is covered by a managed care plan	Inactive for 004030, since 6/99. Use code 24
121	Indemnification adjustment	
122	Psychiatric reduction	
123	Payer refund due to overpayment	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals
124	Payer refund amount – not our patient	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals
125	Payment adjusted due to a submission/billing error(s)	Changed as of 2/01
126	Deductible – Major Medical	New as of 2/97
127	Coinsurance – Major Medical	New as of 2/97
128	Newborn's services are covered in the mother's allowance	New as of 2/97
129	Payment denied – Prior processing information appears incorrect	Changed as of 2/01

	Description	Note
130	Claim submission fee	Changed as of 6/01
131	Claim specific negotiated discount	New as of 2/97
132	Prearranged demonstration project adjustment	New as of 2/97
133	The disposition of this claim/service is pending further review	Changed as of 10/99
134	Technical fees removed from charges	New as of 10/98
135	Claim denied. Interim bills cannot be processed	New as of 10/98
136	Claim adjusted. Plan procedures of a prior payer were not followed	Changed as of 6/00
137	Payment/Reduction for regulatory surcharges, assessments, allowances or health related taxes	New as of 2/99
138	Claim/service denied. Appeal procedures not followed or time limits not met	New as of 6/99
139	Contracted funding agreement – Subscriber is employed by the provider of services	New as of 6/99
140	Patient/Insured health identification number and name do not match	New as of 6/99
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage	Changed as of 6/00
142	Claim adjusted by the monthly Medicaid patient liability amount	New as of 6/00
143	Portion of payment deferred	New as of 2/01
144	Incentive adjustment, e.g. preferred product/service	New as of 6/01
A0	Patient refund amount	
A1	Claim denied charges	
A2	Contractual adjustment	
A3	Medicare secondary payer liability met	Inactive for 004010, since 6/98
A4	Medicare claim PPS capital day outlier amount	
A5	Medicare claim PPS capital cost outlier amount	
A6	Prior hospitalization for 30 day transfer requirement not met	
A7	Presumptive payment adjustment	
A8	Claim denied; ungroupable DRG	
B1	Non-covered visits	
B2	Covered visits	Inactive for 003040
B3	Covered charges	Inactive for 003040
B4	Late filing penalty	
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded	Changed as of 2/01
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty	Changed as of 2/01
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	Changed 10/98
B8	Claim/service not covered/reduced because alternative services were available and should have been utilized	
B9	Services not covered because the patient is enrolled in a Hospice	
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor	
B12	Services not documented in the patient's medical records	
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment	
B14	Payment denied because only one visit or consultation per physician per day is covered	Changed as of 2/01
B15	Payment adjusted because this procedure/service is not paid separately	Changed as of 2/01
B16	Payment adjusted because 'New Patient' qualifications were not met	Changed as of 2/01
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current	Changed as of 2/01
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission	Changed as of 2/01

	<b>Description</b>	<b>Note</b>
B19	Claim/service adjusted because of the finding of a Review Organization	Inactive for 003070
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider	Changed as of 2/01
B21	The charges were reduced because the service/care was partially furnished by another physician	Inactive for 003040
B22	This payment is adjusted based on the Diagnosis	Changed as of 2/01
B23	Payment denied because this provider has failed an aspect of a proficiency testing program	Changed as of 2/01
D1	Claim/service denied. Level of subluxation is missing or inadequate	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D2	Claim lacks the name, strength or dosage of the drug furnished	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D4	Claim/service does not indicate the period of time for which this will be needed	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D5	Claim/service denied. Claim lacks individual lab codes included in the test	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D6	Claim/service denied. Claim did not include patient's medical record for the service	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review'	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used	Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary
D10	Claim/service denied. Completed physician financial relationship form not on file	Inactive for 003070, since 8/97. Use code 17
D11	Claim lacks completed pacemaker registration form	Inactive for 003070, since 8/97. Use code 17
D12	Claim/service denied. Claim does not identify who performed the purchased Diagnostic test or the amount you were charged for the test	Inactive for 003070, since 8/97. Use code 17
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest	Inactive for 003070, since 8/97. Use code 17
D14	Claim lacks indication that plan of treatment is on file	Inactive for 003070, since 8/97. Use code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician	Inactive for 003070, since 8/97. Use code 17.
W1	Workers Compensation State Fee Schedule Adjustment	New as of 2/00.

..This table contains the *Health Care Claims Adjustment Reason Codes*, as published by the Washington Publishing Company on its Web site in the Spring, 2002. These codes can periodically change. For current code lists, access the Washington Publishing Web site at <http://www.wpc-edi.com>