Companion Guide for Real-Time 276 277

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The 277 Claims Inquiry Response returned by Vaya Health (Vaya) should not be interpreted as a guarantee of payment. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

The information in this document is subject to change. Changes will be posted on the Claims Submission page of Vaya's Provider Central website.

Preface

This Companion Guide (CG) to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Vaya. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

The Communications/Connectivity component is included in the Companion Guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange. The Transaction Instruction component is included in the Companion Guide when the publishing entity wants to clarify the Implementation Guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Transaction Instruction (TI) Introduction

Scope

This Companion Guide provides specific requirements for sending Health Care Claim Status Request to Vaya. This document provides information about the Health Care Claim Status Response and intended only for the purpose of clarification and supplements the ASC X12N 276/277 (005010X212).

Overview

This Companion Guide must be used in conjunction with the Claim Status Inquiry/Response (276/277) instructions set forth by the ASC X12 Standards for Electronic Data Interchange (Version 005010X212).

References

- ASC X12 Version 5010 Implementation Guides: wpc-edi.com
- Washington Publishing Company: wpc-edi.com
- ASC X12 Organization: x12.org
- Workgroup for Electronic Data Interchange (WEDI): wedi.org

Overview

This Companion Guide must be used in conjunction with the Claims Status Inquiry/Response (276/277) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange (Version 005010X212).

What Is CAQH?

CAQH stands for the Council for Affordable and Quality Healthcare. It is a nonprofit alliance of health plans, provider networks, and associations with a goal to provide a variety of solutions to simplify health care administration.

What Is CORE?

CORE stands for the Committee on Operating Rules for Information Exchanges. CORE consists of a group of health plans, providers, vendors, Centers for Medicare & Medicaid Services (CMS), and other government agencies, associations, regional entities, standard-setting organizations, and other health care entities that are facilitated by CAQH. CORE's goal is to create, disseminate, and maintain operating rules that enable health care providers to obtain reliable health care eligibility and benefits information quickly and securely. It will decrease the amount of time and resources providers spend verifying patient eligibility, benefits, and other administrative information at the point of care.

What Is CAQH-CORE Certification?

An entity that creates or transmits eligibility data is eligible to become CAQH-CORE certified. The entity must agree to follow the CAQH-CORE operating rules and will be expected to exchange eligibility and benefits information per the requirements of the CORE Phase II rules and policies. To view the CORE Phase II rules and policies, go to caqh.org.

References

- ASC X12 Version 5010 Implementation Guides: x12.org/products
- CAQH/CORE: caqh.org/caqh-core
- SOAP: w3.org/TR/soap12
- MIME Multipart: w3.org/Protocols/rfc1341/7_2_Multipart.html
- CORE XML Schema: caqh.org/core/eligibility-benefits-operating-rules
- Washington Publishing Company: wpc-edi.com
- ASC X12 Organization: x12.org
- U.S. Department of Health and Human Services (HHS): hhs.gov/hipaa/index.html
- Workgroup for Electronic Data Interchange (WEDI): wedi.org
- North Carolina Department of Health and Human Services: ncdhhs.gov
- NC Medicaid (Division of Health Benefits): medicaid.ncdhhs.gov
- NC Division of Public Health: ncdhhs.gov/divisions/public-health
- NC Division of Mental Health, Developmental Disabilities, and Substance Use Services: ncdhhs.gov/divisions/mhddsus

Additional Information

CAQH CORE has defined specific rules regarding Name Normalization, which pertains to normalizing the last name. The rules for Name Normalization are:

- Converting all letters to upper case
- The removal of titles/prefixes/suffixes

- The removal of 16 special characters: ! ‘ & ’ () * + , - . / : ; ? =
- The removal of character strings (prefixes/suffixes) when they are preceded by a space, comma, or forward slash: JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

Connection Type

The IConnect service uses RESTful web services.

Trading Partner Agreements

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement. The Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

To request a Trading Partner Agreement, please email the following information to EDI@vayahealth.com with the subject line “Trading Partner Agreement needed:”

- Provider, clearinghouse, or billing agency’s legal name
- Contact name
- Contact email address
- Contact phone number
- Address
- Federal tax ID number (EIN)
- NPI number(s)
- Clearinghouse (if used)

Testing with the Payer

Vaya requires testing, or third-party certification, prior to approving a Trading Partner to submit claims in production. Once Trading Partner claims are in production, Vaya reserves the right to require re-testing if it is determined that the Trading Partner is receiving/generating an unacceptable volume of errors. Once set up and testing is complete, additional documentation will be provided with the path to upload real-time 276 for processing.

The steps for testing with Vaya are available on the Claims Submission page of our Provider Central website.

To submit your 276 files via FTP, you may request FTP access using the EDI Enrollment Form located on our website.

Contact Information

For electronic data interchange (EDI) technical assistance, email EDI@Vayahealth.com

Control Segments/Envelopes

ISA-IEA

Transactions transmitted during a session are identified by Interchange Header Segment (ISA) and Trailer Segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

GS-GE

EDI transactions of a similar nature that are destined for one trading partner may be gathered into a functional group, identified by a Functional Group Header Segment (GS) and a Functional Group Trailer Segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope.

ST-SE

The beginning of each individual transaction is identified using a Transaction Set Header Segment (ST), and the end of every transaction is marked by a Transaction Set Trailer Segment (SE).

Acknowledgements

For all inbound transactions, a 999 Acknowledgement Report will be sent to the Trading Partner's OUTBOX for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement Reports are available within moments of submission.

