

From: [Floden, Daryl M](mailto:Floden.Daryl.M)
To: ["Ann.M.Hale@HealthPartners.Com"](mailto:Ann.M.Hale@HealthPartners.Com); ["Bellefeuille@centracare.com"](mailto:Bellefeuille@centracare.com); ["Cherie.A.Nauha@HealthPartners.Com"](mailto:Cherie.A.Nauha@HealthPartners.Com);
["Cyndi.Frauendienst@allina.com"](mailto:Cyndi.Frauendienst@allina.com); ["Cyndi.Frauendienst@allina.com"](mailto:Cyndi.Frauendienst@allina.com); ["david.andersen@medica.com"](mailto:david.andersen@medica.com);
["david.haugen@state.mn.us"](mailto:david.haugen@state.mn.us); [Debra Schmidt](mailto:Debra.Schmidt); ["Donald.J.Bechtle@HealthPartners.Com"](mailto:Donald.J.Bechtle@HealthPartners.Com);
["douglas_r_fangmeier@bluecrossmn.com"](mailto:douglas_r_fangmeier@bluecrossmn.com); ["Faye.A.Ostroot@HealthPartners.Com"](mailto:Faye.A.Ostroot@HealthPartners.Com); ["Fischera@centracare.com"](mailto:Fischera@centracare.com);
["Jolene.Bendix@bluecrossmn.com"](mailto:Jolene.Bendix@bluecrossmn.com); ["lisa.wichterman@state.mn.us"](mailto:lisa.wichterman@state.mn.us); [Lorri Vickerman](mailto:Lorri.Vickerman);
["mhotujec@healtheast.org"](mailto:mhotujec@healtheast.org); ["Scott.DeLong@ParkNicollet.com"](mailto:Scott.DeLong@ParkNicollet.com); [Frost, Kimberly K](mailto:Frost.Kimberly.K)
Cc: ["Bendix, Jolene"](mailto:Bendix.Jolene); ["DeLong, Scott H."](mailto:DeLong.Scott.H); [Haugen, David \(MDH\)](mailto:Haugen.David); ["Andersen, David"](mailto:Andersen.David); ["Fischer, Anna"](mailto:Fischer.Anna); ["Nauha, Cherie A"](mailto:Nauha.Cherie.A); ["Ostroot, Faye A"](mailto:Ostroot.Faye.A); ["Hale, Ann M"](mailto:Hale.Ann.M); [Wichterman, Lisa \(DLI\)](mailto:Wichterman.Lisa); ["Bellefeuille, Molly"](mailto:Bellefeuille.Molly)
Subject: AUC Acknowledgement TAG v7030
Attachments: [Chng items 42-91 to DF 10-11-16.docx](#)
[Chng Items thru 42 10-11-16.docx](#)

Attached are the documents we reviewed on 10-17-16 with comments. We did identify some of the change log items that we want the different organizations to review because we considered them to be the most impactful changes.

Please make sure your organization reviews these particular ones prior to this meeting.

Change Log items:
62
63
82
83
84

We also marked Change Log Item #1 as one to revisit because I think we found it confusing and that maybe X12 was moving some sections around.

Have a great day!

The information transmitted in this e-mail is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material, including 'protected health information'. If you are not the intended recipient, you are hereby notified that any review, retransmission, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please destroy and delete this message from any computer and contact us immediately by return e-mail.

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
1	<p>1.4.2.1 STC Composite and Code Use Rules (Jan 2007) The following rules apply to use of the composites and codes within the STC segment:</p> <ul style="list-style-type: none"> • STC01 is required <p>• STC10 and STC11 are situational and provide additional clarification to STC01 when needed.</p> <ul style="list-style-type: none"> • The Status Category Code for STC10 and STC11 must be within the same Status Category Code group as that used in STC01, but not necessarily the same Status Category Code. (For example, if STC01 uses the Category Code 'A8 - Acknowledgement / Rejected for relational field in error', STC10 and STC11 must use Category Codes from the 'Acknowledgments Category Group' but not necessarily the 'A8' value. STC10 and STC11 could use Category Codes A6 - Acknowledgement/Rejected for Missing Information or A7 - Acknowledgement/Rejected for Invalid Information.) • For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'Ax' for batch. For real time acknowledgements category types 'Ax' and 'Ex' may be used except for E0. Use of the category type 'Ex' is limited to indicating the business application system is unavailable. • Use of STC12 and Health Care Status Code value '448 - Invalid billing combination' is limited to Claim and Service level status (Loops 2200D and 2220D). • Use of STC12 and Health Care Status Code value '448 - Invalid billing combination' may be used when the assignment of a Health Care Claim Status Code is pending review and publication (between meetings of the Claim Adjustment Reason and Claim Status Code Committee). • Additional use of STC12 and Health Care Status Code value '448 - Invalid billing combination' is strongly discouraged by the guide authors as use of the free form text element dilutes the transaction's business purpose and automation capabilities. Use of Category Code A8 - Acknowledgement / Rejected for relational field in error' is encouraged over use of the 448 status code. • Multiple STC segments must be reported for unrelated edits or statuses. 	<p>1.4.3.1 STC Composite and Code Use Rules The following rules apply to use of the composites and codes within the STC segment:</p> <ul style="list-style-type: none"> • STC01 is required • The Status Category Code for STC10 and STC11 must be within the same Status Category Code group as that used in STC01, but not necessarily the same Status Category Code. (For example, if STC01 uses the Category Code 'A8 - Acknowledgement / Rejected for relational field in error', STC10 and STC11 must use Category Codes from the 'Acknowledgments Category Group' but not necessarily the 'A8' value. STC10 and STC11 could use Category Codes A6 - Acknowledgement/Rejected for Missing Information or A7 - Acknowledgement/Rejected for Invalid Information.) • An Entity Code must be identified when the Health Care Claim Status Code message refers to an Entity. For example the Entity Code '85 - Billing Provider' could be used when Status Code '24 - Entity not approved as an electronic submitter' is used. • An Entity Code may also be identified in conjunction with a Health Care Claim Status code to further clarify the status message when the code does not specifically require its use. • For this business application acknowledgment, use of the Claim Status Category Code is limited to category types 'Ax' for batch. For real time acknowledgements category types 'Ax' and 'Ex' may be used except for E0. Use of the category type 'Ex' is limited to indicating the business application system is unavailable. • Multiple STC segments must be reported for unrelated edits or statuses. 	<p>NEW CHAPTER but SIMILAR TO 1.4.2.1</p> <p>Note to SELF: Change Log items 1 and 2 refer to 1.4.3.1</p> <p>1.4.3.1 id different than the current guide is 1.4.2.1 Unclear about why change was made or what the purpose is</p> <p>REVISIT</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
		<p>1 Location X330 Health Care Claim Acknowledgment 1.4 Business Usage</p> <hr/> <p>Action Add Chapter 1 Section 1.4.3.1 STC Composite and Code Use Rules, bullets 2 and 3:</p> <p>An Entity Code must be identified when the Health Care Claim Status Code or the National Council for Prescription Drug Programs Reject/Payment Code message refers to an Entity. For example the Entity Code '85 - Billing Provider' could be used when Status Code '24 - Entity not approved as an electronic submitter' is used.</p> <p>An Entity Code may also be identified in conjunction with a Health Care Claim Status code to further clarify the status message when the code does not specifically require its use.</p> <hr/> <p>CR 1397 Update front matter to clarify usage of the TR3.</p>	
2		<p>2 Location X330 Health Care Claim Acknowledgment 1.4 Business Usage</p> <hr/> <p>Action Modify Chapter 1 1.4.3.1 STC Composite and Code Use Rules, bulleted item 4.</p> <hr/> <p>CR 1153 To clarify intended use.</p>	Unclear - REVIST

<p>3 NEW CHAPTER NOT IN 5010</p>	<p>1.4.3.2 Status Messaging for Real Time Adjudication or Predetermination/Estimation</p> <p>The 277 Claim Acknowledgment (277CA) is used in the real-time claim adjudication process in specific situations to return a reply of "not accepted" or "accepted" for a claim submitted via the 837 Transaction. If payer responds with an 835 in real-time, a 277CA with status of claim accepted may not occur. The Real-Time Mode 277CA will be used to provide status on:</p> <ul style="list-style-type: none"> • an 837 claim that is rejected (not accepted) as a result of data validation and business data editing (i.e. front-end edits). • an 837 claim that is accepted through data validation and business editing, but cannot complete the adjudication or predetermination processes in real time and therefore cannot be reported on a RT 835 response. <p>Real Time Adjudication</p> <p>For a real time claim accepted into the adjudication system, the payer assigned claim number must be returned in Loop 2200D(Claim Status Trace Number) – Payer Claim Control Number REF of the Real-Time Mode 277CA. This will allow the provider to track the claim through processing, if necessary.</p> <p>All real-time claims that are accepted into adjudication, but can't complete adjudication in real-time mode must be acknowledged using the same status code. This will establish reporting consistency within the health care industry and help manage providers' expectations with the real-time process. The Real-Time Mode 277CA claim status reported for these claims must be:</p> <ul style="list-style-type: none"> • Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-1 Category Code - A2: Acknowledgment/Acceptance into adjudication system • Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-2 Status Code - 685: Claim could not complete adjudication in real- time. Claim will continue processing in a batch mode. Do not resubmit <p>Claims that are accepted into adjudication for real time processing, but can't be finalized and responded to with the RT 835 would continue processing. When processing is complete, the claim adjudication results will be reported in the payer's daily or weekly payment cycle 835.</p> <p>Real Time Predetermination/Estimation</p> <p>All predeterminations that cannot complete processing in real-time must be acknowledged using the same Claim Status Category and Claim Status Codes. This will establish reporting consistency within the health care industry and help manage providers' expectations with the real time process. Predetermination claims do not result in payment and are usually not reported in the payer's daily or weekly payment cycle 835. The finalization and reporting process may vary by payer and as result the Category Code assigned on the 277CA will differ. The 277CA claim status reported for these claims must be:</p> <ul style="list-style-type: none"> • Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-1 Category Code - A2: Acknowledgment/Acceptance into adjudication system 	<p>No Concerns</p>
---	--	--------------------

	<p>AND</p> <p>Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-2 Status Code - 687: Claim estimation cannot be completed in real time. Do not resubmit.</p> <p>OR</p> <ul style="list-style-type: none">Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-1 Category Code - A3: Acknowledgment/Returned as unprocessable claim - The claim/encounter has been rejected and has not been entered into the adjudication system <p>AND</p> <p>Loops 2200D(Claim Status Trace Number), 2220D(Service Line Information) STC01-2 Status Code - 687: Claim estimation cannot be completed in real time. Do not resubmit.</p> <hr/> <p>3 Location X330 Health Care Claim Acknowledgment 1.4 Business Usage</p> <hr/> <p>Action Add Chapter 1 Section 1.4.3.2 Status Messaging for Real Time Adjudication or Predetermination/Estimation</p> <hr/> <p>CR 1037 Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.</p>	
--	--	--

<p>4</p>	<p>NEW SECTION NOT IN 5010</p>	<p>1.4.5 Balancing In order to ensure internal claim integrity, the quantities and amounts reported in the 277CA MUST balance at two different levels — the Information Receiver level and the Provider level.</p> <p>1) Information Receiver The claim counts and amounts reported in the 2200B Information Loop must equal the sum of the claim counts and amounts reported the 2200C Provider Loop.</p> <p>The total accepted claim count reported in Loop ID-2200B QTY02 must balance to the sum of all accepted claim count reported in Loop ID-2200C QTY02.</p> <p>The total rejected claim count reported in Loop ID-2200B QTY02 must balance to the sum of all rejected claim count reported in Loop ID-2200C QTY02.</p> <p>The total accepted amount reported in Loop ID-2200B AMT02 must balance to the sum of all accepted amounts reported in Loop ID-2200C AMT02.</p> <p>The total rejected amount reported in Loop ID-2200B AMT02 must balance to the sum of all rejected amounts reported in Loop ID-2200C AMT02.</p> <p>2) Provider The accepted claim total reported in the Provider Loop 2200C QTY02 must equal the sum of the accepted claims reported in the 2200D STC segment.</p> <p>The accepted claim amount reported in the Provider Loop 2200C AMT02 must equal the sum of the claim accepted amounts in the 2200D STC segment.</p> <p>The rejected claim total reported in the Provider Loop 2200C QTY02 must equal the sum of the rejected claims reported in the 2200D STC segment.</p> <p>The rejected claim amount reported in the Provider Loop 2200C AMT02 must equal the sum of the rejected claim amounts in the 2200D STC segment.</p> <hr/> <p>4 Location X330 Health Care Claim Acknowledgment 1.4 Business Usage</p> <hr/> <p>Action Modify Chapter 1 Added new Section 1.4.5. Balancing</p> <hr/> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>No concerns</p>
----------	---------------------------------------	---	--------------------

<p>5</p>	<p>NEW CHAPTER NOT IN 5010</p>	<p>1.5 Business Terminology The following business terms are used in this implementation guide. Terms in bold are defined consistently across X12 work products, non-bolded terms have a definition unique to this implementation guide.</p> <p>Claim An inclusive term representing both health care claims and health care encounters.</p> <p>Health Care Claim A request from a health care provider to a health plan for payment for health care services, accompanied by supporting information.</p> <p>Health Care Encounter A reporting of health care services from a health care provider to a health plan when there is no direct claim for reimbursement.</p> <p>Information Source Process Date The Information Source Process Date applies to the processing of the 837 claim transaction file through a pre-adjudication/electronic data interchange (EDI) system.</p> <p>Predetermination Request A pre-service request for a statement of the exact benefits that would have been paid had the predetermination request been an actual claim. A predetermination request includes all data necessary to fully adjudicate a claim except for date(s) of service.</p> <p>Predetermination Status Request A request for status on a predetermination request.</p> <p>Real-Time A computer-to-computer communication in which a single communication session is established and remains open and active until a response is received by the entity initiating the communication session.</p> <p>Real-Time Adjudication (RTA) The process of a single claim being submitted by a provider to a payer. The payer fully adjudicates the claim to its final disposition. The payer responds to the provider advising of denial reason(s) or amount to be paid, patient responsibility and adjustments and explanations. The whole process is completed in a single communications session that is established and remains open and active until the adjudicated transaction is received by the entity initiating the communication session.</p>	<p>Are all these comments the same on all other TR3's?</p>
----------	---------------------------------------	--	--

		<p>5 Location X330 Health Care Claim Acknowledgment 1.5 Business Terminology</p> <hr/> <p>Action Add Chapter 1 Section 1.5 Business Terminology</p> <p>Real Time Adjudication - allows providers to submit an electronic claim that is adjudicated in real time and receive a response in real time detailing payment or denial of the rendered service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.</p> <hr/> <p>CR 1037 Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.</p>	
6	<p>NEW CHAPTER NOT IN 5010</p>	<p>6 Location X330 Health Care Claim Acknowledgment 1.5 Business Terminology</p> <hr/> <p>Action Add Chapter 1 Section 1.5 Business Terminology</p> <p>Real Time Predetermination/Estimation - allows providers to submit an electronic claim for a proposed service and receive a response in real time detailing the anticipated payment or denial of the proposed service. The response estimates the payment and member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.</p> <hr/> <p>CR 1037 Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.</p>	Check TR3's
7	<p>NEW CHAPTER NOT IN 5010</p>	<p>7 Location X330 Health Care Claim Acknowledgment 1.5 Business Terminology</p> <hr/> <p>Action Add Chapter 1 Section 1.5 Business Terminology</p> <p>Predetermination Status Request</p> <p>A request for status on a claim that was submitted prior to services being rendered. The predetermination request would include all data necessary to find the predetermination within the payers system, except for date(s) of service. See the 837 TR3 for a definition of a predetermination.</p> <hr/> <p>CR 1192 Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.</p>	Check TR3's

8

1.7.1 The Claim (837)

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

007030X330 | Health Care Claim Acknowledgment | 277CA

1.7.1 The Claim (837)

Submitting a claim using the 837 format may initiate the creation of the Health Care Claim Acknowledgment (277CA) transaction. The 277 Health Care Claim Acknowledgment (277CA) is sent after the 837 transaction was "Accepted" or "Accepted with Errors" by the 999 Implementation Acknowledgement. A 277CA will not be sent if the 837 transaction was rejected in the 999.

The 277CA transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.

8 Location X330 | Health Care Claim Acknowledgment
1.7 Related Transactions

Action **Modify Chapter 1**
1.7.1 The Claim (837), paragraph 1.

Changed to:

Submitting a claim using the 837 format may initiate the creation of the Health Care Claim Acknowledgment (277CA) transaction. The 277 Health Care Claim Acknowledgment (277CA) is sent after the 837 transaction was "Accepted" or "Accepted with Errors" by the 999 Implementation Acknowledgement. A 277CA will not be sent if the 837 transaction was rejected in the 999.

The 277CA transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.

CR 372 Section 1.7.1 should not definitively state that the 837 initiates a 277, as this is not always the case.