Transaction-Specific Information

The following tables contain one or more rows for each segment for which a supplemental instruction is needed.

005010X212 Health Care Eligibility Benefit Inquiry and Response (276/277)

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	Use '00'
	ISA03	Security Information qualifier	00	Use '00'
	ISA05	Interchange ID Qualifier		Use 'ZZ'
	ISA06	Interchange Sender ID		Use the Submitter/Folder ID provided by the Vaya EDI Team
	ISA07	Interchange ID Qualifier		Use 'ZZ'
	ISA08	Interchange Receiver ID		Submitters will use '13010'
Header	GS	Functional Group Header		
	GS01	Healthcare Claim Status Request	HR	HR
	GS02	Application Sender's Code		Use the Submitter/Folder ID provided by the Vaya EDI Team
	GS03	Application Receiver's Code		13010 is used
Header	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	Use '13'
2100A	NM1	Information Source Name		
	NM108	Identification Code Qualifier	PI	Use 'PI'
	NM109	Information Source Primary Identifier		Use '1588903322'
2100C	NM1	Provider Name		
	NM101	Entity Identifier Code	1P	Submitter Use '1P'
	NM108	Provider Identification Code Qualifier	SV,XX	Use 'SV' for Atypical Provider ID Use 'XX' for NPI
2000D	HL	Subscriber Level		The 2000D Subscriber Level loop should be used to identify the recipient, since the recipient is always the subscriber.
2100D	NM1	Subscriber Name		
	NM102	Subscriber Typer Qualifier	1	Use '1'
	NM108	Identification Code Qualifier	MI	Use 'MI'
	NM109	Subscriber Identifier		Use the subscriber's 10-digit identification number ending in an alpha character

277-Specific Information

Loop ID	Reference	Name	Codes	Notes/Comments
Header	ISA	Interchange Control Header		
	ISA01	Authorization Information Qualifier	00	'00' is returned
	ISA03	Security Information qualifier	00	'00' is returned
	ISA05	Interchange ID Qualifier	ZZ	'ZZ' is returned
	ISA06	Interchange Sender ID		'13010' is returned
	ISA07	Interchange ID Qualifier	ZZ	'ZZ' is returned
	ISA14	Acknowledgment Requested	1	'1' is returned
Header	GS	Functional Group Header		
	GS01	Functional Identifier Code	HN	'HN' is returned
	GS02	Application Sender's Code		13010 is used
	GS03	Application Receiver's Code		Submitter Folder ID is returned
Header	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	08	'08' is returned
2100A	NM1	Information Source Name		
	NM108	Identification Code Qualifier	PI	'PI' is returned
	NM109	Identification Code	Vaya	'1588903322' is returned
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	41	'41' is returned
	NM108	Identification Code Qualifier	46	'46' is returned
2100C	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	SV, XX	'SV' or "XX' is returned
2000D	NM1	Subscriber Level		The 2000D Subscriber Level loop should be used to identify the recipient, since the recipient is always the subscriber.
2200D	STC	Claim Level Status Information		
	STC01-2	Health Care Claim Status Code		Status Code refer to Category code and status code set

Category Code and Status Code

Claim Status Category Code Description	Code
Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.	A0
Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.	A1
Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.	A2
Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.	A3
Acknowledgement/Not Found-The claim/encounter cannot be found in the adjudication system.	A4
Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.	A5
Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.	A6
Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.	A7
Acknowledgement/Rejected for relational field in error.	A8
Acknowledgement/Receipt - The claim/encounter has been received. This does not mean the claim has been accepted into the data reporting/processing system. Usage: Can only be used in the Data Reporting Acknowledgement Transaction.	DR01
Acknowledgement/Acceptance into the data reporting/processing system - The claim/encounter has been accepted into the data reporting/processing system. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR02
Acknowledgement/Returned as unprocessable claim - The claim/encounter has been rejected and has not been entered into the data reporting/processing system. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR03
Acknowledgement/Not Found - The claim/encounter can not be found in the data reporting/processing system. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR04
Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR05
Acknowledgment/Rejected for invalid information - The claim/encounter has invalid information as specified in the Status details and has been rejected. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR06
Acknowledgement/Rejected for relational field in error. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR07
Acknowledgement/Warning - The claim/encounter has been accepted into the data reporting/processing system but has received a warning as specified in the Status details. Usage: Can only be used in the Data Reporting Acknowledgment Transaction.	DR08

Claim Status Category Code Description	Code
Pending: Adjudication/Details-This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.	P0
Pending/In Process-The claim or encounter is in the adjudication system.	P1
Pending/Payer Review-The claim/encounter is suspended and is pending review (e.g. medical review, repricing, Third Party Administrator processing).	P2
Pending/Provider Requested Information - The claim or encounter is waiting for information that has already been requested from the provider. (Usage: A Claim Status Code identifying the type of information requested, must be reported)	P3
Pending/Patient Requested Information - The claim or encounter is waiting for information that has already been requested from the patient. (Usage: A status code identifying the type of information requested must be sent)	P4
Pending/Payer Administrative/System hold	P5
Finalized-The claim/encounter has completed the adjudication cycle and no more action will be taken.	F0
Finalized/Payment-The claim/line has been paid.	F1
Finalized/Denial-The claim/line has been denied.	F2
Finalized/Revised - Adjudication information has been changed	F3
Finalized/Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made and the claim/encounter has been forwarded to a subsequent entity as identified on the original claim or in this payer's records.	F3F
Finalized/Not Forwarded-The claim/encounter processing has been completed. Any applicable payment has been made. The claim/encounter has NOT been forwarded to any subsequent entity identified on the original claim.	F3N
Finalized/Adjudication Complete - No payment forthcoming-The claim/encounter has been adjudicated and no further payment is forthcoming.	F4
Response not possible - error on submitted request data	E0
Response not possible - System Status	E1
Information Holder is not responding; resubmit at a later time.	E2
Correction required - relational fields in error.	E3
Trading partner agreement specific requirement not met: Data correction required. (Usage: A status code identifying the type of information requested must be sent)	E4
Data Search Unsuccessful - The payer is unable to return status on the requested claim(s) based on the submitted search criteria.	D0

Claim Status Code Descriptions	Code
Cannot provide further status electronically	0
For more detailed information, see remittance advice	1
More detailed information in letter	2
Claim has been adjudicated and is awaiting payment cycle	3

Claim Status Code Descriptions	Code
Balance due from the subscriber	6
One or more originally submitted procedure codes have been combined	12
One or more originally submitted procedure code have been modified	15
Claim/encounter has been forwarded to entity. Usage: This code requires use of an Entity Code.	16
Claim/encounter has been forwarded by third party entity to entity. Usage: This code requires use of an Entity Code.	17
Entity received claim/encounter, but returned invalid status. Usage: This code requires use of an Entity Code.	18
Entity acknowledges receipt of claim/encounter. Usage: This code requires use of an Entity Code.	19
Accepted for processing	20
Missing or invalid information. Usage: At least one other status code is required to identify the missing or invalid information.	21
Returned to Entity. Usage: This code requires use of an Entity Code.	23
Entity not approved as an electronic submitter. Usage: This code requires use of an Entity Code.	24
Entity not approved. Usage: This code requires use of an Entity Code.	25
Entity not found. Usage: This code requires use of an Entity Code.	26
Policy canceled	27
Subscriber and policy number/contract number mismatched	29
Subscriber and subscriber id mismatched	30
Subscriber and policyholder name mismatched	31
Subscriber and policy number/contract number not found	32
Subscriber and subscriber id not found	33
Subscriber and policyholder name not found	34
Claim/encounter not found	35
Predetermination is on file, awaiting completion of services	37
Awaiting next periodic adjudication cycle	38
Charges for pregnancy deferred until delivery	39
Waiting for final approval	40
Special handling required at payer site	41
Awaiting related charges	42
Charges pending provider audit	44
Awaiting benefit determination	45
Internal review/audit	46
Internal review/audit - partial payment made	47
Pending provider accreditation review	49
Claim waiting for internal provider verification	50
Investigating occupational illness/accident	51
Investigating existence of other insurance coverage	52
Claim being researched for Insured ID/Group Policy Number error	53
Duplicate of a previously processed claim/line	54

Claim Status Code Descriptions	Code
Claim assigned to an approver/analyst	55
Awaiting eligibility determination	56
Pending COBRA information requested	57
Information was requested by a non-electronic method. Usage: At least one other status code is required to identify the requested information.	59
Information was requested by an electronic method. Usage: At least one other status code is required to identify the requested information.	60
Eligibility for extended benefits	61
Re-pricing information	64
Claim/line has been paid	65
Payment reflects usual and customary charges	66
Claim contains split payment	72
Payment made to entity, assignment of benefits not on file. Usage: This code requires use of an Entity Code.	73
Duplicate of an existing claim/line, awaiting processing	78
Contract/plan does not cover pre-existing conditions	81
No coverage for newborns	83
Service not authorized	84
Entity not primary. Usage: This code requires use of an Entity Code	85
Diagnosis and patient gender mismatch	86
Entity not eligible for benefits for submitted dates of service. Usage: This code requires use of an Entity Code.	88
Entity not eligible for dental benefits for submitted dates of service. Usage: This code requires use of an Entity Code.	89
Entity not eligible for medical benefits for submitted dates of service. Usage: This code requires use of an Entity Code.	90
Entity not eligible/not approved for dates of service. Usage: This code requires use of an Entity Code.	91
Entity does not meet dependent or student qualification. Usage: This code requires use of an Entity Code.	92
Entity is not selected primary care provider. Usage: This code requires use of an Entity Code.	93
Entity not referred by selected primary care provider. Usage: This code requires use of an Entity Code.	94
Requested additional information not received	95
No agreement with entity. Usage: This code requires use of an Entity Code.	96
Patient eligibility not found with entity. Usage: This code requires use of an Entity Code.	97
Charges applied to deductible	98
Pre-treatment review	99
Pre-certification penalty taken	100
Claim was processed as adjustment to previous claim	101
Newborn's charges processed on mother's claim	102
Claim combined with other claim(s)	103
Processed according to plan provisions (Plan refers to provisions that exist between the Health Plan and the Consumer or Patient)	104