No
Concerns

9	
---	--

9	<p>Location X330 Health Care Claim Acknowledgment 1.10 Data Overview</p> <hr/> <p>Action Modify Chapter 1 1.7.1 The Claim (837), paragraph 1.</p> <p>Changed to: Submitting a claim using the 837 format may initiate the creation of the Health Care Claim Acknowledgment (277CA) transaction. The 277 Health Care Claim Acknowledgment (277CA) is sent after the 837 transaction was "Accepted" or "Accepted with Errors" by the 999 Implementation Acknowledgement. A 277CA will not be sent if the 837 transaction was rejected in the 999.</p> <p>The 277CA transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.</p> <hr/> <p>CR 372 Section 1.7.1 should not definitively state that the 837 initiates a 277, as this is not always the case.</p>	9	<p>See change Log item #8 SAME AS #8???</p> <p>NO CONCERN</p>
---	--	---	---

1 0	<p>SEGMENT DETAIL</p> <p style="text-align: center;">BHT - BEGINNING OF HIERARCHICAL TRANSACTION</p> <p>X12 Segment Name: Beginning of Hierarchical Transaction</p> <p>X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Example: BHT*0085*08*0000221*20060201*1635*TH~</p> <p>DIAGRAM</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>BHT01</td> <td>1005</td> <td>Hierarchical Structure Code</td> <td>M 1 ID 4/4</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>0085</td> <td>Information Source, Information Receiver, Provider of Service, Patient</td> </tr> </tbody> </table>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	BHT01	1005	Hierarchical Structure Code	M 1 ID 4/4				Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set					0085	Information Source, Information Receiver, Provider of Service, Patient	1 0	<p>No Concern</p>
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																			
REQUIRED	BHT01	1005	Hierarchical Structure Code	M 1 ID 4/4																			
			Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set																				
			0085	Information Source, Information Receiver, Provider of Service, Patient																			

1 0	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p style="text-align: center;">BHT - BEGINNING OF HIERARCHICAL TRANSACTION</p> <p>X12 Name: Beginning of Hierarchical Transaction</p> <p>X12 Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Example: BHT*0085*08*0000221*20110201*1635*TH~</p> <p>DIAGRAM</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>BHT01</td> <td>1005</td> <td>Hierarchical Structure Code</td> <td>M 1 ID 4/4</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>0085</td> <td>Information Source, Information Receiver, Provider of Service, Patient</td> </tr> </tbody> </table> <div style="border: 2px solid red; padding: 5px; margin-top: 10px;"> <p>Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL parent loop at the same hierarchical level.</p> </div>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	BHT01	1005	Hierarchical Structure Code	M 1 ID 4/4				Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set					0085	Information Source, Information Receiver, Provider of Service, Patient	1 0	<p>No Concern</p>
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																			
REQUIRED	BHT01	1005	Hierarchical Structure Code	M 1 ID 4/4																			
			Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set																				
			0085	Information Source, Information Receiver, Provider of Service, Patient																			

	<p>10 Location X330 Health Care Claim Acknowledgment 277 0200 BHT - Beginning of Hierarchical Transaction</p> <hr/> <p>Action Add Data Element Note Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL parent loop at the same hierarchical level.</p> <hr/> <p>CR 1153 To clarify intended use.</p>	
<p>1 1</p> <p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2000A • HL INFORMATION SOURCE LEVEL</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">HL - INFORMATION SOURCE LEVEL</p> <p>X12 Segment Name: Hierarchical Level</p> <p>X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments</p> <p>X12 Comments:</p> <ol style="list-style-type: none"> The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. The HL segment defines a top-down/left-right ordered structure. <p>Loop: 2000A — INFORMATION SOURCE LEVEL Loop Repeat: 1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This entity is the decision maker in the business transaction. For this business use, this entity is the payer or clearinghouse receiving the ASC X12 837 transaction.</p> <p>TR3 Example: HL*1**20*1~</p>	<p style="text-align: right;">◀ ▶ No Concern</p> <p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment 2000A — INFORMATION SOURCE LEVEL</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">HL - INFORMATION SOURCE LEVEL</p> <p>X12 Name: Hierarchical Level</p> <p>X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments</p> <p>X12 Comments:</p> <ol style="list-style-type: none"> The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. The HL segment defines a top-down/left-right ordered structure. <p>Loop: 2000A — INFORMATION SOURCE LEVEL Loop Repeat: 1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This entity is the decision maker in the business transaction.</p> <p>TR3 Example: HL*1**20*1~</p> <hr/> <p>DIAGRAM</p> <pre> graph LR HL01[HL01 628 Hierarch ID Number M 1 AN 1/12] -- * --- HL02[HL02 734 Hierarch Parent ID O 1 AN 1/12] HL02 -- * --- HL03[HL03 735 Hierarch Level Code M 1 ID 1/2] HL03 -- * --- HL04[HL04 736 Hierarch Child Code O 1 ID 1/1] HL04 ~ </pre> <hr/> <p>11 Location X330 Health Care Claim Acknowledgment 277 0100 2000A HL - Information Source Level</p> <hr/> <p>Action Modify Segment Note TR3 Note Change To: This entity is the decision maker in the business transaction.</p> <hr/> <p>CR 1153 To clarify intended use.</p>	

1 2	ELEMENT DETAIL			
	USAGE	REF. DES.	DATA ELEMENT	NAME
	REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. HL01 must begin with the value "1" and increment by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.
				M 1 AN 1/12

ELEMENT DETAIL				No Concern
USAGE	REF. DES.	D.E. NUM.	NAME	
REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.	
			M 1 AN 1/12	
12	Location	X330 Health Care Claim Acknowledgment 277 0100 2000A HL - Information Source Level		
	Action	Modify Data Element Note Loop ID 2000A/HL01 Element Note		
		Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."		
	CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.		

1 3	ELEMENT DETAIL			
	USAGE	REF. DES.	DATA ELEMENT	NAME
	REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual CODE DEFINITION AY Clearinghouse Health care clearinghouse means a public or private entity that does either of the following: (1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction. (2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity. PR Payer
				M 1 ID 2/3

ELEMENT DETAIL				No Concern
USAGE	REF. DES.	D.E. NUM.	NAME	
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual CODE DEFINITION AY Clearinghouse PR Payer TU Third Party Repricing Organization (TPO)	
			M 1 ID 2/3	
13	Location	X330 Health Care Claim Acknowledgment 277 0500 2100A NM1 - Information Source Name		
	Action	Add Data Element Code Value TU - Third Party Repricing Organization (TPO).		
	CR 737	Add Repricer functionality.		

<p>1 4</p>	<p>REQUIRED NM108 66 Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>46</td> <td>Electronic Transmitter Identification Number (ETIN) This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities.</td> </tr> <tr> <td>FI</td> <td>Federal Taxpayer's Identification Number</td> </tr> <tr> <td>PI</td> <td>Payor Identification</td> </tr> </tbody> </table>	CODE	DEFINITION	46	Electronic Transmitter Identification Number (ETIN) This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities.	FI	Federal Taxpayer's Identification Number	PI	Payor Identification	<p>REQUIRED NM108 66 Identification Code Qualifier X 1 ID 1/2 Code specifying the system/method of code structure used for Identification Code (67) SEGMENT SYNTAX: P0809</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>46</td> <td>Electronic Transmitter Identification Number (ETIN)</td> </tr> <tr> <td>FI</td> <td>Federal Taxpayer's Identification Number</td> </tr> <tr> <td>PI</td> <td>Payor Identification</td> </tr> <tr> <td>XV</td> <td>Standard Unique Health Plan Identifier (HPID) Required if the National Plan ID is mandated for use. Otherwise, one of the other listed codes may be used.</td> </tr> </tbody> </table> <p>CODE SOURCE 540: Health Plan Identifier (HPID)</p> <p>14 Location X330 Health Care Claim Acknowledgment 277 0500 2100A NM1 - Information Source Name</p> <p>Action Delete Data Element Code Note Loop ID 2100A/NM108 Identification Code Qualifier</p> <p>46 - Electronic Transmitter Identification Number (ETIN)</p> <p>"This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities."</p> <p>CR 1563 Format code notes consistently.</p>	CODE	DEFINITION	46	Electronic Transmitter Identification Number (ETIN)	FI	Federal Taxpayer's Identification Number	PI	Payor Identification	XV	Standard Unique Health Plan Identifier (HPID) Required if the National Plan ID is mandated for use. Otherwise, one of the other listed codes may be used.	<p>What is the XV? Change refers to 46</p>
CODE	DEFINITION																				
46	Electronic Transmitter Identification Number (ETIN) This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities.																				
FI	Federal Taxpayer's Identification Number																				
PI	Payor Identification																				
CODE	DEFINITION																				
46	Electronic Transmitter Identification Number (ETIN)																				
FI	Federal Taxpayer's Identification Number																				
PI	Payor Identification																				
XV	Standard Unique Health Plan Identifier (HPID) Required if the National Plan ID is mandated for use. Otherwise, one of the other listed codes may be used.																				

<p>1 5</p>	<p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	M 1 AN 1/12	<p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table> <p>15 Location X330 Health Care Claim Acknowledgment 277 0100 2000B HL - Information Receiver Level</p> <p>Action Add Data Element Code Note Loop ID 2000B/HL01</p> <p>The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</p> <p>CR 1109 For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.	M 1 AN 1/12	<p>No Concerns</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	M 1 AN 1/12																			
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.	M 1 AN 1/12																			

1 6	<p>SITUATIONAL STC01 - 3</p>	98	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>36</td> <td>Employer</td> </tr> <tr> <td>40</td> <td>Receiver</td> </tr> <tr> <td>41</td> <td>Submitter</td> </tr> <tr> <td>AY</td> <td>Clearinghouse</td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> </tbody> </table>	CODE	DEFINITION	36	Employer	40	Receiver	41	Submitter	AY	Clearinghouse	PR	Payer	<p>SITUATIONAL STC01-03 98</p>	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>36</td> <td>Employer</td> </tr> <tr> <td>40</td> <td>Receiver</td> </tr> <tr> <td>41</td> <td>Submitter</td> </tr> <tr> <td>AY</td> <td>Clearinghouse</td> </tr> <tr> <td>O4</td> <td>Factor</td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> <tr> <td>PTP</td> <td>Pay-to Plan Name</td> </tr> <tr> <td>TU</td> <td>Third Party Repricing Organization (TPO)</td> </tr> </tbody> </table>	CODE	DEFINITION	36	Employer	40	Receiver	41	Submitter	AY	Clearinghouse	O4	Factor	PR	Payer	PTP	Pay-to Plan Name	TU	Third Party Repricing Organization (TPO)	No Concerns
CODE	DEFINITION																																			
36	Employer																																			
40	Receiver																																			
41	Submitter																																			
AY	Clearinghouse																																			
PR	Payer																																			
CODE	DEFINITION																																			
36	Employer																																			
40	Receiver																																			
41	Submitter																																			
AY	Clearinghouse																																			
O4	Factor																																			
PR	Payer																																			
PTP	Pay-to Plan Name																																			
TU	Third Party Repricing Organization (TPO)																																			
	<p>SITUATIONAL STC10 - 3</p>	98	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-3 for valid values.</p>	<p>SITUATIONAL STC10-03 98</p>	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-03 for valid values.</p>																															
	<p>SITUATIONAL STC11 - 3</p>	98	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-3 for valid values.</p>	<p>SITUATIONAL STC11-03 98</p>	<p>Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-03 for valid values.</p>																															
	<p>16 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <p>Action Modify Data Element Situational Rule STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver." CR 371 Clarify when Claim Status Codes require the transmission of an Entity Code.</p>																																			
1 7	<p>SITUATIONAL STC10</p>	C043	<p>HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line</p> <p>SITUATIONAL RULE: <i>Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.</i></p>	<p>SITUATIONAL STC10</p>	<p>Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line</p> <p>CLICK TO SHOW/HIDE: X12 Composite Semantic Notes</p> <p>SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p>	No Concern																														
	<p>SITUATIONAL STC11</p>	C043	<p>HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line</p> <p>SITUATIONAL RULE: <i>Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.</i></p>	<p>SITUATIONAL STC11</p>	<p>Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line</p> <p>CLICK TO SHOW/HIDE: X12 Composite Semantic Notes</p> <p>SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p>																															

		<p>17 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <hr/> <p>Action Modify Data Element Situational Rule STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."</p> <hr/> <p>CR 1153 To clarify intended use.</p>																															
<p>1 8</p>	<p>SITUATIONAL STC01 - 3 98 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>36</td> <td>Employer</td> </tr> <tr> <td>40</td> <td>Receiver</td> </tr> <tr> <td>41</td> <td>Submitter</td> </tr> <tr> <td>AY</td> <td>Clearinghouse</td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> </tbody> </table>	CODE	DEFINITION	36	Employer	40	Receiver	41	Submitter	AY	Clearinghouse	PR	Payer	<p>SITUATIONAL STC01- 98 Entity Identifier Code O ID 2/3 03 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>36</td> <td>Employer</td> </tr> <tr> <td>40</td> <td>Receiver</td> </tr> <tr> <td>41</td> <td>Submitter</td> </tr> <tr> <td>AY</td> <td>Clearinghouse</td> </tr> <tr> <td>O4</td> <td>Factor</td> </tr> <tr> <td>PR</td> <td>Payer</td> </tr> <tr> <td>PTP</td> <td>Pay-to Plan Name</td> </tr> <tr> <td>TU</td> <td>Third Party Repricing Organization (TPO)</td> </tr> </tbody> </table> <p>18 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <hr/> <p>Action Add Data Element Code Value PTP - Pay to Plan Name.</p> <hr/> <p>CR 378 Add Pay to Plan at the Information Receiver level.</p>	CODE	DEFINITION	36	Employer	40	Receiver	41	Submitter	AY	Clearinghouse	O4	Factor	PR	Payer	PTP	Pay-to Plan Name	TU	Third Party Repricing Organization (TPO)	<p>Log Item 18 = PTP</p> <p>Log Item 19 = O4</p> <p>What is the definition of PTP and when it should be used?</p>
CODE	DEFINITION																																
36	Employer																																
40	Receiver																																
41	Submitter																																
AY	Clearinghouse																																
PR	Payer																																
CODE	DEFINITION																																
36	Employer																																
40	Receiver																																
41	Submitter																																
AY	Clearinghouse																																
O4	Factor																																
PR	Payer																																
PTP	Pay-to Plan Name																																
TU	Third Party Repricing Organization (TPO)																																
<p>1 9</p>		<p>19 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <hr/> <p>Action Add Data Element Code Value O4 - Factor.</p> <hr/> <p>CR 95 The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).</p>	<p>Definition to O4 would be helpful in the guide</p>																														

<p>2 0</p>	<p>REQUIRED STC03 306 Action Code Code indicating type of action</p> <p>O 1 ID 1/2</p> <p>STC03 at this level is intended to convey the electronic transmission status of the ST - SE envelope. The terms "Accept" and "Reject" refer to the electronic transmission status of the 837 transaction not the billing status.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>U</td> <td>Reject Required when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.</td> </tr> <tr> <td>WQ</td> <td>Accept Required when code value "U" is not used. At least one subordinate HL loop must be reported.</td> </tr> </tbody> </table>	CODE	DEFINITION	U	Reject Required when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.	WQ	Accept Required when code value "U" is not used. At least one subordinate HL loop must be reported.	<p>REQUIRED STC03 306 Action Code Code indicating type of action</p> <p>O 1 ID 1/2 No Concern</p> <p>STC03 at this level is intended to convey the electronic transmission status of the ST - SE envelope. The terms "Accept" and "Reject" refer to the electronic transmission status of the 837 transaction not the billing status.</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>U</td> <td>Reject Use when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.</td> </tr> <tr> <td>WQ</td> <td>Accept Use when code value "U" is not used. At least one subordinate HL loop must be reported. Acceptance at this level does not mean all claims have been accepted for processing.</td> </tr> </tbody> </table> <p>20 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <p>Action Modify Data Element Code Note Loop ID 2200B/STC03 Action Code</p> <p>Code Value: WQ - Accept</p> <p>Changed to "Use when code value "U" is not used. At least one subordinate HL loop must be reported. Acceptance at this level does not mean all claims have been accepted for processing."</p> <p>CR 1563 Format code notes consistently.</p>	CODE	DEFINITION	U	Reject Use when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.	WQ	Accept Use when code value "U" is not used. At least one subordinate HL loop must be reported. Acceptance at this level does not mean all claims have been accepted for processing.	
CODE	DEFINITION														
U	Reject Required when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.														
WQ	Accept Required when code value "U" is not used. At least one subordinate HL loop must be reported.														
CODE	DEFINITION														
U	Reject Use when the entire claim transaction (ST-SE) is rejected due to submitter level errors. No subordinate HL information is reported.														
WQ	Accept Use when code value "U" is not used. At least one subordinate HL loop must be reported. Acceptance at this level does not mean all claims have been accepted for processing.														
<p>2 1</p>	<p>REQUIRED STC04 782 Monetary Amount Monetary amount</p> <p>O 1 R 1/18</p> <p>SEMANTIC: STC04 is the amount of original submitted charges.</p> <p>IMPLEMENTATION NAME: Total Submitted Charges for Unit Work</p> <p>This will be the sum of all CLM02 values (claim charge) for the claims being acknowledged. In most instances, this will be the sum of charges submitted from ST to SE of a single 837 transaction set.</p> <p>In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged.</p>	<p>REQUIRED STC04 782 Monetary Amount Monetary amount</p> <p>O 1 R 1/18</p> <p>SEMANTIC: STC04 is the total charge amount.</p> <p>INDUSTRY NAME: Total Submitted Charges for Unit Work</p> <p>This will be the sum of all CLM02 values (claim charge) for the claims being acknowledged. In most instances, this will be the sum of charges submitted from ST to SE of a single 837 transaction set.</p> <p>In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged.</p> <p>Monetary Amounts returned in this element may exceed 10 characters.</p> <p>21 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information</p> <p>Action Add Data Element Note to DE 782 (Monetary Amount):</p> <p>The maximum length of this instance of data element 782 is 10.</p> <p>CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	<p>Contrary to Change log which says maximum 10 characters</p>												