Claim Status Code Descriptions	Code
Claim/line is capitated	105
This amount is not entity's responsibility. Usage: This code requires use of an Entity Code.	106
Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)	107
Entity not eligible. Usage: This code requires use of an Entity Code.	109
Claim requires pricing information	110
At the policyholder's request these claims cannot be submitted electronically	111
Claim/service should be processed by entity. Usage: This code requires use of an Entity Code	114
Claim submitted to incorrect payer	116
Claim requires signature-on-file indicator	117
Service line number greater than maximum allowable for payer	121
Additional information requested from entity. Usage: This code requires use of an Entity Code.	123
Entity's name, address, phone and id number. Usage: This code requires use of an Entity Code.	124
Entity's name. Usage: This code requires use of an Entity Code.	125
Entity's address. Usage: This code requires use of an Entity Code.	126
Entity's Communication Number. Usage: This code requires use of an Entity Code.	127
Entity's tax id. Usage: This code requires use of an Entity Code.	128
Entity's Blue Cross provider id. Usage: This code requires use of an Entity Code.	129
Entity's Blue Shield provider id. Usage: This code requires use of an Entity Code.	130
Entity's Medicare provider id. Usage: This code requires use of an Entity Code.	131
Entity's Medicaid provider id. Usage: This code requires use of an Entity Code.	132
Entity's UPIN. Usage: This code requires use of an Entity Code.	133
Entity's TRICARE provider id. Usage: This code requires use of an Entity Code.	134
Entity's commercial provider id. Usage: This code requires use of an Entity Code.	135
Entity's health industry id number. Usage: This code requires use of an Entity Code.	136
Entity's plan network id. Usage: This code requires use of an Entity Code.	137
Entity's site id . Usage: This code requires use of an Entity Code.	138
Entity's health maintenance provider id (HMO). Usage: This code requires use of an Entity Code.	139
Entity's preferred provider organization id (PPO). Usage: This code requires use of an Entity Code.	140
Entity's administrative services organization id (ASO). Usage: This code requires use of an Entity Code.	141
Entity's license/certification number. Usage: This code requires use of an Entity Code.	142
Entity's state license number. Usage: This code requires use of an Entity Code.	143
Entity's specialty license number. Usage: This code requires use of an Entity Code.	144
Entity's specialty/taxonomy code. Usage: This code requires use of an Entity Code.	145
Entity's anesthesia license number. Usage: This code requires use of an Entity Code.	146
Entity's qualification degree/designation (e.g. RN,PhD,MD). Usage: This code requires use of an Entity Code.	147
Entity's social security number. Usage: This code requires use of an Entity Code.	148
Entity's employer id. Usage: This code requires use of an Entity Code.	149
Entity's drug enforcement agency (DEA) number. Usage: This code requires use of an Entity Code.	150
Pharmacy processor number	152

Claim Status Code Descriptions	Code
Entity's id number. Usage: This code requires use of an Entity Code.	153
Relationship of surgeon & assistant surgeon	154
Entity's relationship to patient. Usage: This code requires use of an Entity Code.	155
Patient relationship to subscriber	156
Entity's Gender. Usage: This code requires use of an Entity Code.	157
Entity's date of birth. Usage: This code requires use of an Entity Code.	158
Entity's date of death. Usage: This code requires use of an Entity Code.	159
Entity's marital status. Usage: This code requires use of an Entity Code.	160
Entity's employment status. Usage: This code requires use of an Entity Code.	161
Entity's health insurance claim number (HICN). Usage: This code requires use of an Entity Code.	162
Entity's policy/group number. Usage: This code requires use of an Entity Code.	163
Entity's contract/member number. Usage: This code requires use of an Entity Code.	164
Entity's employer name, address and phone. Usage: This code requires use of an Entity Code.	165
Entity's employer name. Usage: This code requires use of an Entity Code.	166
Entity's employer address. Usage: This code requires use of an Entity Code.	167
Entity's employer phone number. Usage: This code requires use of an Entity Code.	168
Entity's employee id. Usage: This code requires use of an Entity Code.	170
Other insurance coverage information (health, liability, auto, etc.)	171
Other employer name, address and telephone number	172
Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber. Usage: This code requires use of an Entity Code.	173
Entity's student status. Usage: This code requires use of an Entity Code.	174
Entity's school name. Usage: This code requires use of an Entity Code.	175
Entity's school address. Usage: This code requires use of an Entity Code.	176
Transplant recipient's name, date of birth, gender, relationship to insured	177
Submitted charges	178
Outside lab charges	179
Hospital s semi-private room rate	180
Hospital s room rate	181
Allowable/paid from other entities coverage Usage: This code requires the use of an entity code.	182
Amount entity has paid. Usage: This code requires use of an Entity Code.	183
Purchase price for the rented durable medical equipment	184
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Date(s) of service	187
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Facility admission date	189
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Date of Last Menstrual Period (LMP)	191
Date of first service for current series/symptom/illness	192

Claim Status Code Descriptions	Code
First consultation/evaluation date	193
Confinement dates	194
Unable to work dates/Disability Dates	195
Return to work dates	196
Effective coverage date(s)	197
Medicare effective date	198
Date of conception and expected date of delivery	199
Date of equipment return	200
Date of dental appliance prior placement	201
Date of dental prior replacement/reason for replacement	202
Date of dental appliance placed	203
Date dental canal(s) opened and date service completed	204
Date(s) dental root canal therapy previously performed	205
Most recent date of curettage, root planing, or periodontal surgery	206
Dental impression and seating date	207
Most recent date pacemaker was implanted	208
Most recent pacemaker battery change date	209
Date of the last x-ray	210
Date(s) of dialysis training provided to patient	211
Date of last routine dialysis	212
Date of first routine dialysis	213
Original date of prescription/orders/referral	214
Date of tooth extraction/evolution	215
Drug information	216
Drug name, strength and dosage form	217
NDC number	218
Prescription number	219
Drug dispensing units and average wholesale price (AWP)	222
Route of drug/myelogram administration	223
Anatomical location for joint injection	224
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Hospital information	227
Type of bill for UB claim	228
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Hospital admission hour	230
Hospital admission type	231

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Dental information	239
Tooth surface(s) involved	240
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Tooth numbers, surfaces, and/or quadrants involved	242
Months of dental treatment remaining	243
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Dental quadrant/arch	245
Total orthodontic service fee, initial appliance fee, monthly fee, length of service	246
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Total anesthesia minutes	251
Entity's prior authorization/certification number. Usage: This code requires the use of an Entity Code.	252
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Days/units for procedure/revenue code	258
Frequency of service	259
Length of medical necessity, including begin date	260
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Type of surgery/service for which anesthesia was administered	262
Length of time for services rendered	263
Number of liters/minute & total hours/day for respiratory support	264
Number of lesions excised	265
Facility point of origin and destination - ambulance	266

Claim Status Code Descriptions	Code
Number of miles patient was transported	267
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Patient release of information authorization	333
Oxygen certification	334
Durable medical equipment certification	335
Chiropractic certification	336
Ambulance certification/documentation	337
Enteral/parenteral certification	339
Pacemaker certification	340
Private duty nursing certification	341
Podiatric certification	342
Documentation that facility is state licensed and Medicare approved as a surgical facility	343
Documentation that provider of physical therapy is Medicare Part B approved	344
Treatment plan for service/diagnosis	345

Claim Status Code Descriptions	Code
Proposed treatment plan for next 6 months	346
Duration of treatment plan	352
Orthodontics treatment plan	353
Treatment plan for replacement of remaining missing teeth	354
Benefits Assignment Certification Indicator	360
Possible Workers' Compensation	363
Is accident/illness/condition employment related?	364
Is service the result of an accident?	365
Is injury due to auto accident?	366
Is prescribed lenses a result of cataract surgery?	374
Was refraction performed?	375
CRNA supervision/medical direction	380
Did provider authorize generic or brand name dispensing?	382
Nerve block use (surgery vs. pain management)	383
Is prosthesis/crown/inlay placement an initial placement or a replacement?	384
Is appliance upper or lower arch & is appliance fixed or removable?	385
Orthodontic Treatment/Purpose Indicator	386
Date patient last examined by entity. Usage: This code requires use of an Entity Code.	387
Date post-operative care assumed	388
Date post-operative care relinquished	389
Date of most recent medical event necessitating service(s)	390
Date(s) dialysis conducted	391
Date(s) of most recent hospitalization related to service	394
Date entity signed certification/recertification Usage: This code requires use of an Entity Code.	395
Date home dialysis began	396
Date of onset/exacerbation of illness/condition	397
Visual field test results	398
Claim is out of balance	400
Source of payment is not valid	401
Amount must be greater than zero. Usage: At least one other status code is required to identify which amount element is in error.	402
Entity referral notes/orders/prescription. Effective 05/01/2018: Entity referral notes/orders/prescription. Usage: this code requires use of an entity code.	403
Brief medical history as related to service(s)	406

Claim Status Code Descriptions	Code
Complications/mitigating circumstances	407
Initial certification	408
Medication logs/records (including medication therapy)	409
Necessity for concurrent care (more than one physician treating the patient)	414
Prior testing, including result(s) and date(s) as related to service(s)	417
Individual test(s) comprising the panel and the charges for each test	419
Name, dosage and medical justification of contrast material used for radiology procedure	420
Reason for transport by ambulance	428
Nearest appropriate facility	430
Patient's condition/functional status at time of service	431
Date benefits exhausted	432
Copy of patient revocation of hospice benefits	433
Reasons for more than one transfer per entitlement period	434
Notice of Admission	435
Entity professional qualification for service(s)	441
Modalities of service	442
Initial evaluation report	443
Projected date to discontinue service(s)	449
Awaiting spend down determination	450
Preoperative and post-operative diagnosis	451
Total visits in total number of hours/day and total number of hours/week	452
Procedure Code Modifier(s) for Service(s) Rendered	453
Procedure code for services rendered	454
Revenue code for services rendered	455
Covered Day(s)	456
Non-Covered Day(s	457
Coinsurance Day(s)	458
Lifetime Reserve Day(s)	459
NUBC Condition Code(s)	460
Payer Assigned Claim Control Number	464
Principal Procedure Code for Service(s) Rendered	465
Entity's Original Signature. Usage: This code requires use of an Entity Code.	466
Entity Signature Date. Usage: This code requires use of an Entity Code.	467

Claim Status Code Descriptions	Code
Patient Signature Source	468
Purchase Service Charge	469
Was service purchased from another entity? Usage: This code requires use of an Entity Code.	470
Were services related to an emergency?	471
Ambulance Run Sheet	472
Missing or invalid lab indicator	473
Procedure code and patient gender mismatch	474
Procedure code and patient gender mismatch	475
Missing or invalid units of service	476
Diagnosis code pointer is missing or invalid	477
Claim submitter's identifier	478
Other Carrier payer ID is missing or invalid	479
Entity's claim filing indicator. Usage: This code requires use of an Entity Code	480
Claim/submission format is invalid	481
Maximum coverage amount met or exceeded for benefit period	483
Business Application Currently Not Available	484
More information available than can be returned in real time mode. Narrow your current search criteria. This change effective September 1, 2017: More information available than can be returned in real-time mode. Narrow your current search criteria.	485
Principal Procedure Date	486
Claim not found, claim should have been submitted to/through 'entity'. Usage: This code requires use of an Entity Code.	487
Diagnosis code(s) for the services rendered	488
Attachment Control Number	489
Other Procedure Code for Service(s) Rendered	490
Entity not eligible for encounter submission. Usage: This code requires use of an Entity Code.	491
Other Procedure Date	492
Version/Release/Industry ID code not currently supported by information holder	493
Real-Time requests not supported by the information holder, resubmit as batch request This change effective September 1, 2017: Real-time requests not supported by the information holder, resubmit as batch request.	494
Requests for re-adjudication must reference the newly assigned payer claim control number for this previously adjusted claim. Correct the payer claim control number and re-submit.	495
Submitter not approved for electronic claim submissions on behalf of this entity. Usage: This code requires use of an Entity Code.	496
Sales tax not paid	497