<p>2 2</p>	<p>REQUIRED STC04 782 Monetary Amount Monetary amount SEMANTIC: STC04 is the amount of original submitted charges. IMPLEMENTATION NAME: Total Submitted Charges for Unit Work This will be the sum of all CLM02 values (claim charge) for the claims being acknowledged. In most instances, this will be the sum of charges submitted from ST to SE of a single 837 transaction set. In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged.</p>	<p>REQUIRED STC04 782 Monetary Amount Monetary amount SEMANTIC: STC04 is the total charge amount. INDUSTRY NAME: Total Submitted Charges for Unit Work This will be the sum of all CLM02 values (claim charge) for the claims being acknowledged. In most instances, this will be the sum of charges submitted from ST to SE of a single 837 transaction set. In situations where the 837 transaction from the Information Receiver is separated (e.g. due to clearinghouse involvement), this amount will be the sum of the CLM02 values for the claims being acknowledged. Monetary Amounts returned in this element may exceed 10 characters.</p> <p>22 Location X330 Health Care Claim Acknowledgment 277 1000 2200B STC - Information Receiver Status Information Action Add Data Element Note Loop ID 2200B / STC04 (Total Submitted Charges for Unit of Work) Monetary Amounts returned in this element may exceed 10 characters. CR 1510 Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.</p>	<p>See 22 is this a fix to 21?</p>
<p>2 3</p>	<p>SEGMENT DETAIL</p> <p>QTY - TOTAL ACCEPTED QUANTITY X12 Segment Name: Quantity Information X12 Purpose: To specify quantity information X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required. 2. E0204 Only one of QTY02 or QTY04 may be present. Loop: 2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send. TR3 Notes: 1. The purpose of this segment is to report the total number of claims accepted by the Information Source. TR3 Example: QTY*90*102~</p>	<p>SEGMENT DETAIL</p> <p>QTY - TOTAL ACCEPTED QUANTITY X12 Name: Quantity Information X12 Purpose: To specify quantity information X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required. 2. E0204 Only one of QTY02 or QTY04 may be present. Loop: 2200B — INFORMATION RECEIVER TRACE IDENTIFIER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send. TR3 Notes: 1. The purpose of this segment is to report the total number of claims accepted by the Information Source. 2. For QTY segment balancing, see Section 1.4.5 (Balancing). TR3 Example: QTY*90*102~</p> <p>23 Location X330 Health Care Claim Acknowledgment 277 1210 2200B QTY - Total Accepted Quantity Action Add Segment Note Shared TR3 Note added to Loop ID 2200B/QTY For QTY segment balancing, see Section 1.4.5 (Balancing) CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>No Concern</p>

2
4

SEGMENT DETAIL

QTY - TOTAL REJECTED QUANTITY

X12 Segment Name: Quantity Information
X12 Purpose: To specify quantity information
X12 Syntax: 1. **R0204**
 At least one of QTY02 or QTY04 is required.
 2. **E0204**
 Only one of QTY02 or QTY04 may be present.
Loop: 2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER
Segment Repeat: 1
Usage: SITUATIONAL
Situational Rule: Required when at least one claim is rejected for this Information Receiver. If not required by this implementation guide, do not send.
TR3 Notes: 1. The purpose of this segment is to report the total number of claims rejected for this Information Receiver (e.g. not accepted) by the Information Source.
TR3 Example: QTY*AA*98~

007030X330 | Health Care Claim Acknowledgment | 277CA



No Concern

277 | X330 | Claim Acknowledgment | Total Rejected Quantity

SEGMENT DETAIL

QTY - TOTAL REJECTED QUANTITY

X12 Name: Quantity Information
X12 Purpose: To specify quantity information
X12 Syntax: 1. **R0204**
 At least one of QTY02 or QTY04 is required.
 2. **E0204**
 Only one of QTY02 or QTY04 may be present.
Loop: 2200B — INFORMATION RECEIVER TRACE IDENTIFIER
Segment Repeat: 1
Usage: SITUATIONAL
Situational Rule: Required when at least one claim is rejected for this Information Receiver. If not required by this implementation guide, do not send.
TR3 Notes: 1. The purpose of this segment is to report the total number of claims rejected for this Information Receiver (e.g. not accepted) by the Information Source.
 2. For QTY segment balancing, see Section 1.4.5 (Balancing).
TR3 Example: QTY*AA*98~

24 Location X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200B
 QTY - Total Rejected Quantity

Action Add Segment Note
 Shared TR3 Note added to Loop ID 2200B/QTY

For QTY segment balancing, see Section 1.4.5 (Balancing)
 CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

<p>2 5</p>	<p>SEGMENT DETAIL</p> <p>STC - BILLING PROVIDER STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: >1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when needed to provide the status of a specific Billing Provider's group of claims. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.</p> <p>TR3 Notes: 1. See Section 1.4.2 - Status Information (STC) Segment Usage for specific STC segment information, composites and code use.</p> <p>TR3 Example: STC*A1:19**WQ*432.55~</p>	<p>SEGMENT DELETED- NOT IN 7030</p> <p>25 Location X269 Health Care Claim Acknowledgment STC - Billing Provider Status Information</p> <p>Action Delete Segment Loop ID 2200C / STC (Billing Provider Status Information)</p> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	<p>Why is this being deleted?</p>
<p>2 6</p>	<p>SEGMENT DETAIL</p> <p>AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) accepted by the Information Source for the Billing Provider in this acknowledgment.</p> <p>TR3 Example: AMT*YU*1000.5~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Accepted Amount</p> <p>SEGMENT DETAIL</p> <p>AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting totals for a specific billing provider and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) accepted by the Information Source for the Billing Provider in this acknowledgment. 2. For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: AMT*YU*5053.52~</p> <p>26 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Accepted Amount</p> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200B/AMT</p> <p>For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>No Concern</p>

<p>2 7</p>	<p>YU In Process REQUIRED AMT02 782 Monetary Amount Monetary amount M 1 R 1/18 IMPLEMENTATION NAME: Total Accepted Amount</p>	<p>REQUIRED AMT02 782 Monetary Amount Monetary amount M 1 R 1/18 INDUSTRY NAME: Total Accepted Amount Monetary Amounts returned in this element may exceed 10 characters. 27 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Accepted Amount Action Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10. CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	<p>Contrary to change log? What is correct</p>
<p>2 8</p>		<p>28 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Accepted Amount Action Add Data Element Note Loop ID 2200B / AMT02 (Total Accepted Amount) Monetary Amounts returned in this element may exceed 10 characters. CR 1510 Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.</p>	<p>Is this a correction to 27?</p>
<p>2 9</p>	<p>SEGMENT DETAIL AMT - TOTAL REJECTED AMOUNT X12 Segment Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send. TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment. TR3 Example: AMT*YY*52~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA AMT - TOTAL REJECTED AMOUNT X12 Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send. TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment. 2. For AMT segment balancing, see Section 1.4.5 (Balancing). TR3 Example: AMT*YY*99.5~ 29 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Rejected Amount Action Add Segment Note Shared TR3 Note added to Loop ID 2200B/AMT For AMT segment balancing, see Section 1.4.5 (Balancing). CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>No Concern</p>

<p>3 0</p>	<p>REQUIRED AMT02 782 Monetary Amount Monetary amount M 1 R 1/18 IMPLEMENTATION NAME: Total Rejected Amount</p>	<p>REQUIRED AMT02 782 Monetary Amount Monetary amount M 1 R 1/18 INDUSTRY NAME: Total Rejected Amount Monetary Amounts returned in this element may exceed 10 characters.</p> <p>30 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Rejected Amount Action Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10. CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	<p>Change log inconsistent with change</p>
<p>3 1</p>		<p>31 Location X330 Health Care Claim Acknowledgment 277 1220 2200B AMT - Total Rejected Amount Action Add Data Element Note Loop ID 2200B / AMT02 (Total Rejected Amount) Monetary Amounts returned in this element may exceed 10 characters. CR 1510 Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.</p>	<p>Is this a correction of 30</p>
<p>3 2</p>	<p>SEGMENT DETAIL HL - BILLING PROVIDER OF SERVICE LEVEL X12 Segment Name: Hierarchical Level X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments X12 Comments: 1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. 2. The HL segment defines a top-down/left-right ordered structure. Loop: 2000C — BILLING PROVIDER OF SERVICE LEVEL Loop Repeat: >1 Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when STC03 at the Information Receiver Level (2200B) is equal to "WQ" (ACCEPTED). If not required by this implementation guide, do not send. TR3 Notes: 1. This loop and all subsequent loops are not used when the Information Receiver STC03 is equal to "U" (REJECT). TR3 Example: HL*3*2*19*1~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA 277 X330 Claim Acknowledgment 2000C — BILLING PROVIDER LEVEL SEGMENT DETAIL HL - BILLING PROVIDER LEVEL X12 Name: Hierarchical Level X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments X12 Comments: 1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. 2. The HL segment defines a top-down/left-right ordered structure. Loop: 2000C — BILLING PROVIDER LEVEL Loop Repeat: >1 Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when STC03 at the Information Receiver Level (2200B) is equal to "WQ" (ACCEPTED). If not required by this implementation guide, do not send. TR3 Notes: 1. This loop may be used to provide totals and amounts by billing provider or when a secondary provider identifier needs to be reported in the Provider Secondary REF segment. TR3 Example: HL*3*2*19*1~</p>	<p>Wording changed from Billing Provider of Service Level to Billing Provider Level not documented as a change. Can this be used when a "U" is used?</p>

		<p>32 Location X330 Health Care Claim Acknowledgment 277 0100 2000C HL - Billing Provider Level</p> <hr/> <p>Action Modify Segment Note CHANGE TO: This loop may be used to provide totals and amounts by billing provider or when a secondary provider identifier needs to be reported in the Provider Secondary REF segment.</p> <hr/> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>																					
<p>3 3</p>	<p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table> <p>A unique number assigned by the sender to identify a particular data segment in a hierarchical structure</p> <p>COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.</p>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12	<p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table> <p>A unique number assigned by the sender to identify a particular data segment in a hierarchical structure</p> <p>COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.</p> <p>The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</p> <hr/> <p>33 Location X330 Health Care Claim Acknowledgment 277 0100 2000C HL - Billing Provider Level</p> <hr/> <p>Action Add Data Element Code Note Loop ID 2000C/HL01</p> <p>The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</p> <hr/> <p>CR 1109 For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12	<p>No Concerns</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12																			
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12																			

3 4	REQUIRED	NM108	66	Identification Code Qualifier	X 1 ID 1/2
	Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809				
		CODE	DEFINITION		
		FI	Federal Taxpayer's Identification Number		
		XX	Centers for Medicare and Medicaid Services National Provider Identifier		
		The "XX" qualifier is required only when the National Provider ID is mandated for use.			
		After the National Provider ID implementation period, enumerated providers use only the NM108 and NM109 data elements and discontinue the generation of the REF segment in Loop ID 2200C.			
		CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier			

34	REQUIRED	NM108	66	Identification Code Qualifier	X 1 ID 1/2	No Concerns
	Code specifying the system/method of code structure used for Identification Code (67) SEGMENT SYNTAX: P0809					
		CODE	DEFINITION			
		FI	Federal Taxpayer's Identification Number			
		XX	Standard Unique Health Identifier for Health Care Providers (NPI)			
		Use when the provider is in the United States or its territories and is eligible to receive a National Provider Identifier (NPI).				
		OR				
		Use when the provider is not in the United States or its territories and has received an NPI.				
		CODE SOURCE 537: National Provider Identifier (NPI)				
34 Location X330 Health Care Claim Acknowledgment 277 0500 2100C NM1 - Billing Provider Name						
Action Modify Data Element Code Note NM108 - Identification Code Qualifier						
XX - Standard Unique Health Identifier for Health Care Providers (NPI)						
Changed to "Use when the provider is in the United States or its territories and is eligible to receive a National Provider Identifier (NPI). OR Use when the provider is not in the United States or its territories and has received an NPI."						
CR 1563 Format code notes consistently.						

3 5	SEGMENT DETAIL					
	TRN - PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER					
X12 Segment Name: Trace						
X12 Purpose: To uniquely identify a transaction to an application						
Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER						
Loop Repeat: 1						
Segment Repeat: 1						
Usage: SITUATIONAL						
Situational Rule: Required when 2200C Loop is used to provide the status of a specific provider's group of claims in the STC segment or a secondary provider identifier needs to be reported in the Provider Secondary REF segment. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.						
TR3 Notes: 1. Because the TRN segment is syntactically required in order to use Loop 2200C, TRN02 can either be a sender assigned value or a default value of zero (0).						
TR3 Example: TRN*1*0~						

007030X330 Health Care Claim Acknowledgment 277CA						TR3 Note has also changed but not documented
277 X330 Claim Acknowledgment 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER						
SEGMENT DETAIL						
TRN - PROVIDER OF SERVICE TRACE IDENTIFIER						
X12 Name: Trace						
X12 Purpose: To uniquely identify a transaction to an application						
Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER						
Loop Repeat: 1						
Segment Repeat: 1						
Usage: SITUATIONAL						
Situational Rule: Required when 2200C Loop is used to provide totals and amounts by billing provider or a secondary provider identifier needs to be reported in the Provider Secondary REF segment. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.						
TR3 Notes: 1. The TRN Segment is syntactically required in order to use Loop 2200C. TRN02 must be default value of zero (0).						
TR3 Example: TRN*1*0~						

		<p>35 Location X330 Health Care Claim Acknowledgment 277 0900 2200C TRN - Provider of Service Trace Identifier</p> <hr/> <p>Action Modify Segment Situational Rule Changed To: Required when 2200C Loop is used to provide totals and amounts by billing provider or a secondary provider identifier needs to be reported in the Provider Secondary REF segment. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <hr/> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	
<p>3 6</p>	<p>SEGMENT DETAIL</p> <hr/> <p>QTY - TOTAL ACCEPTED QUANTITY</p> <p>X12 Segment Name: Quantity Information</p> <p>X12 Purpose: To specify quantity information</p> <p>X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required.</p> <p>2. E0204 Only one of QTY02 or QTY04 may be present.</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total number of claims (sum of CLM02) accepted to the adjudication process by the Information Source for the Billing Provider in this acknowledgment.</p> <p>TR3 Example: QTY*QA*5~</p>	<p>SEGMENT DETAIL</p> <hr/> <p>QTY - TOTAL ACCEPTED QUANTITY</p> <p>X12 Name: Quantity Information</p> <p>X12 Purpose: To specify quantity information</p> <p>X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required.</p> <p>2. E0204 Only one of QTY02 or QTY04 may be present.</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting totals for a specific billing provider and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total number of claims accepted to the adjudication process by the Information Source for the Billing Provider in this acknowledgment.</p> <p>2. For QTY segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: QTY*QA*5~</p> <p>36 Location X330 Health Care Claim Acknowledgment 277 1210 2200C QTY - Total Accepted Quantity</p> <hr/> <p>Action Modify Segment Note Loop ID 2200C / QTY (Total Accepted Quantity)</p> <p>Changed to: The purpose of this segment is to report the total number of claims accepted to the adjudication process by the Information Source for the Billing Provider in this acknowledgment.</p> <hr/> <p>CR 1153 To clarify intended use.</p>	<p>Example Used for Change Log Item 36, 37 and 38</p> <p>No Concern</p>
<p>3 7</p>		<p>37 Location X330 Health Care Claim Acknowledgment 277 1210 2200C QTY - Total Accepted Quantity</p> <hr/> <p>Action Modify Segment Situational Rule Changed to "Required when reporting totals for a specific billing provider and</p>	<p>See Change Log Item 36 No Concern</p>

		<p>at least one claim is accepted. If not required by this implementation guide, do not send."</p> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	
3 8		<p>38 Location X330 Health Care Claim Acknowledgment 277 1210 2200C QTY - Total Accepted Quantity</p> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200C/QTY</p> <p>For QTY segment balancing, see Section 1.4.5 (Balancing)</p> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	See Change Log Item 36 No Concern
3 9	<p>SEGMENT DETAIL</p> <p>QTY - TOTAL REJECTED QUANTITY</p> <p>X12 Segment Name: Quantity Information</p> <p>X12 Purpose: To specify quantity information</p> <p>X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required.</p> <p>2. E0204 Only one of QTY02 or QTY04 may be present.</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total number of claims rejected by the Information Source for the Billing Provider.</p> <p>TR3 Example: QTY*QC*1~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Rejected Quantity</p> <p>SEGMENT DETAIL</p> <p>QTY - TOTAL REJECTED QUANTITY</p> <p>X12 Name: Quantity Information</p> <p>X12 Purpose: To specify quantity information</p> <p>X12 Syntax: 1. R0204 At least one of QTY02 or QTY04 is required.</p> <p>2. E0204 Only one of QTY02 or QTY04 may be present.</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total number of claims rejected by the Information Source for the Billing Provider. 2. For QTY segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: QTY*QC*1~</p> <p>39 Location X330 Health Care Claim Acknowledgment 277 1210 2200C QTY - Total Rejected Quantity</p> <p>Action Modify Segment Situational Rule Changed to "Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send."</p> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	Example Used for Change Log Item # 39 and 40 No Concern