Claim Status Code Descriptions	Code
Maximum leave days exhausted	498
No rate on file with the payer for this service for this entity Usage: This code requires use of an Entity Code.	499
Entity's Postal/Zip Code. Usage: This code requires use of an Entity Code.	500
Entity's State/Province. Usage: This code requires use of an Entity Code.	501
Entity's City. Usage: This code requires use of an Entity Code.	502
Entity's Street Address. Usage: This code requires use of an Entity Code.	503
Entity's Last Name. Usage: This code requires use of an Entity Code.	504
Entity's First Name. Usage: This code requires use of an Entity Code.	505
Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse. Usage: This code requires use of an Entity Code.	506
HCPCS	507
ICD9 Usage: At least one other status code is required to identify the related procedure code or diagnosis code.	508
External Cause of Injury Code	509
Future date. Usage: At least one other status code is required to identify the data element in error.	510
Invalid character. Usage: At least one other status code is required to identify the data element in error.	511
Length invalid for receiver's application system. Usage: At least one other status code is required to identify the data element in error.	512
HIPPS Rate Code for services Rendered	513
Entity's Middle Name Usage: This code requires use of an Entity Code.	514
Managed Care review	515
Other Entity's Adjudication or Payment/Remittance Date. Usage: An Entity code is required to identify the Other Payer Entity, i.e. primary, secondary.	516
Adjusted Repriced Claim Reference Number.	517
Adjusted Repriced Line item Reference Number	518
Adjustment Amount	519
Adjustment Quantity	520
Adjustment Reason Code	521
Anesthesia Modifying Units	522
Anesthesia Unit Count	523
Arterial Blood Gas Quantity	524
Begin Therapy Date	525
Bundled or Unbundled Line Number	526
Certification Condition Indicator.	527
Certification Period Projected Visit Count	528

Claim Status Code Descriptions	Code
Certification Revision Date	529
Claim Adjustment Indicator	530
Claim Disproportinate Share Amount	531
Claim DRG Amount	532
Claim DRG Outlier Amount	533
Claim ESRD Payment Amount	534
Claim Frequency Code	535
Claim Indirect Teaching Amount	536
Claim MSP Pass-through Amount	537
Claim or Encounter Identifier	538
Claim PPS Capital Amount	539
Claim PPS Capital Outlier Amount	540
Claim Submission Reason Code	541
Claim Total Denied Charge Amount	542
Clearinghouse or Value Added Network Trace	543
Clinical Laboratory Improvement Amendment (CLIA) Number	544
Contract Amount	545
Contract Code	546
Contract Percentage	547
Contract Type Code	548
Contract Version Identifier.	549
Coordination of Benefits Code	550
Coordination of Benefits Total Submitted Charge	551
Cost Report Day Count	552
Covered Amount	553
Date Claim Paid	554
Delay Reason Code	555
Demonstration Project Identifier	556
Diagnosis Date	557
Discount Amount	558
Document Control Identifier	559
Entity's Additional/Secondary Identifier. Usage: This code requires use of an Entity Code.	560
Entity's Contact Name. Usage: This code requires use of an Entity Code.	561

Claim Status Code Descriptions	Code
Entity's National Provider Identifier (NPI). Usage: This code requires use of an Entity Code.	562
Entity's Tax Amount. Usage: This code requires use of an Entity Code.	563
EPSDT Indicator	564
Estimated Claim Due Amount	565
Exception Code	566
Facility Code Qualifier	567
Family Planning Indicator	568
Fixed Format Information	569
Frequency Count	571
Frequency Period	572
Functional Limitation Code	573
HCPCS Payable Amount Home Health	574
Homebound Indicator	575
Immunization Batch Number	576
Industry Code	577
Insurance Type Code	578
Investigational Device Exemption Identifier	579
Last Certification Date	580
Last Worked Date	581
Lifetime Psychiatric Days Count	582
Line Item Charge Amount	583
Line Item Control Number	584
Denied Charge or Non-covered Charge	585
Line Note Text	586
Measurement Reference Identification Code	587
Medical Record Number	588
Provider Accept Assignment Code	589
Medicare Coverage Indicator	590
Medicare Paid at 100% Amount	591
Medicare Paid at 80% Amount	592
Medicare Section 4081 Indicator	593
Mental Status Code	594
Monthly Treatment Count	595