40		<p>40 Location X330 Health Care Claim Acknowledgment 277 1210 2200C QTY - Total Rejected Quantity</p> <hr/> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200C/QTY</p> <hr/> <p>For QTY segment balancing, see Section 1.4.5 (Balancing)</p> <hr/> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>See change log Item #39 No Concern</p>
41	<p>SEGMENT DETAIL</p> <p>AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) accepted by the Information Source for the Billing Provider in this acknowledgment.</p> <p>TR3 Example: AMT*YU*1000.5~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Accepted Amount</p> <p>SEGMENT DETAIL</p> <p>AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting totals for a specific billing provider and at least one claim is accepted. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) accepted by the Information Source for the Billing Provider in this acknowledgment. 2. For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: AMT*YU*5053.52~</p> <p>41 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Accepted Amount</p> <hr/> <p>Action Modify Segment Situational Rule Changed to "Required when reporting totals for a specific billing provider and at least one claim is accepted. If not required by this implementation guide, do not send."</p> <hr/> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	<p>Example used for Change Log Item 41 and 42 No Concern</p>
42		<p>42 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Accepted Amount</p> <hr/> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200C/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <hr/> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>See Change Log Item 41 for example No Concern</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
42 (starts on the bottom of page 12)	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200B • AMT TOTAL ACCEPTED AMOUNT</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200B — INFORMATION RECEIVER APPLICATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims accepted by the Information Source.</p> <p>TR3 Example: AMT*YU*5053.52~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Accepted Amount</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200B — INFORMATION RECEIVER TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when at least one claim is accepted for this Information Receiver. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims accepted by the Information Source. 2. For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: AMT*YU*5053.52~</p> <hr/> <p>Change log:</p> <p>Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Accepted Amount</p> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200C/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p> <p>What changed: The item circled in red above was added to the 7030.</p> <p>Reason for change: CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>The change log locates the change in the 2200C loop, but CR 1497 says 2200B loop. The side by side comparison shown here is for the 2200B loop.</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																											
43 (page 13)	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200C • AMT TOTAL ACCEPTED AMOUNT</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code to qualify amount</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YU In Process</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>IMPLEMENTATION NAME: Total Accepted Amount</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3				CODE DEFINITION					YU In Process		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				IMPLEMENTATION NAME: Total Accepted Amount		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>277 X330 Claim Acknowledgment Total Accepted Amount</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code specifying the amount qualifier</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YU In Process</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>INDUSTRY NAME: Total Accepted Amount</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Monetary Amounts returned in this element may exceed 10 characters</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table> <p>Change log:</p> <p>Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Accepted Amount</p> <p>Action Add Data Element Note to DE 782 (Monetary Amount):</p> <p style="padding-left: 40px;">The maximum length of this instance of data element 782 is 10.</p> <p>CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p> <p>Note: Change in change log is: "Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10." The change log change is different than what is shown above.</p> <p>Reason for change: CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3				CODE DEFINITION					YU In Process		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				INDUSTRY NAME: Total Accepted Amount					Monetary Amounts returned in this element may exceed 10 characters		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>Addn. to 7030 that was not in change log: "Monetary Amounts returned in this element may exceed 10 characters." (This is opposite of change log change)</p> <p>Contradictory to change log</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YU In Process																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			IMPLEMENTATION NAME: Total Accepted Amount																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YU In Process																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			INDUSTRY NAME: Total Accepted Amount																																																																											
			Monetary Amounts returned in this element may exceed 10 characters																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																											
44	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200C • AMT TOTAL ACCEPTED AMOUNT</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code to qualify amount</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YU In Process</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>IMPLEMENTATION NAME: Total Accepted Amount</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3				CODE DEFINITION					YU In Process		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				IMPLEMENTATION NAME: Total Accepted Amount		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Accepted Amount</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL ACCEPTED AMOUNT</p> <p>X12 Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>....</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code specifying the amount qualifier</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YU In Process</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>INDUSTRY NAME: Total Accepted Amount</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Monetary Amounts returned in this element may exceed 10 characters.</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table> <p>44 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Accepted Amount</p> <p>Action Add Data Element Note Loop ID 2200C / AMT02 (Total Accepted Amount) Monetary Amounts returned in this element may exceed 10 characters.</p> <p>CR 1510 Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3				CODE DEFINITION					YU In Process		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				INDUSTRY NAME: Total Accepted Amount					Monetary Amounts returned in this element may exceed 10 characters.		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>Is this a correction to 43</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YU In Process																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			IMPLEMENTATION NAME: Total Accepted Amount																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YU In Process																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			INDUSTRY NAME: Total Accepted Amount																																																																											
			Monetary Amounts returned in this element may exceed 10 characters.																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
45	<p>005010X214 • 277 • 2200C • AMT TOTAL REJECTED AMOUNT</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment.</p> <p>TR3 Example: AMT*YY*52~</p> <p>DIAGRAM</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Rejected Amount</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment. 2. For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: AMT*YY*99.5~</p> <p>45 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Rejected Amount</p> <p style="text-align: center;">Action Modify Segment Situational Rule</p> <p>Changed to "Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send."</p> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
46	<p>005010X214 • 277 • 2200C • AMT TOTAL REJECTED AMOUNT</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting status for a specific provider's group of claims and at least one claim is rejected. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment.</p> <p>TR3 Example: AMT*YY*52~</p> <p>DIAGRAM</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Total Rejected Amount</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Name: Monetary Amount Information</p> <p>X12 Purpose: To indicate the total monetary amount</p> <p>Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send.</p> <p>TR3 Notes: 1. The purpose of this segment is to report the total dollar amount of claims (sum of CLM02) rejected by the Information Source for the Billing Provider in this acknowledgment. 2. For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>TR3 Example: AMT*YY*99.5~</p> <p>46 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Rejected Amount</p> <p>Action Add Segment Note Shared TR3 Note added to Loop ID 2200C/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).</p> <p>CR 1497 Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.</p>	<p>Amount in example also changed</p> <p>No Concern</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																											
47	<p>005010X214 • 277 • 2200C • AMT TOTAL REJECTED AMOUNT ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p>AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code to qualify amount</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YY Returned</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>IMPLEMENTATION NAME: Total Rejected Amount</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3				CODE DEFINITION					YY Returned		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				IMPLEMENTATION NAME: Total Rejected Amount		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code specifying the amount qualifier</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YY Returned</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>INDUSTRY NAME: Total Rejected Amount</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Monetary Amounts returned in this element may exceed 10 characters.</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table> <p>47 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Rejected Amount</p> <p>Action Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.</p> <p>48CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3				CODE DEFINITION					YY Returned		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				INDUSTRY NAME: Total Rejected Amount					Monetary Amounts returned in this element may exceed 10 characters.		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>Note: Change in change log is different than in 7030.</p> <p>Also – “Implementation Name was changed to “Industry Name”</p> <p>Contradictory to change log?</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YY Returned																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			IMPLEMENTATION NAME: Total Rejected Amount																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YY Returned																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			INDUSTRY NAME: Total Rejected Amount																																																																											
			Monetary Amounts returned in this element may exceed 10 characters.																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																											
48	<p>005010X214 • 277 • 2200C • AMT TOTAL REJECTED AMOUNT ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p>AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Segment Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>DATA ELEMENT</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code to qualify amount</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YY Returned</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>IMPLEMENTATION NAME: Total Rejected Amount</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3				CODE DEFINITION					YY Returned		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				IMPLEMENTATION NAME: Total Rejected Amount		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>AMT - TOTAL REJECTED AMOUNT</p> <p>X12 Name: Monetary Amount Information X12 Purpose: To indicate the total monetary amount Loop: 2200C — PROVIDER OF SERVICE TRACE IDENTIFIER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1"> <thead> <tr> <th>USAGE</th> <th>REF. DES.</th> <th>D.E. NUM.</th> <th>NAME</th> <th>ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>AMT01</td> <td>522</td> <td>Amount Qualifier Code Code specifying the amount qualifier</td> <td>M 1 ID 1/3</td> </tr> <tr> <td></td> <td></td> <td></td> <td>CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>YY Returned</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>AMT02</td> <td>782</td> <td>Monetary Amount Monetary amount</td> <td>M 1 R 1/18</td> </tr> <tr> <td></td> <td></td> <td></td> <td>INDUSTRY NAME: Total Rejected Amount</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Monetary Amounts returned in this element may exceed 10 characters.</td> <td></td> </tr> <tr> <td>NOT USED</td> <td>AMT03</td> <td>478</td> <td>Credit/Debit Flag Code</td> <td>O 1 ID 1/1</td> </tr> </tbody> </table> <p>48 Location X330 Health Care Claim Acknowledgment 277 1220 2200C AMT - Total Rejected Amount</p> <p>Action Add Data Element Note Loop ID 2200C / AMT02 (Total Rejected Amount) Monetary Amounts returned in this element may exceed 10 characters.</p> <p>CR 1510 Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3				CODE DEFINITION					YY Returned		REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18				INDUSTRY NAME: Total Rejected Amount					Monetary Amounts returned in this element may exceed 10 characters.		NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1	Correction to 47?
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YY Returned																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			IMPLEMENTATION NAME: Total Rejected Amount																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																																																																										
REQUIRED	AMT01	522	Amount Qualifier Code Code specifying the amount qualifier	M 1 ID 1/3																																																																										
			CODE DEFINITION																																																																											
			YY Returned																																																																											
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18																																																																										
			INDUSTRY NAME: Total Rejected Amount																																																																											
			Monetary Amounts returned in this element may exceed 10 characters.																																																																											
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1																																																																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
49	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2000D • HL PATIENT LEVEL</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">HL - PATIENT LEVEL</p> <p>X12 Segment Name: Hierarchical Level</p> <p>X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments</p> <p>X12 Comments:</p> <ol style="list-style-type: none"> The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. The HL segment defines a top-down/left-right ordered structure. <p>Loop: 2000D — PATIENT LEVEL Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when reporting claim status at the patient level. If not required by this guide, do not send.</p> <p>TR3 Notes:</p> <ol style="list-style-type: none"> This HL level contains information about the Patient identified in the 837 transaction. See Section 1.4.1.1 - Defining the Patient Participant 	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2000D — PATIENT LEVEL</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">HL - PATIENT LEVEL</p> <p>X12 Name: Hierarchical Level</p> <p>X12 Purpose: To identify dependencies among and the content of hierarchically related groups of data segments</p> <p>X12 Comments:</p> <ol style="list-style-type: none"> The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data. The HL segment defines a top-down/left-right ordered structure. <p>Loop: 2000D — PATIENT LEVEL Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes:</p> <ol style="list-style-type: none"> This HL level contains information about the Patient identified in the 837 transaction. See Section 1.4.2.1 - Defining the Patient Participant for information on identifying the Patient data from the 837 Transaction. <p>TR3 Example: HL*4*3*PT~</p> <p>49 Location X330 Health Care Claim Acknowledgment 277 0100 2000D HL - Patient Level</p> <p style="text-align: center;">Action Modify Segment Usage</p> <p>Change Segment Usage to Required.</p> <p>CR 379 Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																				
50	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2000D • HL PATIENT LEVEL</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">HL - PATIENT LEVEL</p> <p>X12 Segment Name: Hierarchical Level</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">USAGE</th> <th style="text-align: left;">REF. DES.</th> <th style="text-align: left;">DATA ELEMENT</th> <th style="text-align: left;">NAME</th> <th style="text-align: left;">ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table> <p>A unique number assigned by the sender to identify a particular data segment in a hierarchical structure</p> <p><small>COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.</small></p>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2000D — PATIENT LEVEL</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">HL - PATIENT LEVEL</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">USAGE</th> <th style="text-align: left;">REF. DES.</th> <th style="text-align: left;">D.E. NUM.</th> <th style="text-align: left;">NAME</th> <th style="text-align: left;">ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>HL01</td> <td>628</td> <td>Hierarchical ID Number</td> <td>M 1 AN 1/12</td> </tr> </tbody> </table> <p>A unique number assigned by the sender to identify a particular data segment in a hierarchical structure</p> <p><small>COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.</small></p> <div style="border: 2px solid red; border-radius: 50%; padding: 5px; margin: 10px 0;"> <p>The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</p> </div> <p>50 Location X330 Health Care Claim Acknowledgment 277 0100 2000D HL - Patient Level</p> <p style="text-align: center;">Action Add Data Element Code Note</p> <p>Loop ID 2000D/HL01</p> <p>The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.</p> <p>CR 1109 For consistency, consider restricting HL01 to numeric values and requiring that</p>	USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES	REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12	No Concern
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12																			
USAGE	REF. DES.	D.E. NUM.	NAME	ATTRIBUTES																			
REQUIRED	HL01	628	Hierarchical ID Number	M 1 AN 1/12																			

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																						
		enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.																																																																							
51	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2100D • NM1 PATIENT NAME</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc; padding: 2px;">SITUATIONAL</td> <td style="padding: 2px;">NM104</td> <td style="padding: 2px;">1036</td> <td style="padding: 2px;">Name First Individual first name</td> <td style="padding: 2px; text-align: right;">O 1 AN 1/35</td> </tr> <tr> <td colspan="5" style="padding: 2px;"><i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i></td> </tr> <tr> <td colspan="5" style="padding: 2px;">IMPLEMENTATION NAME: Patient First Name</td> </tr> <tr> <td colspan="5" style="padding: 2px;"> </td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">SITUATIONAL</td> <td style="padding: 2px;">NM105</td> <td style="padding: 2px;">1037</td> <td style="padding: 2px;">Name Middle Individual middle name or initial</td> <td style="padding: 2px; text-align: right;">O 1 AN 1/25</td> </tr> <tr> <td colspan="5" style="padding: 2px;"><i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i></td> </tr> <tr> <td colspan="5" style="padding: 2px;">IMPLEMENTATION NAME: Patient Middle Name or Initial</td> </tr> </table>	SITUATIONAL	NM104	1036	Name First Individual first name	O 1 AN 1/35	<i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i>					IMPLEMENTATION NAME: Patient First Name										SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	O 1 AN 1/25	<i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i>					IMPLEMENTATION NAME: Patient Middle Name or Initial					<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p style="text-align: right;">◀ ▶</p> <p>277 X330 Claim Acknowledgment 2100D — PATIENT NAME</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc; padding: 2px;">SITUATIONAL</td> <td style="padding: 2px;">NM104</td> <td style="padding: 2px;">1036</td> <td style="padding: 2px;">Name First Individual first name</td> <td style="padding: 2px; text-align: right;">O 1 AN 1/35</td> </tr> <tr> <td colspan="5" style="padding: 2px;"><i>SITUATIONAL RULE: Required when the person has a first name that is known. If not required by this implementation guide, do not send.</i></td> </tr> <tr> <td colspan="5" style="padding: 2px;">INDUSTRY NAME: Patient First Name</td> </tr> <tr> <td colspan="5" style="padding: 2px;"> </td> </tr> <tr> <td style="background-color: #cccccc; padding: 2px;">SITUATIONAL</td> <td style="padding: 2px;">NM105</td> <td style="padding: 2px;">1037</td> <td style="padding: 2px;">Name Middle Individual middle name or initial</td> <td style="padding: 2px; text-align: right;">O 1 AN 1/25</td> </tr> <tr> <td colspan="5" style="padding: 2px;"><i>SITUATIONAL RULE: Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send.</i></td> </tr> <tr> <td colspan="5" style="padding: 2px;">INDUSTRY NAME: Patient Middle Name or Initial</td> </tr> </table> <p>51 Location X330 Health Care Claim Acknowledgment 277 0500 2100D NM1 - Patient Name</p> <p>Action Modify Data Element Situational Rule Changed to "Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send."</p> <p>CR 1153 To clarify intended use</p>	SITUATIONAL	NM104	1036	Name First Individual first name	O 1 AN 1/35	<i>SITUATIONAL RULE: Required when the person has a first name that is known. If not required by this implementation guide, do not send.</i>					INDUSTRY NAME: Patient First Name										SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	O 1 AN 1/25	<i>SITUATIONAL RULE: Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send.</i>					INDUSTRY NAME: Patient Middle Name or Initial					<p>The change log doesn't specify the data element – here it is assumed to be NM105</p> <p>No Concern</p>
SITUATIONAL	NM104	1036	Name First Individual first name	O 1 AN 1/35																																																																					
<i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i>																																																																									
IMPLEMENTATION NAME: Patient First Name																																																																									
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	O 1 AN 1/25																																																																					
<i>SITUATIONAL RULE: Required when information was submitted on the claim. If not required by this implementation guide, do not send.</i>																																																																									
IMPLEMENTATION NAME: Patient Middle Name or Initial																																																																									
SITUATIONAL	NM104	1036	Name First Individual first name	O 1 AN 1/35																																																																					
<i>SITUATIONAL RULE: Required when the person has a first name that is known. If not required by this implementation guide, do not send.</i>																																																																									
INDUSTRY NAME: Patient First Name																																																																									
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	O 1 AN 1/25																																																																					
<i>SITUATIONAL RULE: Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send.</i>																																																																									
INDUSTRY NAME: Patient Middle Name or Initial																																																																									