Claim Status Code Descriptions	Code
Non-covered Charge Amount	596
Non-payable Professional Component Amount	597
Non-payable Professional Component Billed Amount	598
Note Reference Code	599
Oxygen Saturation Qty	600
Oxygen Test Condition Code	601
Oxygen Test Date	602
Old Capital Amount	603
Originator Application Transaction Identifier	604
Orthodontic Treatment Months Count	605
Paid From Part A Medicare Trust Fund Amount	606
Paid From Part B Medicare Trust Fund Amount	607
Paid Patient Discharge Facility Type Code Unit Count	608
Participation Agreement	609
Patient Discharge Facility Type Code	610
Peer Review Authorization Number	611
Per Day Limit Amount	612
Physician Contact Date	613
Physician Order Date	614
Policy Compliance Code	615
Policy Name	616
Postage Claimed Amount	617
PPS-Capital DSH DRG Amount	618
PPS-Capital Exception Amount	619
PPS-Capital FSP DRG Amount	620
PPS-Capital HSP DRG Amount	621
PPS-Capital IME Amount	622
PPS-Operating Federal Specific DRG Amount	623
PPS-Operating Hospital Specific DRG Amount	624
Predetermination of Benefits Identifier	625
Pregnancy Indicator	626
Pre-Tax Claim Amount	627
Pricing Methodology	628

Claim Status Code Descriptions	Code
Property Casualty Claim Number	629
Referring CLIA Number	630
Reimbursement Rate	631
Reject Reason Code	632
Related Causes Code (Accident, auto accident, employment)	633
Remark Code	634
Repriced Ambulatory Patient Group Code	635
Repriced Line Item Reference Number	636
Repriced Saving Amount	637
Repricing Per Diem or Flat Rate Amount	638
Responsibility Amount	639
Sales Tax Amount	640
Service Authorization Exception Code	642
Service Line Paid Amount	643
Service Line Rate	644
Service Tax Amount	645
Ship, Delivery or Calendar Pattern Code	646
Shipped Date	647
Similar Illness or Symptom Date	648
Skilled Nursing Facility Indicator	649
Special Program Indicator	650
State Industrial Accident Provider Number	651
Terms Discount Percentage	652
Test Performed Date	653
Total Denied Charge Amount	654
Total Medicare Paid Amount	655
Total Visits Projected This Certification Count	656
Total Visits Rendered Count	657
Treatment Code	658
Unit or Basis for Measurement Code	659
Universal Product Number	660
Visits Prior to Recertification Date Count CR702	661
X-ray Availability Indicator	662

Claim Status Code Descriptions	Code
Entity's Group Name. Usage: This code requires use of an Entity Code.	663
Orthodontic Banding Date	664
Surgery Date	665
Surgical Procedure Code	666
Real-Time requests not supported by the information holder, do not resubmit This change effective September 1, 2017: Real-time requests not supported by the information holder, do not resubmit.	667
Missing Endodontics treatment history and prognosis	668
Dental service narrative needed	669
Funds applied from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts.	670
Funds may be available from a consumer spending account such as consumer directed/driven health plan (CDHP), Health savings account (H S A) and or other similar accounts.	671
Other Payer's payment information is out of balance	672
Patient Reason for Visit	673
Authorization exceeded	674
Facility admission through discharge dates	675
Entity possibly compensated by facility. Usage: This code requires use of an Entity Code.	676
Entity not affiliated. Usage: This code requires use of an Entity Code.	677
Revenue code and patient gender mismatch	678
Submit newborn services on mother's claim	679
Entity's Country. Usage: This code requires use of an Entity Code.	680
Claim currency not supported	681
Cosmetic procedure	682
Awaiting Associated Hospital Claims	683
Rejected. Syntax error noted for this claim/service/inquiry. See Functional or Implementation Acknowledgement for details. (Usage: Only for use to reject claims or status requests in transactions that were 'accepted with errors' on a 997 or 999 Acknowledgement.)	684
Claim could not complete adjudication in real time. Claim will continue processing in a batch mode. Do not resubmit. This change effective September 1, 2017: Claim could not complete adjudication in real-time. Claim will continue processing in a batch mode. Do not resubmit.	685
The claim/ encounter has completed the adjudication cycle and the entire claim has been voided.	686
Claim estimation can not be completed in real time. Do not resubmit. This change effective September 1, 2017: Claim predetermination/estimation could not be completed in real-time. Do not resubmit.	687
Present on Admission Indicator for reported diagnosis code(s).	688
Entity was unable to respond within the expected time frame. Usage: This code requires use of an Entity Code.	689

Claim Status Code Descriptions	Code
Multiple claims or estimate requests cannot be processed in real time. This change effective September 1, 2017: Multiple claims or estimate requests cannot be processed in real-time.	690
Multiple claim status requests cannot be processed in real time. This change effective September 1, 2017: Multiple claim status requests cannot be processed in real-time.	691
Contracted funding agreement-Subscriber is employed by the provider of services	692
Amount must be greater than or equal to zero. Usage: At least one other status code is required to identify which amount element is in error.	693
Amount must not be equal to zero. Usage: At least one other status code is required to identify which amount element is in error.	694
Entity's Country Subdivision Code. Usage: This code requires use of an Entity Code.	695
Claim Adjustment Group Code.	696
Invalid Decimal Precision. Usage: At least one other status code is required to identify the data element in error.	697
Form Type Identification	698
Question/Response from Supporting Documentation Form	699
ICD10. Usage: At least one other status code is required to identify the related procedure code or diagnosis code.	700
Repriced Claim Reference Number	702
Advanced Billing Concepts (ABC) code	703
Claim Note Text	704
Repriced Allowed Amount	705
Repriced Approved Amount	706
Repriced Approved Ambulatory Patient Group Amount	707
Repriced Approved Revenue Code	708
Repriced Approved Service Unit Count	709
Line Adjudication Information. Usage: At least one other status code is required to identify the data element in error.	710
Stretcher purpose	711
Obstetric Additional Units	712
Patient Condition Description	713
Care Plan Oversight Number	714
Acute Manifestation Date	715
Repriced Approved DRG Code	716
This claim has been split for processing.	717
Claim/service not submitted within the required timeframe (timely filing).	718
NUBC Occurrence Code(s)	719

Claim Status Code Descriptions	Code
NUBC Occurrence Code Date(s)	720
NUBC Occurrence Span Code(s)	721
NUBC Occurrence Span Code Date(s)	722
Drug days supply	723
Drug dosage. This change effective 5/01/2017: Drug Quantity	724
NUBC Value Code(s)	725
NUBC Value Code Amount(s)	726
Accident date	727
Accident state	728
Accident description	729
Accident cause	730
Measurement value/test result	731
Information submitted inconsistent with billing guidelines. Usage: At least one other status code is required to identify the inconsistent information.	732
Prefix for entity's contract/member number.	733
Verifying premium payment	734
This service/claim is included in the allowance for another service or claim.	735
A related or qualifying service/claim has not been received/adjudicated.	736
Current Dental Terminology (CDT) Code	737
Home Infusion EDI Coalition (HEIC) Product/Service Code	738
Jurisdiction Specific Procedure or Supply Code	739
Drop-Off Location	740
Entity must be a person. Usage: This code requires use of an Entity Code.	741
Payer Responsibility Sequence Number Code	742
Entity's credential/enrollment information. Usage: This code requires use of an Entity Code.	743
Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	744
Identifier Qualifier Usage: At least one other status code is required to identify the specific identifier qualifier in error.	745
Duplicate Submission Usage: use only at the information receiver level in the Health Care Claim Acknowledgement transaction.	746
Hospice Employee Indicator	747
Corrected Data Usage: Requires a second status code to identify the corrected data.	748
Date of Injury/Illness	749
Auto Accident State or Province Code	750

Claim Status Code Descriptions	Code
Ambulance Pick-up State or Province Code	751
Ambulance Drop-off State or Province Code	752
Co-pay status code.	753
Entity Name Suffix. Usage: This code requires the use of an Entity Code.	754
Entity's primary identifier. Usage: This code requires the use of an Entity Code.	755
Entity's Received Date. Usage: This code requires the use of an Entity Code.	756
Last seen date.	757
Repriced approved HCPCS code.	758
Round trip purpose description.	759
Tooth status code.	760
Entity's referral number. Usage: This code requires the use of an Entity Code.	761
Locum Tenens Provider Identifier. Code must be used with Entity Code 82 - Rendering Provider	762
Ambulance Pickup ZipCode	763
Professional charges are non covered	764
Institutional charges are non covered	765
Services were performed during a Health Insurance Exchange (HIX) premium payment grace period.	766
Qualifications for emergent/urgent care	767
Service date outside the accidental injury coverage period	768
DME Repair or Maintenance	769
Duplicate of a claim processed or in process as a crossover/coordination of benefits claim	770
Claim submitted prematurely. Please resubmit after crossover/payer to payer COB allotted waiting period.	771
The greatest level of diagnosis code specificity is required	772
One calendar year per claim	773
Experimental/Investigational	774
Entity Type Qualifier (Person/Non-Person Entity). Usage: this code requires use of an entity code.	775
Pre/Post-operative care	776
Processed based on multiple or concurrent procedure rules.	777
Non-Compensable incident/event. Usage: To be used for Property and Casualty only.	778
Service submitted for the same/similar service within a set timeframe.	779
Lifetime benefit maximum	780
Claim has been identified as a readmission	781
Second surgical opinion	782
Federal sequestration adjustment	783

Claim Status Code Descriptions	Code
Electronic Visit Verification criteria do not match	784
Missing/Invalid Sterilization/Abortion/Hospital Consent Form	785
Submit claim to the third party property and casualty automobile insurer.	786
Resubmit a new claim, not a replacement claim.	787
Submit these services to the patient's Pharmacy Plan for further consideration. This definition will change on 7/1/2023 to: Submit these services to the Pharmacy plan/processor for further consideration/adjudication.	788
Submit these services to the patient's Medical Plan for further consideration.	789
Submit these services to the patient's Dental Plan for further consideration.	790
Submit these services to the patient's Vision Plan for further consideration.	791
Submit these services to the patient's Behavioral Health Plan for further consideration.	792
Submit these services to the patient's Property and Casualty Plan for further consideration.	793
Claim could not complete adjudication in real time. Resubmit as a batch request.	794
Claim submitted prematurely. Please provide the prior payer's final adjudication.	795
Procedure code not valid for date of service	796
Claim predetermination/estimation could not be completed in real time. Claim requires manual review upon submission. Do not resubmit.	798
Resubmit a replacement claim, not a new claim.	799
Entity's required reporting has been forwarded to the jurisdiction. Usage: This code requires use of an Entity Code. To be used for Property and Casualty only.	800
Entity's required reporting was accepted by the jurisdiction. Usage: This code requires use of an Entity Code. To be used for Property and Casualty only.	801
Entity's required reporting was rejected by the jurisdiction. Usage: This code requires use of an Entity Code. To be used for Property and Casualty only.	802
Provider reporting has been rejected due to non-compliance with the jurisdiction's mandated registration. To be used for Property and Casualty only.	803