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																								
52	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2100D • NM1 PATIENT NAME</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <table border="0"> <tr> <td style="vertical-align: top;">REQUIRED</td> <td style="vertical-align: top;">NM108</td> <td style="vertical-align: top;">66</td> <td style="vertical-align: top;"> Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 </td> </tr> </table> <table border="0"> <thead> <tr> <th style="text-align: left;">CODE</th> <th style="text-align: left;">DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Required if the HIPAA Individual Patient Identifier is mandated for use. If not required use MI.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table> <p>...</p>	REQUIRED	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Required if the HIPAA Individual Patient Identifier is mandated for use. If not required use MI.	MI	Member Identification Number	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2100D — PATIENT NAME</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <table border="0"> <tr> <td style="vertical-align: top;">SITUATIONAL</td> <td style="vertical-align: top;">NM108</td> <td style="vertical-align: top;">66</td> <td style="vertical-align: top;"> Identification Code Qualifier X 1 ID 1/2 Code specifying the system/method of code structure used for Identification Code (67) SEGMENT SYNTAX: P0809 SITUATIONAL RULE: <i>Required when NM109 is used. If not required by this implementation guide, do not send.</i> </td> </tr> </table> <table border="0"> <thead> <tr> <th style="text-align: left;">CODE</th> <th style="text-align: left;">DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Use when the HIPAA Individual Patient Identifier is mandated for use.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table> <p>52 Location X330 Health Care Claim Acknowledgment 277 0500 2100D NM1 - Patient Name</p> <p style="text-align: center;">Action Modify Data Element Usage Changed NM108 from Required to Situational.</p> <p>CR 1386 Consistency across all guides.</p>	SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code specifying the system/method of code structure used for Identification Code (67) SEGMENT SYNTAX: P0809 SITUATIONAL RULE: <i>Required when NM109 is used. If not required by this implementation guide, do not send.</i>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Use when the HIPAA Individual Patient Identifier is mandated for use.	MI	Member Identification Number	No Concern
REQUIRED	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809																								
CODE	DEFINITION																										
II	Standard Unique Health Identifier for each Individual in the United States																										
	Required if the HIPAA Individual Patient Identifier is mandated for use. If not required use MI.																										
MI	Member Identification Number																										
SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code specifying the system/method of code structure used for Identification Code (67) SEGMENT SYNTAX: P0809 SITUATIONAL RULE: <i>Required when NM109 is used. If not required by this implementation guide, do not send.</i>																								
CODE	DEFINITION																										
II	Standard Unique Health Identifier for each Individual in the United States																										
	Use when the HIPAA Individual Patient Identifier is mandated for use.																										
MI	Member Identification Number																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
53	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2100D • NM1 PATIENT NAME</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <p>SITUATIONAL NM109 67 Identification Code X 1 AN 2/80</p> <p>Code identifying a party or other code</p> <p>SEGMENT SYNTAX: P0809</p> <p>SITUATIONAL RULE: <i>Required when a Subscriber ID was submitted in the 2010BA NM109 or a Property and Casualty Patient Identifier was submitted in the 2010CA REF02 of the 837. If not required by this implementation guide, do not send.</i></p> <p>INDUSTRY NAME: Patient Identification Number</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment 2100D — PATIENT NAME</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">NM1 - PATIENT NAME</p> <p>...</p> <p>SITUATIONAL NM109 67 Identification Code X 1 AN 2/80</p> <p>Code identifying a party or other code</p> <p>SEGMENT SYNTAX: P0809</p> <p>SITUATIONAL RULE: <i>Required when a Subscriber ID was submitted in the 2010BA NM109 or a Property and Casualty Patient Identifier was submitted in the 2010CA REF02 of the 837. If not required by this implementation guide, do not send.</i></p> <p>INDUSTRY NAME: Patient Identification Number</p> <p>53 Location X330 Health Care Claim Acknowledgment 277 0500 2100D NM1 - Patient Name</p> <p style="text-align: center;">Action Modify Data Element Usage</p> <p>Changed NM109 from Required to Situational.</p> <p>CR 1386 Consistency across all guides</p>	<p>Did not see any change? What was the intention?</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																															
54	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3 005010X214 • 277 • 2100D • NM1 PATIENT NAME</p> <p>SEGMENT DETAIL</p> <p>NM1 - PATIENT NAME</p> <p>...</p> <table border="1"> <thead> <tr> <th>REQUIRED</th> <th>NM108</th> <th>66</th> <th>Identification Code Qualifier</th> <th>X 1</th> <th>ID</th> <th>1/2</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td>Code designating the system/method of code structure used for Identification Code (67)</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>SYNTAX: P0809</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td><table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	REQUIRED	NM108	66	Identification Code Qualifier	X 1	ID	1/2				Code designating the system/method of code structure used for Identification Code (67)							SYNTAX: P0809							<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.	MI	Member Identification Number				<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2100D — PATIENT NAME</p> <p>SEGMENT DETAIL</p> <p>NM1 - PATIENT NAME</p> <p>...</p> <table border="1"> <thead> <tr> <th>SITUATIONAL</th> <th>NM108</th> <th>66</th> <th>Identification Code Qualifier</th> <th>X 1</th> <th>ID</th> <th>1/2</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td>Code specifying the system/method of code structure used for Identification Code (67)</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>SEGMENT SYNTAX: P0809</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>SITUATIONAL RULE: Required when NM109 is used. If not required by this implementation guide, do not send.</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td><table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Use when the HIPAA Individual Patient Identifier is mandated for use.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>54 Location X330 Health Care Claim Acknowledgment 277 0500 2100D NM1 - Patient Name</p> <p>Action Modify Data Element Situational Rule Loop ID 2100D NM108 Identification Code Qualifier Changed to "Required when NM109 is used. If not required by this implementation guide, do not send."</p> <p>CR 1478 Remove duplication of situational rules between the element and the code qualifier across the TR3.</p>	SITUATIONAL	NM108	66	Identification Code Qualifier	X 1	ID	1/2				Code specifying the system/method of code structure used for Identification Code (67)							SEGMENT SYNTAX: P0809							SITUATIONAL RULE: Required when NM109 is used. If not required by this implementation guide, do not send.							<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Use when the HIPAA Individual Patient Identifier is mandated for use.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Use when the HIPAA Individual Patient Identifier is mandated for use.	MI	Member Identification Number				No Concern
REQUIRED	NM108	66	Identification Code Qualifier	X 1	ID	1/2																																																																												
			Code designating the system/method of code structure used for Identification Code (67)																																																																															
			SYNTAX: P0809																																																																															
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.	MI	Member Identification Number																																																																							
CODE	DEFINITION																																																																																	
II	Standard Unique Health Identifier for each Individual in the United States																																																																																	
	Required if the HIPAA Individual Patient Identifier mandated for use. If not required use MI.																																																																																	
MI	Member Identification Number																																																																																	
SITUATIONAL	NM108	66	Identification Code Qualifier	X 1	ID	1/2																																																																												
			Code specifying the system/method of code structure used for Identification Code (67)																																																																															
			SEGMENT SYNTAX: P0809																																																																															
			SITUATIONAL RULE: Required when NM109 is used. If not required by this implementation guide, do not send.																																																																															
			<table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>II</td> <td>Standard Unique Health Identifier for each Individual in the United States</td> </tr> <tr> <td></td> <td>Use when the HIPAA Individual Patient Identifier is mandated for use.</td> </tr> <tr> <td>MI</td> <td>Member Identification Number</td> </tr> </tbody> </table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States		Use when the HIPAA Individual Patient Identifier is mandated for use.	MI	Member Identification Number																																																																							
CODE	DEFINITION																																																																																	
II	Standard Unique Health Identifier for each Individual in the United States																																																																																	
	Use when the HIPAA Individual Patient Identifier is mandated for use.																																																																																	
MI	Member Identification Number																																																																																	

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
55	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • TRN CLAIM STATUS TRACKING NUMBER</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">TRN - CLAIM STATUS TRACKING NUMBER</p> <p>X12 Segment Name: Trace</p> <p>X12 Purpose: To uniquely identify a transaction to an application</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This segment is the patient control number submitted in the CLM01 of the 837. 2. This number must be returned exactly as submitted in the 837 up to the 20 character limit as defined in the 837 guide.</p> <p>TR3 Example: TRN*2*SMITHSON20060801~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2200D — CLAIM STATUS TRACE NUMBER</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">TRN - CLAIM STATUS TRACE NUMBER</p> <p>X12 Name: Trace</p> <p>X12 Purpose: To uniquely identify a transaction to an application</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This segment is the Provider's Assigned Claim Identifier submitted in the CLM01 of the 837.</p> <p>TR3 Example: TRN*2*ABC12345~</p> <p>55 Location X330 Health Care Claim Acknowledgment 277 0900 2200D TRN - Claim Status Trace Number</p> <p>Action Modify Data Element Industry Name Replace the Industry Name 'Patient Control Number' with 'Provider's Assigned Claim Identifier.'</p>	<p>Is the “TRN Claim Status Tracking Number” now called the “TRN Claim Status Trace Number” in the 7030 (there is no “Claim Status Tracking Number” in the 7030)? (and similar question regarding the loop name)</p> <p>What happened to note #2 in the TR# notes of the 5010? – we would want this required...was this deleted in error?</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
56	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • TRN CLAIM STATUS TRACKING NUMBER</p> <hr/> <p>SEGMENT DETAIL</p> <p>TRN - CLAIM STATUS TRACKING NUMBER</p> <p>X12 Segment Name: Trace</p> <p>X12 Purpose: To uniquely identify a transaction to an application</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This segment is the patient control number submitted in the CLM01 of the 837.</p> <p>2. This number must be returned exactly as submitted in the 837 up to the 20 character limit as defined in the 837 guide.</p> <p>TR3 Example: TRN*2*SMITHSON20060801~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2200D — CLAIM STATUS TRACE NUMBER</p> <hr/> <p>SEGMENT DETAIL</p> <p>TRN - CLAIM STATUS TRACE NUMBER</p> <p>X12 Name: Trace</p> <p>X12 Purpose: To uniquely identify a transaction to an application</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. This segment is the Provider's Assigned Claim Identifier submitted in the CLM01 of the 837.</p> <p>TR3 Example: TRN*2*ABC12345~</p> <p>56 Location X330 Health Care Claim Acknowledgment 277 0900 2200D TRN - Claim Status Trace Number</p> <p>Action Modify Segment Note</p> <p>This segment is the Provider's Assigned Claim Identifier submitted in the CLM01 of the 837.</p> <p>CR 1119 Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.</p>	See comments as above.

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																											
57	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • TRN CLAIM STATUS TRACKING NUMBER</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">TRN - CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <p>ELEMENT DETAIL</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">USAGE</th> <th style="text-align: left;">REF. DES.</th> <th style="text-align: left;">DATA ELEMENT</th> <th style="text-align: left;">NAME</th> <th style="text-align: left;">ATTRIBUTES</th> </tr> </thead> <tbody> <tr> <td>REQUIRED</td> <td>TRN01</td> <td>481</td> <td>Trace Type Code Code identifying which transaction is being referenced</td> <td>M 1 ID 1/2</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">CODE DEFINITION</td> <td></td> </tr> <tr> <td></td> <td></td> <td>2</td> <td>Referenced Transaction Trace Numbers</td> <td></td> </tr> <tr> <td>REQUIRED</td> <td>TRN02</td> <td>127</td> <td>Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</td> <td>M 1 AN 1/50</td> </tr> <tr> <td></td> <td></td> <td></td> <td>SEMANTIC: TRN02 provides unique identification for the transaction.</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>IMPLEMENTATION NAME: Patient Control Number</td> <td></td> </tr> </tbody> </table>	USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	REQUIRED	TRN01	481	Trace Type Code Code identifying which transaction is being referenced	M 1 ID 1/2				CODE DEFINITION				2	Referenced Transaction Trace Numbers		REQUIRED	TRN02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M 1 AN 1/50				SEMANTIC: TRN02 provides unique identification for the transaction.					IMPLEMENTATION NAME: Patient Control Number		<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2200D — CLAIM STATUS TRACE NUMBER</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">TRN - CLAIM STATUS TRACE NUMBER</p> <p>...</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">REQUIRED</th> <th style="text-align: left;">TRN02 127</th> <th style="text-align: left;">Reference Identification</th> <th style="text-align: left;">M 1 AN 1/80</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</td> <td></td> </tr> <tr> <td></td> <td></td> <td>SEMANTIC: TRN02 provides unique identification for the transaction.</td> <td></td> </tr> <tr> <td></td> <td></td> <td>INDUSTRY NAME: Provider's Assigned Claim Identifier</td> <td></td> </tr> <tr> <td></td> <td></td> <td>Maximum length of this element is constrained by B.1.1.3.1.</td> <td></td> </tr> <tr> <td></td> <td></td> <td style="border: 2px solid red;">The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.</td> <td></td> </tr> </tbody> </table> <p>57 Location X330 Health Care Claim Acknowledgment 277 0900 2200D TRN - Claim Status Trace Number</p> <p>Action Add Data Element Note</p> <p>The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.</p> <p>CR 1119 Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.</p>	REQUIRED	TRN02 127	Reference Identification	M 1 AN 1/80			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				SEMANTIC: TRN02 provides unique identification for the transaction.				INDUSTRY NAME: Provider's Assigned Claim Identifier				Maximum length of this element is constrained by B.1.1.3.1.				The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.		<p>Change log is not specific about the data element being changed. TRN02 has other changes as well – “Maximum length ... “Provider’s Assigned Claim Number”</p> <p>Max length of element changed from 1/50 to 1/80</p>
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																																																										
REQUIRED	TRN01	481	Trace Type Code Code identifying which transaction is being referenced	M 1 ID 1/2																																																										
			CODE DEFINITION																																																											
		2	Referenced Transaction Trace Numbers																																																											
REQUIRED	TRN02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M 1 AN 1/50																																																										
			SEMANTIC: TRN02 provides unique identification for the transaction.																																																											
			IMPLEMENTATION NAME: Patient Control Number																																																											
REQUIRED	TRN02 127	Reference Identification	M 1 AN 1/80																																																											
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier																																																												
		SEMANTIC: TRN02 provides unique identification for the transaction.																																																												
		INDUSTRY NAME: Provider's Assigned Claim Identifier																																																												
		Maximum length of this element is constrained by B.1.1.3.1.																																																												
		The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.																																																												

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
58	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <p>SITUATIONAL STC01 - 3 98 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>...</p> <p>SITUATIONAL STC10 - 3 98 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC10-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-3 for valid values.</p> <p>...</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Claim Level Status Information</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>Segment Repeat: >1</p> <p>...</p> <p>SITUATIONAL STC01- 98 Entity Identifier Code O ID 2/3 03 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>...</p> <p>SITUATIONAL STC10- 98 Entity Identifier Code O ID 2/3 03 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-03 for valid values.</p> <p>...</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
	<p>SITUATIONAL STC11 - 3 98 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-3 for valid values.</p>	<p>SITUATIONAL STC11- 98 03 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-03 for valid values.</p> <p>58 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Modify Data Element Situational Rule STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver." CR 371 Clarify when Claim Status Codes require the transmission of an Entity Code.</p>	

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
59	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p>STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information X12 Purpose: To report the status, required action, and paid information of a claim or service line Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>... SITUATIONAL STC10 C043 HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line SITUATIONAL RULE: <i>Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.</i></p> <p>... SITUATIONAL STC11 C043 HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line SITUATIONAL RULE: <i>Required if additional clarification to STC01 and STC10 is needed. If not required by this implementation guide, do not send.</i></p>	<p>007030X330 Health Care Claim Acknowledgment 277CA 277 X330 Claim Acknowledgment Claim Level Status Information</p> <p>SEGMENT DETAIL</p> <p>STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information X12 Purpose: To report the status, required action, and paid information of a claim or service line Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: >1</p> <p>... SITUATIONAL STC10 C043 Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line CLICK TO SHOW/HIDE: X12 Composite Semantic Notes SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p> <p>... SITUATIONAL STC11 C043 Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line CLICK TO SHOW/HIDE: X12 Composite Semantic Notes SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p> <p>59 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Modify Data Element Situational Rule STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																								
60	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <table border="1"> <tr> <td>SITUATIONAL</td> <td>STC12</td> <td>933</td> <td>Free-form Message Text</td> <td>O 1 AN</td> <td>1/264</td> </tr> </table> <p>Free-form message text</p> <p>SEMANTIC: STC12 allows additional free-form status information.</p> <p>SITUATIONAL RULE: <i>Required when Health Care Claim Status Code 448 is used in STC01-2, STC10-2, or STC11-2. If not required by this implementation guide, do not send.</i></p> <p>IMPLEMENTATION NAME: Free Form Message Text</p> <p>See Section 1.4.2.1 for more information on use of STC12 and Status Code '448'.</p>	SITUATIONAL	STC12	933	Free-form Message Text	O 1 AN	1/264	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Claim Level Status Information</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>Segment Repeat: >1</p> <p>...</p> <table border="1"> <tr> <td>NOT USED</td> <td>STC11- 1270</td> <td>Code List Qualifier Code</td> <td>O</td> <td>ID</td> <td>1/3</td> </tr> <tr> <td></td> <td>04</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr style="border: 2px solid red;"> <td>NOT USED</td> <td>STC12 933</td> <td>Free-form Message Text</td> <td>O 1</td> <td>AN</td> <td>1/264</td> </tr> </table> <p>60 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Modify Data Element Usage</p> <p>Loop ID 2200D / STC12 (Free-form Message Text)</p> <p>Changed to NOT USED</p> <p>CR 1229 Data element usage change is required to meet industry needs.</p>	NOT USED	STC11- 1270	Code List Qualifier Code	O	ID	1/3		04					NOT USED	STC12 933	Free-form Message Text	O 1	AN	1/264	No Concern
SITUATIONAL	STC12	933	Free-form Message Text	O 1 AN	1/264																						
NOT USED	STC11- 1270	Code List Qualifier Code	O	ID	1/3																						
	04																										
NOT USED	STC12 933	Free-form Message Text	O 1	AN	1/264																						

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																																															
61	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <table border="0"> <tr> <td style="border: 1px solid black; padding: 2px;">SITUATIONAL</td> <td style="border: 1px solid black; padding: 2px;">STC01 - 3</td> <td style="border: 1px solid black; padding: 2px;">98</td> <td style="border: 1px solid black; padding: 2px;">Entity Identifier Code</td> <td style="border: 1px solid black; padding: 2px;">O</td> <td style="border: 1px solid black; padding: 2px;">ID</td> <td style="border: 1px solid black; padding: 2px;">2/3</td> </tr> <tr> <td colspan="7" style="font-size: small;">Code identifying an organizational entity, a physical location, property or an individual</td> </tr> <tr> <td colspan="7" style="font-size: x-small;">SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</td> </tr> <tr> <td colspan="7" style="font-size: x-small;">SITUATIONAL RULE: Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr><td>03</td><td>Dependent</td></tr> <tr><td>1P</td><td>Provider</td></tr> <tr><td>1Z</td><td>Home Health Care</td></tr> <tr><td>40</td><td>Receiver</td></tr> <tr><td>41</td><td>Submitter</td></tr> <tr><td>71</td><td>Attending Physician</td></tr> <tr><td>72</td><td>Operating Physician</td></tr> </tbody> </table>	SITUATIONAL	STC01 - 3	98	Entity Identifier Code	O	ID	2/3	Code identifying an organizational entity, a physical location, property or an individual							SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.							SITUATIONAL RULE: Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.							CODE	DEFINITION	03	Dependent	1P	Provider	1Z	Home Health Care	40	Receiver	41	Submitter	71	Attending Physician	72	Operating Physician	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Claim Level Status Information</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>Segment Repeat: >1</p> <p>...</p> <table border="0"> <tr> <td style="border: 1px solid black; padding: 2px;">SITUATIONAL</td> <td style="border: 1px solid black; padding: 2px;">STC01-03</td> <td style="border: 1px solid black; padding: 2px;">98</td> <td style="border: 1px solid black; padding: 2px;">Entity Identifier Code</td> <td style="border: 1px solid black; padding: 2px;">O</td> <td style="border: 1px solid black; padding: 2px;">ID</td> <td style="border: 1px solid black; padding: 2px;">2/</td> </tr> <tr> <td colspan="7" style="font-size: small;">Code identifying an organizational entity, a physical location, property or an individual</td> </tr> <tr> <td colspan="7" style="font-size: x-small;">SITUATIONAL RULE: Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr><td>03</td><td>Dependent</td></tr> <tr><td>1P</td><td>Provider</td></tr> <tr><td>1U</td><td>Long Term Care Facility</td></tr> <tr><td>1W</td><td>Psychiatric Health Facility</td></tr> <tr><td>1X</td><td>Laboratory</td></tr> <tr><td>2B</td><td>Third-Party Administrator</td></tr> <tr><td>36</td><td>Employer</td></tr> <tr><td>3F</td><td>Rehabilitation Facility</td></tr> <tr><td>3T</td><td>Alcoholism and Other Chemical Dependency Facility</td></tr> <tr><td>40</td><td>Receiver</td></tr> <tr><td>41</td><td>Submitter</td></tr> <tr><td>45</td><td>Drop-off Location</td></tr> <tr><td>71</td><td>Attending Physician</td></tr> <tr><td>72</td><td>Operatina Phvsician</td></tr> </tbody> </table>	SITUATIONAL	STC01-03	98	Entity Identifier Code	O	ID	2/	Code identifying an organizational entity, a physical location, property or an individual							SITUATIONAL RULE: Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.							CODE	DEFINITION	03	Dependent	1P	Provider	1U	Long Term Care Facility	1W	Psychiatric Health Facility	1X	Laboratory	2B	Third-Party Administrator	36	Employer	3F	Rehabilitation Facility	3T	Alcoholism and Other Chemical Dependency Facility	40	Receiver	41	Submitter	45	Drop-off Location	71	Attending Physician	72	Operatina Phvsician	<p>REVIST</p> <p>There are a number of changes in the codes below.</p> <p>The following codes were in 5010 but are not in 7030: 1Z - Home health care HK – Subscriber LI – Independent Lab QD – Responsible party TL – Testing laboratory</p> <p>The following codes are in the 7030 but not in 5010: 1U 1W 1X 2B 36 3F 3T</p>
SITUATIONAL	STC01 - 3	98	Entity Identifier Code	O	ID	2/3																																																																																												
Code identifying an organizational entity, a physical location, property or an individual																																																																																																		
SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.																																																																																																		
SITUATIONAL RULE: Required when an entity must be identified to further clarify the code message in STC01-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.																																																																																																		
CODE	DEFINITION																																																																																																	
03	Dependent																																																																																																	
1P	Provider																																																																																																	
1Z	Home Health Care																																																																																																	
40	Receiver																																																																																																	
41	Submitter																																																																																																	
71	Attending Physician																																																																																																	
72	Operating Physician																																																																																																	
SITUATIONAL	STC01-03	98	Entity Identifier Code	O	ID	2/																																																																																												
Code identifying an organizational entity, a physical location, property or an individual																																																																																																		
SITUATIONAL RULE: Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.																																																																																																		
CODE	DEFINITION																																																																																																	
03	Dependent																																																																																																	
1P	Provider																																																																																																	
1U	Long Term Care Facility																																																																																																	
1W	Psychiatric Health Facility																																																																																																	
1X	Laboratory																																																																																																	
2B	Third-Party Administrator																																																																																																	
36	Employer																																																																																																	
3F	Rehabilitation Facility																																																																																																	
3T	Alcoholism and Other Chemical Dependency Facility																																																																																																	
40	Receiver																																																																																																	
41	Submitter																																																																																																	
45	Drop-off Location																																																																																																	
71	Attending Physician																																																																																																	
72	Operatina Phvsician																																																																																																	

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
	73 Other Physician 77 Service Location 82 Rendering Provider 85 Billing Provider 87 Pay-to Provider DK Ordering Physician DN Referring Provider DQ Supervising Physician FA Facility GB Other Insured HK Subscriber IL Insured or Subscriber LI Independent Lab MSC Mammography Screening Center PR Payer PRP Primary Payer QB Purchase Service Provider QC Patient QD Responsible Party SEP Secondary Payer TL Testing Laboratory TTP Tertiary Payer TU Third Party Repricing Organization (TPO)	73 Other Physician 74 Corrected Insured 77 Service Location 82 Rendering Provider 85 Billing Provider 87 Pay-to Provider AY Clearinghouse DD Assistant Surgeon DK Ordering Physician DN Referring Provider DQ Supervising Physician FA Facility GB Other Insured GK Previous Insured HH Home Health Agency I3 Independent Physicians Association (IPA) IL Insured or Subscriber MSC Mammography Screening Center O4 Factor OD Doctor of Optometry OOP Other Operating Physician P2 Primary Insured or Subscriber P3 Primary Care Provider PR Payer PRP Primary Payer PTP Pay-to Plan Name PW Pickup Address QA Pharmacy QB Purchase Service Provider QC Patient QE Policyholder QL Chiropractor QN Dentist QO Doctor of Osteopathy QS Podiatrist QY Medical Doctor S4 Skilled Nursing Facility SEP Secondary Payer TQ Third Party Reviewing Organization (TPO) TTP Tertiary Payer	45 74 AY DD GK HH I3 O4 OD OOP P2 P# PTP PW QA QB QE QL QN QO QS QY S4 SEP TQ X3 X5 ZZ

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
		<p>TTP Tertiary Payer TU Third Party Repricing Organization (TPO) X3 Utilization Management Organization X5 Durable Medical Equipment Supplier ZZ Mutually Defined</p> <p>61 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Modify Data Element Code Value Loop ID 2200D / STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim and Service Levels.</p> <p>CR 419 STC: Standardize use of the same Entity Codes across the TR3s.</p>	
62	7030 has specific code changes from those shown in #61 above	<p>62 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Add Data Element Code Value OOP - Other Operating Physician</p> <p>CR 952 Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.</p>	REVISIT

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes										
63	7030 has specific code changes from those shown in #61 above	<p>63 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Add Data Element Code Value AY - Clearinghouse</p> <p>CR 1120 Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.</p>	REVISIT										
64	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="background-color: #cccccc;">STC04</td> <td style="background-color: #cccccc;">782</td> <td style="background-color: #cccccc;">Monetary Amount Monetary amount</td> <td style="background-color: #cccccc;">O 1 R 1/18</td> </tr> </table> <p><small>SEMANTIC: STC04 is the amount of original submitted charges.</small></p> <p style="background-color: #cccccc;"><small>IMPLEMENTATION NAME: Total Claim Charge Amount</small></p> <p style="background-color: #cccccc;"><small>Zero is an acceptable amount.</small></p> <p style="background-color: #cccccc;"><small>Sum of the charges (CLM02) submitted from original claim. If an original claim is split, report the original claim total here. Note that this amount may be reported in two or more claims.</small></p>	REQUIRED	STC04	782	Monetary Amount Monetary amount	O 1 R 1/18	<p style="background-color: #cccccc;">007030X330 Health Care Claim Acknowledgment 277CA</p> <p style="background-color: #cccccc;">277 X330 Claim Acknowledgment Claim Level Status Information</p> <hr/> <p style="background-color: #cccccc;">SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="background-color: #cccccc;">STC04</td> <td style="background-color: #cccccc;">782</td> <td style="background-color: #cccccc;">Monetary Amount Monetary amount</td> <td style="background-color: #cccccc;">O 1 R 1/18</td> </tr> </table> <p><small>SEMANTIC: STC04 is the total charge amount.</small></p> <p style="background-color: #cccccc;"><small>INDUSTRY NAME: Total Claim Charge Amount</small></p> <p style="background-color: #cccccc;"><small>Zero is an acceptable amount.</small></p> <p style="background-color: #cccccc;"><small>Sum of the charges (CLM02) submitted from original claim. If an original claim is split, report the original claim total here. Note that this amount may be reported in two or more claims.</small></p> <p>64 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.</p> <p>CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	REQUIRED	STC04	782	Monetary Amount Monetary amount	O 1 R 1/18	Note: I do not see the change referenced in the change log.
REQUIRED	STC04	782	Monetary Amount Monetary amount	O 1 R 1/18									
REQUIRED	STC04	782	Monetary Amount Monetary amount	O 1 R 1/18									

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																														
65	<p>005010X214 • 277 • 2200D • STC CLAIM LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>...</p> <table border="1"> <tr> <td>SITUATIONAL</td> <td>STC12</td> <td>933</td> <td>Free-form Message Text</td> <td style="border: 1px solid black; text-align: center;">?</td> <td>O 1</td> <td>AN</td> <td>1/264</td> </tr> </table> <p>Free-form message text</p> <p>SEMANTIC: STC12 allows additional free-form status information.</p> <p>SITUATIONAL RULE: <i>Required when Health Care Claim Status Code 448 is used in STC01-2, STC10-2, or STC11-2. If not required by this implementation guide, do not send.</i></p> <p>IMPLEMENTATION NAME: Free Form Message Text</p> <p>See Section 1.4.2.1 for more information on use of STC12 and Status Code '448'.</p>	SITUATIONAL	STC12	933	Free-form Message Text	?	O 1	AN	1/264	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Claim Level Status Information</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - CLAIM LEVEL STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>...</p> <table border="1"> <tr> <td>NOT USED</td> <td>STC12</td> <td>933</td> <td>Free-form Message Text</td> <td></td> <td>O 1</td> <td>AN</td> <td>1/264</td> </tr> <tr style="border: 2px solid red;"> <td>SITUATIONAL</td> <td>STC13</td> <td>1383</td> <td>Claim Submission Reason Code</td> <td></td> <td>O 1</td> <td>ID</td> <td>2/2</td> </tr> </table> <p>Code identifying reason for claim submission</p> <p>SITUATIONAL RULE: <i>Required when the entire claim was submitted as a predetermination request. If not required by this implementation guide, do not send.</i></p> <p>INDUSTRY NAME: Predetermination of Benefits Code</p> <table border="1"> <thead> <tr> <th>CODE</th> <th>DEFINITION</th> </tr> </thead> <tbody> <tr> <td>08</td> <td>Pre-Determination Use when the claim is for a medical related predetermination (Professional or Institutional)</td> </tr> <tr> <td>PB</td> <td>Predetermination of Dental Benefits</td> </tr> </tbody> </table>	NOT USED	STC12	933	Free-form Message Text		O 1	AN	1/264	SITUATIONAL	STC13	1383	Claim Submission Reason Code		O 1	ID	2/2	CODE	DEFINITION	08	Pre-Determination Use when the claim is for a medical related predetermination (Professional or Institutional)	PB	Predetermination of Dental Benefits	<p>What about situational to not used? Is that picked up in the change log anywhere? What is the benefit of this?</p>
SITUATIONAL	STC12	933	Free-form Message Text	?	O 1	AN	1/264																										
NOT USED	STC12	933	Free-form Message Text		O 1	AN	1/264																										
SITUATIONAL	STC13	1383	Claim Submission Reason Code		O 1	ID	2/2																										
CODE	DEFINITION																																
08	Pre-Determination Use when the claim is for a medical related predetermination (Professional or Institutional)																																
PB	Predetermination of Dental Benefits																																
		<p>65 Location X330 Health Care Claim Acknowledgment 277 1000 2200D STC - Claim Level Status Information</p> <p>Action Add Data Element</p> <p>Loop ID 2200D / STC13 (Predetermination of Benefits Code)</p> <p>CR 1192 Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.</p>																															

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
66	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • REF PAYER CLAIM CONTROL NUMBER</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - PAYER CLAIM CONTROL NUMBER</p> <p>X12 Segment Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when a payer assigns a specific number to the claim for processing and the number is available at the time of this acknowledgment. If not required by this implementation guide, do not send.</p> <p>TR3 Notes: 1. This number will be used to track the adjudication of the claim throughout the adjudication system.</p> <p>TR3 Example: REF*1K*012421017500~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Payer Claim Control Number</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - PAYER CLAIM CONTROL NUMBER</p> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>Segment Repeat: 1 Usage: SITUATIONAL</p> <p>Situational Rule: Required when Loop ID 2100A NM101 value is PR and the claim has been accepted for adjudication. If not required by this implementation guide, maybe provided at the sender's discretion but cannot be required by the receiver.</p> <p>TR3 Notes: 1. This number will be used to track the adjudication of the claim throughout the adjudication system.</p> <p>TR3 Example: REF*1K*9918046987~</p> <p>66 Location X330 Health Care Claim Acknowledgment 277 1100 2200D REF - Payer Claim Control Number</p> <p>Action Modify Segment Situational Rule Loop ID 2200D REF - Payer Claim Control Number TO: Required when Loop ID 2100A NM101 value is PR and the claim has been accepted for adjudication. If not required by this implementation guide, maybe provided at the sender's discretion but cannot be required by the receiver.</p> <p>CR 1121 Requiring the payer claim number to be returned on the 277CA for accepted claims, would allow providers to improve front-end automation and would support downstream processes.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
67	N/A (Segment shown to the right is currently not in the 5010)	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Repriced Claim Number</p> <p>SEGMENT DETAIL</p> <p>REF - REPRICED CLAIM NUMBER</p> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: 1 Usage: SITUATIONAL</p> <p>Situational Rule: Required when the value in the 2100A NM101 is equal to TU (Third Party Repricing Organization) and the claim was accepted for repricing. If not required by this implementation guide, do not send.</p> <p>TR3 Example: REF*9A*RJ5555~</p> <hr/> <p>67 Location X330 Health Care Claim Acknowledgment 277 1100 2200D REF - Repriced Claim Number</p> <p>Action Add Segment Loop ID 2200D REF - Repriced Claim Number</p>	No Concern

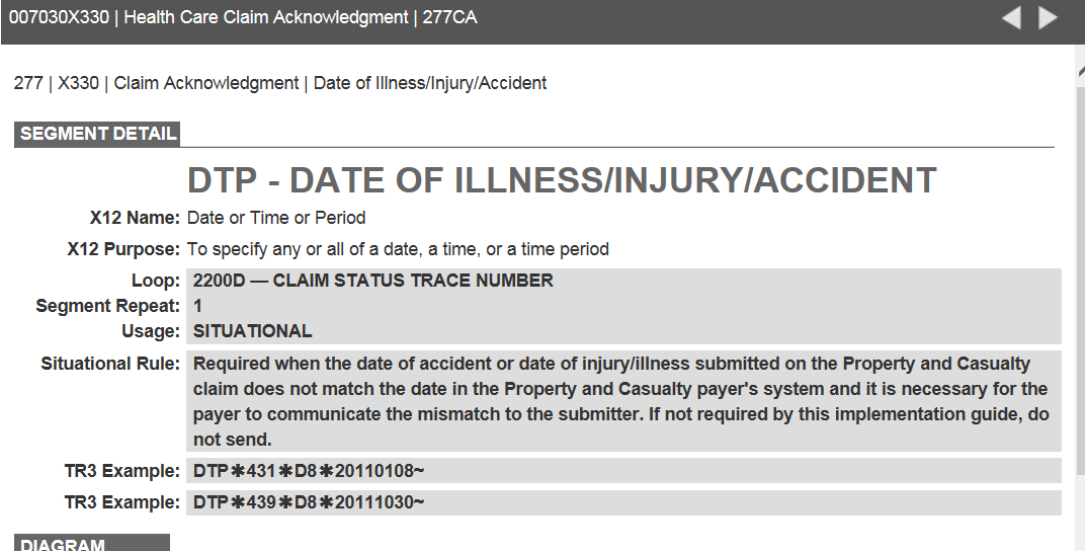
Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
68	N/A (Segment shown to the right is currently not in the 5010)	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Property & Casualty Claim Number</p> <p>SEGMENT DETAIL</p> <p>REF - PROPERTY & CASUALTY CLAIM NUMBER</p> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: 1 Usage: SITUATIONAL</p> <p>Situational Rule: Required when the Property & Casualty Claim Number has been validated by the Property & Casualty payer. If not required by this implementation guide, do not send.</p> <p>TR3 Example: REF*Y4*444555~</p> <p>DIAGRAM</p> <p>68 Location X330 Health Care Claim Acknowledgment 277 1100 2200D REF - Property & Casualty Claim Number</p> <p>Action Add Segment Loop ID 2200D REF - Property & Casualty Claim Number</p> <p>CR 385 Support the Property and Casualty industry need for a P&C Claim Number.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
69	N/A (Segment shown to the right is currently not in the 5010)	<div data-bbox="1276 280 2352 305" style="background-color: #333; color: #fff; padding: 2px;">007030X330 Health Care Claim Acknowledgment 277CA</div> <div data-bbox="1276 334 1661 355">277 X330 Claim Acknowledgment EDI Control Number</div> <div data-bbox="1276 375 1446 396" style="background-color: #ccc; padding: 2px;">SEGMENT DETAIL</div> <div data-bbox="1446 407 1870 435" style="text-align: center;">REF - EDI CONTROL NUMBER</div> <div data-bbox="1365 443 1661 516"> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203</p> </div> <div data-bbox="1462 516 1749 537" style="padding-left: 20px;">At least one of REF02 or REF03 is required.</div> <div data-bbox="1325 540 1749 602"> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: 1 Usage: SITUATIONAL</p> </div> <div data-bbox="1325 605 2341 667" style="background-color: #eee; padding: 2px;"> <p>Situational Rule: Required when an EDI Control Number is assigned to claim data during the front-end process and is used for tracking purposes or problem resolution. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> </div> <div data-bbox="1365 675 2341 737" style="background-color: #eee; padding: 2px;"> <p>TR3 Notes: 1. This number is assigned by the Receiver of the 837 to track individual claim data in the EDI front-end and is not used to track the claim through the adjudication system. Assignment of the EDI Control Number does not indicate the claim has been accepted into an adjudication system for processing.</p> </div> <div data-bbox="1325 740 1749 761" style="background-color: #eee; padding: 2px;"> <p>TR3 Example: REF*WF*ED51234567890123456789012~</p> </div> <p data-bbox="1276 818 2327 880">69 Location X330 Health Care Claim Acknowledgment 277 1100 2200D REF - EDI Control Number</p> <p data-bbox="1365 927 1634 954" style="text-align: center;">Action Add Segment</p> <p data-bbox="1276 963 1768 990">Loop ID 2200D REF - EDI Control Number</p> <p data-bbox="1276 1036 2252 1097">CR 382 Some payers use EDI Control Number when a Payer Claim ID has not been assigned. Add support for this identifier to the 277.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
70	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3 005010X214 • 277 • 2200D • DTP CLAIM LEVEL SERVICE DATE</p> <p>SEGMENT DETAIL</p> <p>DTP - CLAIM LEVEL SERVICE DATE</p> <p>X12 Segment Name: Date or Time or Period X12 Purpose: To specify any or all of a date, a time, or a time period Loop: 2200D — CLAIM STATUS TRACKING NUMBER Segment Repeat: 1 Usage: REQUIRED TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01 - 434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01-472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472). TR3 Example: DTP*472*RD8*20060820-20060825~ OR DTP*472*D8*20060823~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Service Date</p> <p>SEGMENT DETAIL</p> <p>DTP - SERVICE DATE</p> <p>X12 Name: Date or Time or Period X12 Purpose: To specify any or all of a date, a time, or a time period Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver. TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date. TR3 Example: DTP *472 *D8 *20110201~ OR DTP *472 *RD8 *20110201-20110205~</p> <p>70 Location X330 Health Care Claim Acknowledgment 277 1200 2200D DTP - Service Date</p> <p>Action Modify Segment Usage Change usage from Required to Situational.</p> <p>CR 383 Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.</p>	<p>CTP name changed but not documented in the log.</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
71	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • DTP CLAIM LEVEL SERVICE DATE</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - CLAIM LEVEL SERVICE DATE</p> <p>X12 Segment Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01 - 434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472).</p> <p>TR3 Example: DTP*472*RD8*20060820-20060825~ OR DTP*472*D8*20060823~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p style="text-align: right;">◀ ▶</p> <p>277 X330 Claim Acknowledgment Service Date</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - SERVICE DATE</p> <p>X12 Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <p>TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.</p> <p>TR3 Example: DTP *472 *D8 *20110201~ OR DTP *472 *RD8 *20110201-20110205~</p> <hr/> <p>71 Location X330 Health Care Claim Acknowledgment 277 1200 2200D DTP - Service Date</p> <p>Action Modify Segment Note Update Segment Note: For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.</p> <p>CR 383 Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.</p>	DTP name change

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
72	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2200D • DTP CLAIM LEVEL SERVICE DATE</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - CLAIM LEVEL SERVICE DATE</p> <p>X12 Segment Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2200D — CLAIM STATUS TRACKING NUMBER</p> <p>Segment Repeat: 1</p> <p>Usage: REQUIRED</p> <p>TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01 - 434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01-472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472).</p> <p>TR3 Example: DTP*472*RD8*20060820-20060825~ OR DTP*472*D8*20060823~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Service Date</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - SERVICE DATE</p> <p>X12 Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2200D — CLAIM STATUS TRACE NUMBER</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <p>TR3 Notes: 1. For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.</p> <p>TR3 Example: DTP *472 *D8 *20110201~ OR DTP *472 *RD8 *20110201-20110205~</p> <hr/> <p>72 Location X330 Health Care Claim Acknowledgment 277 1200 2200D DTP - Service Date</p> <p>Action Modify Segment Situational Rule Update Situational Rule to: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</p> <p>CR 383 Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.</p>	Same as 71

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
73	N/A (Segment shown to the right is currently not in the 5010)	 <p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Date of Illness/Injury/Accident</p> <p>SEGMENT DETAIL</p> <p>DTP - DATE OF ILLNESS/INJURY/ACCIDENT</p> <p>X12 Name: Date or Time or Period X12 Purpose: To specify any or all of a date, a time, or a time period Loop: 2200D — CLAIM STATUS TRACE NUMBER Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when the date of accident or date of injury/illness submitted on the Property and Casualty claim does not match the date in the Property and Casualty payer's system and it is necessary for the payer to communicate the mismatch to the submitter. If not required by this implementation guide, do not send.</p> <p>TR3 Example: DTP*431*D8*20110108~ TR3 Example: DTP*439*D8*20111030~</p> <p>DIAGRAM</p> <p>73 Location X330 Health Care Claim Acknowledgment 277 1200 2200D DTP - Date of Illness/Injury/Accident</p> <p>Action Add Segment Loop ID 2200D DTP - DATE OF ILLNESS/INJURY/ACCIDENT</p> <p>CR 387 277 Response: Support the Property and Casualty industry need for Corrected Date of Illness and Date of Accident.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
74	<p>005010X214 • 277 • 2220D • SVC SERVICE LINE INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Segment Name: Service Information</p> <p>X12 Purpose: To supply payment and control information to a provider for a particular service</p> <p>Loop: 2220D — SERVICE LINE INFORMATION Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when a service line is being rejected and caused the rejection of a claim. If not required by this implementation guide, do not send.</p> <p>TR3 Notes:</p> <ul style="list-style-type: none"> 1. Not used if the claim is being accepted into the adjudication system. 2. For Institutional claims, when both an NUBC revenue code and HCPCS or HIPPS code are reported, the HCPCS or HIPPS code is reported in SVC01-2 and the revenue code is reported in SVC04. When only a revenue code is used, it is reported in SVC01-2. 	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment 2220D — SERVICE LINE INFORMATION</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Name: Service Information</p> <p>X12 Purpose: To supply payment and control information to a provider for a particular service</p> <p>Loop: 2220D — SERVICE LINE INFORMATION Loop Repeat: >1</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when a service line is being rejected and caused the rejection of a claim. If not required by this implementation guide, do not send.</p> <p>TR3 Notes:</p> <ul style="list-style-type: none"> 1. For Institutional claims, when both an NUBC revenue code and a HCPCS or HIPPS code are reported, the HCPCS or HIPPS code is reported in SVC01-02 and the revenue code is reported in SVC04. When only a revenue code is used, it is reported in SVC01-02. 2. Not used if the claim is being accepted into the adjudication system. <p>TR3 Example: SVC*NU:0710*15.61~ OR SVC*HC:99213*35~</p> <p>74 Location X330 Health Care Claim Acknowledgment 277 1800 2220D SVC - Service Line Information</p> <p style="text-align: center;">Action Add Data Element Situational Rule</p> <p>"Required if submitted on the original claim service line. If not required by this implementation guide, do not send."</p> <p>CR 384 Revise the SVC01 as necessary to accommodate more than 4 modifiers.</p>	<p>We found the change of adding 4 more segments for modifiers but this was not clearly described in the change log.</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																				
75	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2220D • SVC SERVICE LINE INFORMATION</p> <table border="0"> <tr> <td style="vertical-align: top;">ER</td> <td> <p>Jurisdiction Specific Procedure and Supply Codes</p> <p>This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.</p> </td> </tr> <tr> <td></td> <td> <p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p> </td> </tr> <tr> <td style="vertical-align: top;">HC</td> <td> <p>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p> </td> </tr> <tr> <td></td> <td> <p>CODE SOURCE 130: Healthcare Common Procedural Coding System</p> </td> </tr> <tr> <td style="vertical-align: top;">HP</td> <td> <p>Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code</p> </td> </tr> <tr> <td></td> <td> <p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities</p> </td> </tr> <tr> <td style="vertical-align: top;">IV</td> <td> <p>Home Infusion EDI Coalition (HIEC) Product/Service Code</p> </td> </tr> <tr> <td></td> <td> <p>CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List</p> </td> </tr> <tr> <td style="vertical-align: top;">NU</td> <td> <p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>This is the NUBC code.</p> </td> </tr> <tr> <td></td> <td> <p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p> </td> </tr> <tr> <td style="vertical-align: top;">WK</td> <td> <p>Advanced Billing Concepts (ABC) Codes</p> </td> </tr> </table>	ER	<p>Jurisdiction Specific Procedure and Supply Codes</p> <p>This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.</p>		<p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p>	HC	<p>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p>		<p>CODE SOURCE 130: Healthcare Common Procedural Coding System</p>	HP	<p>Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code</p>		<p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities</p>	IV	<p>Home Infusion EDI Coalition (HIEC) Product/Service Code</p>		<p>CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List</p>	NU	<p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>This is the NUBC code.</p>		<p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p>	WK	<p>Advanced Billing Concepts (ABC) Codes</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2220D — SERVICE LINE INFORMATION</p> <p>SEGMENT DETAIL</p> <p>SVC - SERVICE LINE INFORMATION</p> <p>X12 Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <table border="0"> <tr> <td colspan="2">INDUSTRY NAME: Procedure Code</td> </tr> <tr> <td>CODE</td> <td>DEFINITION</td> </tr> <tr> <td>AD</td> <td>American Dental Association Codes CODE SOURCE 135: American Dental Association</td> </tr> <tr> <td>ER</td> <td> <p>Jurisdiction Specific Procedure and Supply Codes</p> <p>Use when a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR Use when the Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR Use when reporting Jurisdiction Specific Procedure and Supply Codes for claims which are not covered under HIPAA.</p> <p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p> </td> </tr> <tr> <td>HC</td> <td> <p>Healthcare Common Procedure Coding System (HCPCS) Codes</p> <p>Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.</p> <p>CODE SOURCE 130: Healthcare Common Procedure Coding System</p> </td> </tr> <tr> <td>HP</td> <td> <p>Health Insurance Prospective Payment System (HIPPS) Rate Code</p> <p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code</p> </td> </tr> <tr> <td>NU</td> <td> <p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>Use when reporting a NUBC Revenue Code</p> <p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p> </td> </tr> </table> <p>75 Location X330 Health Care Claim Acknowledgment 277 1800 2220D SVC - Service Line Information</p> <p>Action Delete Data Element Code Value Loop ID 2220D/SVC01-01 WK - Advanced Billing Concepts (ABC) Codes</p> <p>CR 749 Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS</p>	INDUSTRY NAME: Procedure Code		CODE	DEFINITION	AD	American Dental Association Codes CODE SOURCE 135: American Dental Association	ER	<p>Jurisdiction Specific Procedure and Supply Codes</p> <p>Use when a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR Use when the Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR Use when reporting Jurisdiction Specific Procedure and Supply Codes for claims which are not covered under HIPAA.</p> <p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p>	HC	<p>Healthcare Common Procedure Coding System (HCPCS) Codes</p> <p>Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.</p> <p>CODE SOURCE 130: Healthcare Common Procedure Coding System</p>	HP	<p>Health Insurance Prospective Payment System (HIPPS) Rate Code</p> <p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code</p>	NU	<p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>Use when reporting a NUBC Revenue Code</p> <p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p>	No Concern
ER	<p>Jurisdiction Specific Procedure and Supply Codes</p> <p>This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.</p>																																						
	<p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p>																																						
HC	<p>Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p>																																						
	<p>CODE SOURCE 130: Healthcare Common Procedural Coding System</p>																																						
HP	<p>Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code</p>																																						
	<p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities</p>																																						
IV	<p>Home Infusion EDI Coalition (HIEC) Product/Service Code</p>																																						
	<p>CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List</p>																																						
NU	<p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>This is the NUBC code.</p>																																						
	<p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p>																																						
WK	<p>Advanced Billing Concepts (ABC) Codes</p>																																						
INDUSTRY NAME: Procedure Code																																							
CODE	DEFINITION																																						
AD	American Dental Association Codes CODE SOURCE 135: American Dental Association																																						
ER	<p>Jurisdiction Specific Procedure and Supply Codes</p> <p>Use when a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR Use when the Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR Use when reporting Jurisdiction Specific Procedure and Supply Codes for claims which are not covered under HIPAA.</p> <p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p>																																						
HC	<p>Healthcare Common Procedure Coding System (HCPCS) Codes</p> <p>Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.</p> <p>CODE SOURCE 130: Healthcare Common Procedure Coding System</p>																																						
HP	<p>Health Insurance Prospective Payment System (HIPPS) Rate Code</p> <p>CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code</p>																																						
NU	<p>National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>Use when reporting a NUBC Revenue Code</p> <p>CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</p>																																						

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
		has discontinued the associated pilot project.	
76	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2220D • SVC SERVICE LINE INFORMATION</p> <hr/> <p>SITUATIONAL SVC07 380 Quantity O 1 R 1/15</p> <p>Numeric value of quantity</p> <p>SEMANTIC: SVC07 is the original submitted units of service.</p> <p>SITUATIONAL RULE: <i>Required if submitted on the original claim service line. If not required by this implementation guide, do not send.</i></p> <p>IMPLEMENTATION NAME: Original Units of Service Count</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment 2220D — SERVICE LINE INFORMATION</p> <p>SEGMENT DETAIL</p> <p>SVC - SERVICE LINE INFORMATION</p> <p>X12 Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>SITUATIONAL SVC07 380 Quantity O 1 R 1/15</p> <p>Numeric value of quantity</p> <p>SEMANTIC: SVC07 is the original submitted units of service.</p> <p>SITUATIONAL RULE: <i>Required if submitted on the original claim service line. If not required by this implementation guide, do not send.</i></p> <p>INDUSTRY NAME: Original Units of Service Count</p> <div style="border: 1px solid red; padding: 5px; margin-top: 10px;"> <p>The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed.</p> </div> <p>Previous Next</p> <p>76 Location X330 Health Care Claim Acknowledgment 277 1800 2220D SVC - Service Line Information</p> <p>Action Add Data Element Note</p> <p>SVC07 Original Units of Service Count</p> <p>The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed.</p> <p>CR 1410 Negative values are being submitted in the Claim Status Amount and Service Unit data elements of the Claim Status transactions where they do not make business sense. Such negative values should be disallowed.</p>	<p>Change indicates an 11 character limit but the guide indicates up to 15. "1/15"</p>

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																																						
77	<p>005010X214 • 277 • 2220D • SVC SERVICE LINE INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Segment Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION Loop Repeat: >1</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="padding: 0 10px;">SVC02</td> <td style="padding: 0 10px;">782</td> <td style="padding: 0 10px;">Monetary Amount Monetary amount</td> <td style="padding: 0 10px;">M 1</td> <td style="padding: 0 10px;">R</td> <td style="padding: 0 10px;">1/18</td> </tr> <tr> <td colspan="7">SEMANTIC: SVC02 is the submitted service charge.</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">IMPLEMENTATION NAME: Line Item Charge Amount</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">Zero is an acceptable amount.</td> </tr> <tr> <td style="background-color: #cccccc;">NOT USED</td> <td style="padding: 0 10px;">SVC03</td> <td style="padding: 0 10px;">782</td> <td style="padding: 0 10px;">Monetary Amount</td> <td style="padding: 0 10px;">O 1</td> <td style="padding: 0 10px;">R</td> <td style="padding: 0 10px;">1/18</td> </tr> </table>	REQUIRED	SVC02	782	Monetary Amount Monetary amount	M 1	R	1/18	SEMANTIC: SVC02 is the submitted service charge.							IMPLEMENTATION NAME: Line Item Charge Amount							Zero is an acceptable amount.							NOT USED	SVC03	782	Monetary Amount	O 1	R	1/18	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment 2220D — SERVICE LINE INFORMATION</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="padding: 0 10px;">SVC02</td> <td style="padding: 0 10px;">782</td> <td style="padding: 0 10px;">Monetary Amount Monetary amount</td> <td style="padding: 0 10px;">M 1</td> <td style="padding: 0 10px;">R</td> <td style="padding: 0 10px;">1/18</td> </tr> <tr> <td colspan="7">SEMANTIC: SVC02 is the submitted service charge.</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">INDUSTRY NAME: Line Item Charge Amount</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">Zero is an acceptable amount.</td> </tr> <tr> <td style="background-color: #cccccc;">NOT USED</td> <td style="padding: 0 10px;">SVC03</td> <td style="padding: 0 10px;">782</td> <td style="padding: 0 10px;">Monetary Amount</td> <td style="padding: 0 10px;">O 1</td> <td style="padding: 0 10px;">R</td> <td style="padding: 0 10px;">1/18</td> </tr> </table> <p>77 Location X330 Health Care Claim Acknowledgment 277 1800 2220D SVC - Service Line Information</p> <p>Action Add Data Element Note to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.</p> <p>CR 1013 Add a consistent element note explaining the maximum length to every monetary amount element.</p>	REQUIRED	SVC02	782	Monetary Amount Monetary amount	M 1	R	1/18	SEMANTIC: SVC02 is the submitted service charge.							INDUSTRY NAME: Line Item Charge Amount							Zero is an acceptable amount.							NOT USED	SVC03	782	Monetary Amount	O 1	R	1/18	<p>Note: I did not see this change. ChANge says length 10 but the document shows 18.</p>
REQUIRED	SVC02	782	Monetary Amount Monetary amount	M 1	R	1/18																																																																			
SEMANTIC: SVC02 is the submitted service charge.																																																																									
IMPLEMENTATION NAME: Line Item Charge Amount																																																																									
Zero is an acceptable amount.																																																																									
NOT USED	SVC03	782	Monetary Amount	O 1	R	1/18																																																																			
REQUIRED	SVC02	782	Monetary Amount Monetary amount	M 1	R	1/18																																																																			
SEMANTIC: SVC02 is the submitted service charge.																																																																									
INDUSTRY NAME: Line Item Charge Amount																																																																									
Zero is an acceptable amount.																																																																									
NOT USED	SVC03	782	Monetary Amount	O 1	R	1/18																																																																			

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
78	<p>005010X214 • 277 • 2220D • SVC SERVICE LINE INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Segment Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION Loop Repeat: >1</p> <p>...</p> <p style="text-align: center;">For claims which are not covered under HIPAA.</p> <p>CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes</p> <p>HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p> <p>CODE SOURCE 130: Healthcare Common Procedural Coding System</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment 2220D — SERVICE LINE INFORMATION</p> <hr/> <p>SEGMENT DETAIL</p> <hr/> <p style="text-align: center;">SVC - SERVICE LINE INFORMATION</p> <p>X12 Name: Service Information X12 Purpose: To supply payment and control information to a provider for a particular service Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>HC Healthcare Common Procedure Coding System (HCPCS) Codes</p> <div style="border: 1px solid red; padding: 2px;"> <p>Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.</p> </div> <p>CODE SOURCE 130: Healthcare Common Procedure Coding System</p> <p>78 Location X330 Health Care Claim Acknowledgment 277 1800 2220D SVC - Service Line Information</p> <p style="text-align: center;">Action Modify Data Element Code Note</p> <p>HC (Healthcare Common Procedure Coding System (HCPCS) Codes) Changed to: Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.</p> <p>CR 1542 Improve the consistency of the code value notes within and across the TR3s.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
	<p>SITUATIONAL STC11 - 3 98 Entity Identifier Code O ID 2/3 Code identifying an organizational entity, a physical location, property or an individual</p> <p>SEMANTIC: C043-03 identifies the entity associated with the Health Care Claim Status Code.</p> <p>SITUATIONAL RULE: <i>Required when an entity must be identified to further clarify the code message in STC11-2. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.</i></p> <p>See STC01-3 for valid values.</p>	<p>Service Line Status Information</p> <p>Action Modify Data Element Situational Rule STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."</p> <p>CR 371 Clarify when Claim Status Codes require the transmission of an Entity Code.</p>	
80	<p>005010X214 • 277 • 2220D • STC SERVICE LINE LEVEL STATUS INFORMATION ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p>STC - SERVICE LINE LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information X12 Purpose: To report the status, required action, and paid information of a claim or service line Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>SITUATIONAL STC10 C043 HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line</p> <p>SITUATIONAL RULE: <i>Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.</i></p> <p>...</p> <p>SITUATIONAL STC10 C043 HEALTH CARE CLAIM STATUS O 1 Used to convey status of the entire claim or a specific service line</p> <p>SITUATIONAL RULE: <i>Required if additional clarification to STC01 is needed. If not required by this implementation guide, do not send.</i></p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Service Line Status Information</p> <p>SEGMENT DETAIL</p> <p>STC - SERVICE LINE STATUS INFORMATION</p> <p>X12 Name: Status Information X12 Purpose: To report the status, required action, and paid information of a claim or service line Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>SITUATIONAL STC10 C043 Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line</p> <p>CLICK TO SHOW/HIDE: X12 Composite Semantic Notes</p> <p>SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p> <p>...</p> <p>SITUATIONAL STC11 C043 Health Care Claim Status O 1 Used to convey status of the entire claim or a specific service line</p> <p>CLICK TO SHOW/HIDE: X12 Composite Semantic Notes</p> <p>SITUATIONAL RULE: <i>Required when additional status information is needed. If not required by this implementation guide, do not send.</i></p> <p>80 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information</p> <p>Action Modify Data Element Situational Rule STC10 and STC11</p> <p>Changed to "Required when additional status information is needed. If not required by this</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
81	<p>005010X214 • 277 • 2220D • STC SERVICE LINE LEVEL STATUS INFORMATION</p> <p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p>SEGMENT DETAIL</p> <p>STC - SERVICE LINE LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>SITUATIONAL STC12 933 Free-form Message Text O 1 AN 1/264 Free-form message text</p> <p>SEMANTIC: STC12 allows additional free-form status information.</p> <p>SITUATIONAL RULE: <i>Required when Health Care Claim Status Code 448 is used in STC01-2, STC10-2, or STC11-2. If not required by this implementation guide, do not send.</i></p> <p>IMPLEMENTATION NAME: Free Form Message Text</p> <p>See Section 1.4.2.1 for more information on use of STC12 and Status Code '448'.</p>	<p>implementation guide, do not send." 007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Service Line Status Information</p> <p>SEGMENT DETAIL</p> <p>STC - SERVICE LINE STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <p>NOT USED STC12 933 Free-form Message Text O 1 AN 1/264</p> <p>81 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information</p> <p>Action Modify Data Element Usage STC12 Changed to Not Used.</p> <p>CR 1229 Data element usage change is required to meet industry needs.</p>	No Concern
82	See notes for #61 above	<p>82 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information</p> <p>Action Modify Data Element Code Value Loop ID 2220D / STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim and Service Levels.</p> <p>CR 419 STC: Standardize use of the same Entity Codes across the TR3s.</p>	Note: See list of code changes for change log number 61 above REVISIT

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
83	See notes for #61 above	83 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information Action Add Data Element Code Value O4 - Factor. CR 95 The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).	See note for #61 above. REVISIT
84	See notes for #61 above	84 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information Action Add Data Element Code Value OOP - Other Operating Physician CR 952 Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.	See note for #61 above REVISIT
85	See notes for #61 above	85 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information Action Add Data Element Code Value AY - Clearinghouse CR 1120 Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.	See note for #61 above REVISIT

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																								
86	<p>005010X214 • 277 • 2220D • STC SERVICE LINE LEVEL STATUS INFORMATION</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - SERVICE LINE LEVEL STATUS INFORMATION</p> <p>X12 Segment Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Service Line Status Information</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">STC - SERVICE LINE STATUS INFORMATION</p> <p>X12 Name: Status Information</p> <p>X12 Purpose: To report the status, required action, and paid information of a claim or service line</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <table border="1" style="border: 2px solid red;"> <tr> <td style="background-color: #cccccc;">SITUATIONAL</td> <td style="background-color: #cccccc;">STC13</td> <td style="background-color: #cccccc;">1383</td> <td style="background-color: #cccccc;">Claim Submission Reason Code</td> <td style="text-align: right;">O 1</td> <td style="text-align: right;">ID</td> <td style="text-align: right;">2/2</td> </tr> <tr> <td colspan="7">Code identifying reason for claim submission</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">SITUATIONAL RULE: <i>Required when the service line was submitted as a predetermination request. If not required by this implementation guide, do not send.</i></td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">INDUSTRY NAME: Service Line Predetermination of Benefits Code</td> </tr> <tr> <td colspan="7">CODE DEFINITION</td> </tr> <tr> <td style="background-color: #cccccc;">08</td> <td colspan="6" style="background-color: #cccccc;">Pre-Determination</td> </tr> <tr> <td colspan="7" style="background-color: #cccccc;">Use when the service line is for a medical related predetermination (Professional or Institutional)</td> </tr> <tr> <td style="background-color: #cccccc;">PB</td> <td colspan="6" style="background-color: #cccccc;">Predetermination of Dental Benefits</td> </tr> </table> <p>86 Location X330 Health Care Claim Acknowledgment 277 1900 2220D STC - Service Line Status Information</p> <p style="text-align: center;">Action Add Data Element</p> <p>Loop ID 2220D / STC13 (Service Line Predetermination of Benefits Code)</p> <p>CR 1192 Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.</p>	SITUATIONAL	STC13	1383	Claim Submission Reason Code	O 1	ID	2/2	Code identifying reason for claim submission							SITUATIONAL RULE: <i>Required when the service line was submitted as a predetermination request. If not required by this implementation guide, do not send.</i>							INDUSTRY NAME: Service Line Predetermination of Benefits Code							CODE DEFINITION							08	Pre-Determination						Use when the service line is for a medical related predetermination (Professional or Institutional)							PB	Predetermination of Dental Benefits						<p>What is the benefit of this?</p>
SITUATIONAL	STC13	1383	Claim Submission Reason Code	O 1	ID	2/2																																																					
Code identifying reason for claim submission																																																											
SITUATIONAL RULE: <i>Required when the service line was submitted as a predetermination request. If not required by this implementation guide, do not send.</i>																																																											
INDUSTRY NAME: Service Line Predetermination of Benefits Code																																																											
CODE DEFINITION																																																											
08	Pre-Determination																																																										
Use when the service line is for a medical related predetermination (Professional or Institutional)																																																											
PB	Predetermination of Dental Benefits																																																										

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
87	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2220D • REF SERVICE LINE ITEM IDENTIFICATION</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - SERVICE LINE ITEM IDENTIFICATION</p> <p>X12 Segment Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required. Loop: 2220D — SERVICE LINE INFORMATION Segment Repeat: 1 Usage: REQUIRED TR3 Notes: 1. This is the line Item Control Number exactly as submitted on the original claim in Loop 2400, REF02 (REF01-6R). If a Line Item Control Number is not submitted, this will be the line sequence number (LX01) of the service line. TR3 Example: REF*FJ*001~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Line Item Control Number</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - LINE ITEM CONTROL NUMBER</p> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required. Loop: 2220D — SERVICE LINE INFORMATION Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when a Service Line Item Control Number was submitted on the claim. If not required by this implementation guide, do not send. TR3 Example: REF*6R*54321~</p> <p>DIAGRAM</p> <p>87 Location X330 Health Care Claim Acknowledgment 277 2000 2220D REF - Line Item Control Number</p> <p style="text-align: center;">Action Add Segment Situational Rule Required when a Service Line Item Control Number was submitted on the claim. If not required by this implementation guide, do not send.</p> <p>CR 394 Make a decision on the usage requirement for the Line Item Control Number (required or situational) and apply the decision consistently across the TR3s.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
88	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2220D • REF SERVICE LINE ITEM IDENTIFICATION</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - SERVICE LINE ITEM IDENTIFICATION</p> <p>X12 Segment Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required. Loop: 2220D — SERVICE LINE INFORMATION Segment Repeat: 1 Usage: REQUIRED TR3 Notes: 1. This is the line Item Control Number exactly as submitted on the original claim in Loop 2400, REF02 (REF01-6R). If a Line Item Control Number is not submitted, this will be the line sequence number (LX01) of the service line. TR3 Example: REF*FJ*001~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Line Item Control Number</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - LINE ITEM CONTROL NUMBER</p> <p>X12 Name: Reference Information X12 Purpose: To specify identifying information X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required. Loop: 2220D — SERVICE LINE INFORMATION Segment Repeat: 1 Usage: SITUATIONAL Situational Rule: Required when a Service Line Item Control Number was submitted on the claim. If not required by this implementation guide, do not send. TR3 Example: REF*6R*54321~</p> <p>DIAGRAM</p> <p>88 Location X330 Health Care Claim Acknowledgment 277 2000 2220D REF - Line Item Control Number</p> <p style="text-align: center;">Action Modify Segment Name From: Service Line Item Identification Changed to: Line Item Control Number</p> <p>CR 1539 Modify the 2000A REF segment situational rule and the segment name in 275, 276 and 277 guides.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes																																																						
89	<p>005010X214 • 277 • 2220D • REF PHARMACY PRESCRIPTION NUMBER</p> <p style="text-align: right;">ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - PHARMACY PRESCRIPTION NUMBER</p> <p>X12 Segment Name: Reference Information</p> <p>X12 Purpose: To specify identifying information</p> <p>X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="padding: 0 10px;">REF02</td> <td style="padding: 0 10px;">127</td> <td style="padding: 0 10px;">Reference Identification</td> <td style="padding: 0 10px;">X 1 AN</td> <td style="padding: 0 10px;">1/50</td> </tr> <tr> <td colspan="6">Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</td> </tr> <tr> <td colspan="6">SYNTAX: R0203</td> </tr> <tr> <td colspan="6" style="background-color: #cccccc;">IMPLEMENTATION NAME: Pharmacy Prescription Number</td> </tr> </table>	REQUIRED	REF02	127	Reference Identification	X 1 AN	1/50	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						SYNTAX: R0203						IMPLEMENTATION NAME: Pharmacy Prescription Number						<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Pharmacy Prescription Number</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">REF - PHARMACY PRESCRIPTION NUMBER</p> <p>X12 Name: Reference Information</p> <p>X12 Purpose: To specify identifying information</p> <p>X12 Syntax: 1. R0203 At least one of REF02 or REF03 is required.</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>...</p> <table border="0"> <tr> <td style="background-color: #cccccc;">REQUIRED</td> <td style="padding: 0 10px;">REF02</td> <td style="padding: 0 10px;">127</td> <td style="padding: 0 10px;">Reference Identification</td> <td style="padding: 0 10px;">X 1 AN</td> <td style="padding: 0 10px;">1/80</td> </tr> <tr> <td colspan="6">Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</td> </tr> <tr> <td colspan="6">SEGMENT SYNTAX: R0203</td> </tr> <tr> <td colspan="6" style="background-color: #cccccc;">INDUSTRY NAME: Pharmacy Prescription Number</td> </tr> <tr> <td colspan="6" style="border: 2px solid red; background-color: #cccccc;">This is the Pharmacy Prescription Number submitted in the 2410 REF02 from the 837 claim. Maximum length of this element is constrained by B.1.1.3.1.</td> </tr> </table> <p>89 Location X330 Health Care Claim Acknowledgment 277 2000 2220D REF - Pharmacy Prescription Number</p> <p style="text-align: center;">Action Add Data Element Note</p> <p>This is the Pharmacy Prescription Number submitted in the 2410 REF02 from the 837 claim.</p>	REQUIRED	REF02	127	Reference Identification	X 1 AN	1/80	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						SEGMENT SYNTAX: R0203						INDUSTRY NAME: Pharmacy Prescription Number						This is the Pharmacy Prescription Number submitted in the 2410 REF02 from the 837 claim. Maximum length of this element is constrained by B.1.1.3.1.						No Concern
REQUIRED	REF02	127	Reference Identification	X 1 AN	1/50																																																				
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier																																																									
SYNTAX: R0203																																																									
IMPLEMENTATION NAME: Pharmacy Prescription Number																																																									
REQUIRED	REF02	127	Reference Identification	X 1 AN	1/80																																																				
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier																																																									
SEGMENT SYNTAX: R0203																																																									
INDUSTRY NAME: Pharmacy Prescription Number																																																									
This is the Pharmacy Prescription Number submitted in the 2410 REF02 from the 837 claim. Maximum length of this element is constrained by B.1.1.3.1.																																																									

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
90	<p>ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3</p> <p style="text-align: right;">005010X214 • 277 • 2220D • DTP SERVICE LINE DATE</p> <hr/> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - SERVICE LINE DATE</p> <p>X12 Segment Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when the Date of Service from the original submitted claim for a specific line item is present. If not required by this implementation guide, do not send.</p> <p>TR3 Example: DTP*472*RD8*20060822-20060825~ OR DTP*472*D8*20060823~</p>	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <hr/> <p>277 X330 Claim Acknowledgment Service Date</p> <p>SEGMENT DETAIL</p> <p style="text-align: center;">DTP - SERVICE DATE</p> <p>X12 Name: Date or Time or Period</p> <p>X12 Purpose: To specify any or all of a date, a time, or a time period</p> <p>Loop: 2220D — SERVICE LINE INFORMATION</p> <p>Segment Repeat: 1</p> <p>Usage: SITUATIONAL</p> <p>Situational Rule: Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.</p> <p>TR3 Example: DTP*472*D8*20110201~ OR DTP*472*RD8*20110201-20110205~</p> <hr/> <p>90 Location X330 Health Care Claim Acknowledgment 277 2100 2220D DTP - Service Date</p> <p>Action Add Segment Situational Rule Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.</p> <p>CR 395 The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.</p>	No Concern

Chng Log No.	5010	7030 with proposed changes (circled/highlighted)	Notes
91	N/A – the segment added in the 7030 was not in the 5010	<p>007030X330 Health Care Claim Acknowledgment 277CA</p> <p>277 X330 Claim Acknowledgment Tooth Information</p> <p>SEGMENT DETAIL</p> <p>TOO - TOOTH INFORMATION</p> <p>X12 Name: Tooth Identification X12 Purpose: To identify a tooth by number and, if applicable, one or more tooth surfaces X12 Syntax: 1. P0102 If either TOO01 or TOO02 is present, then the other is required.</p> <p>Loop: 2220D — SERVICE LINE INFORMATION Segment Repeat: 32 Usage: SITUATIONAL</p> <p>Situational Rule: Required when tooth information is needed to further define the service. If not required by this implementation guide, do not send.</p> <p>TR3 Example: TOO*JP*12*L:O~</p> <p>91 Location X330 Health Care Claim Acknowledgment 277 2150 2220D TOO - Tooth Information</p> <p>Action Add Segment Loop ID 2220D TOO - TOOTH INFORMATION</p> <p>CR 1516 For consistency across guides.</p>	No Concern