

837P Health Care Claim Professional

Revision summary

| Revision Number | Date | Summary of Changes |
|-----------------|----------|---|
| 6.0 | 5/27/04 | Verbiage changes throughout the companion guide |
| 7.0 | 06/29/04 | Updated to include the appropriate Amerihealth qualifier "G2" on pages 15 and 17. |
| 8.0 | 10/26/06 | NPI Requirements add to page 6. |
| 9.0 | 11/10/06 | REF segment qualifier update |
| 10.0 | 03/12/08 | Add MC to SBR segment for Family Planning |

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Disclaimer

This AmeriHealth (hereinafter referred to as "AH") Companion Guide to EDI Transactions (the "Companion Guide") provides trading partners with guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12N Implementation Guides require transmitters and receivers to make certain determinations/elections (*e.g.*, whether, or to what extent, situational data elements apply), this Companion Guide documents those determinations, elections, assumptions, or data issues that are permitted to be specific to AH's business processes when implementing the HIPAA ASC X12N 4010A1 Implementation Guides.

This Companion Guide does not replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of AH that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AH specific codes relevant to AH's business processes and rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

This Companion Guide provides supplemental information to the Trading Partner Agreement that exists between AH and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to AH's legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on AH's business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

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

Overview of Document

This Companion Guide is to be used as a supplement to the 837 Professional Health Care Claim Implementation Guide, version 4010A1, issued October 2002. As such, this Companion Guide must be referred to for transmitting the 837 Professional Health Care Claim transaction to AH.

The purpose of this Companion Guide is to outline AH requirements for handling the 837 Professional and to delineate specific data requirements for the submission of the 837P to AH.

This Companion Guide was developed to guide organizations through the implementation process so that the resulting transaction will meet the following business objectives:

- **Convey all required business information required by AH to process transactions.**
- **Interpret information in the same way:** The definition of the transaction will be specific so that trading partners can correctly interpret, from a business perspective, the information that is received from each other.
- **Simplify the communication:** The transaction will be standard to simplify communication between trading partners and to follow the requirements of HIPAA. [TOP](#)

General Instructions

The 837P can be used to submit health care claim billing information, encounter information, or both, from providers of health care services either directly or via trading partner or clearinghouse.

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Payers include, but not limited to:

- Insurance Company
- Health Maintenance Organization (HMO)
- Government Agency (Medicare, Medicaid, CHAMPUS, etc.)

Transmission Size

5,000 Claims per ST (limit is for CLM segment). [TOP](#)

Transaction Structure & Processing -- Batch Mode

There will be a separate ISA-IEA set for each different type of transaction. For example, if an electronic transmission between two trading partners contains claims and authorizations, there will be two ISA-IEA sets; one for claims (837) and one for authorizations (278).

This Companion Guide reflects conventions for batch implementation of the ANSI X12 837P. [TOP](#)

Batch Mode Process

The 837P will be implemented in batch mode. The submitting organization will send the 837P to AH through some means of telecommunications and will not remain connected while AH processes the transaction.

If a portion of or the entire ISA segment is unreadable or does not comply with the Implementation Guide and if there is sufficient routing information that can be extracted from the ISA, AH will respond with an appropriate TA1 transaction. Otherwise, AH will be unable to respond. In either case, the batch will not be processed.

AH will respond with a 997 transaction as an acknowledgment to every batch file of 837P transactions that is received. This 997 acknowledgment will be sent whether or not the provider, or its intermediary, requests it. The acknowledgment 997 transaction will indicate whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide, AH may not be able to process the transaction.

If the information associated with any of the claims in the 837P ST-SE batch is not correctly formatted from a syntactical perspective, all claims between the ST-SE will be rejected. Providers should consider this possible response when determining how many patients and claims they will submit in a single 837P. [TOP](#)

National Provider Identifier (NPI)

AmeriHealth will require the submission of the National Provider Identification Number (NPI) for all electronic claims (837) submitted May 23rd 2007 or thereafter.

If you have obtained your NPI(s) and submitted them to us, you may begin to report them **in addition to your current provider identification numbers.** [TOP](#)

837 Professional: Segment Usage Detail

The 837 Professional Data Element Segment identifies the specific data content required by AH.

AH Business Rules referenced in the Segment Usage Detail represent the following situations:

- The element is required by the Implementation Guide and required by AH.
- The element is situational by the Implementation Guide and, when the situation exists, is required to be included by AH.
- The element is situational by the Implementation Guide and, based on AH's business, is always required by AH.

Segment: **BHT** Beginning of Hierarchical Transaction
Loop: **Beginning of Hierarchical Transaction**
Level: **Detail**
Usage: Required by Implementation Guide
Business Rule: **AH requires submission with only the following data elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-----------------------|-------------------|
| BHT06 | Transaction Type Code | Enter code value: |

CH = Use when submitting claims
RP = Use when submitting encounters

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Segment: **PRV** Billing/Pay to Provider Specialty Information
 Loop: **2000A Billing/Pay-to Provider Hierarchical Level**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **AH does not require submission of the following data elements for this segment. To submit the sending provider taxonomy code, please use the PRV segment in either loop 2310B or 2420A:**
 Rule:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| PRV01 | Provider Code | Enter code value: BI Billing PT Pay-To |
| PRV02 | Reference Identification Qualifier | ZZ Mutually Defined Healthcare Provider Taxonomy Code list |
| PRV03 | Reference Identification | Provider Taxonomy Code |

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Segment: **NM1** Billing Provider Name
 Loop: **2010AA Billing Provider Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-------------------------------|---|
| NM108 | Identification Code Qualifier | Enter code value: XX - Health Care Financing Administration National Provider Identifier "If XX-NPI is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop." |
| NM109 | Identification Code | Enter the appropriate National Provider ID (NPI). |

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Segment: **REF** Billing Provider Secondary Identification
 Loop: **2010AA Billing Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|--|
| REF01 | Reference Identification Qualifier | Enter code value: G2 for AH Products 1C for Medicare Crossover Claims 1D for Family Planning Claims and BQ for Family Planning Claims EI Provider Tax ID number for all claims Note: Since the NPI is mandated, the billing provider's tax id number must be submitted in the secondary reference segment. SY Social Security Number |
| REF02 | Reference Identification | Enter the appropriate provider identification number. |

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Segment: **SBR** Subscriber Information
 Loop: **2000B Subscriber Hierarchical Level**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-----------------------------|--|
| SBR09 | Claim Filing Indicator Code | Enter value: (choose one) CI for AH Products MA or MB for Medicare Crossover Claims MC for Family Planning Claims only |

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Segment: **NM1** Subscriber Name
 Loop: **2010BA Subscriber Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-------------------------------|--|
| NM109 | Subscriber Primary Identifier | Enter the value from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only, are not part of the identification code, and therefore should not be submitted in this transaction. |

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Segment: **NM1** Payer Name
 Loop: **2010BB Payer Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-------------------------------|--|
| NM108 | Identification Code Qualifier | Enter code value: PI (Payer Identification) |
| NM109 | Payer Primary Identifier | Enter value: (choose one) 60061 AH NJ PPO AH NJ CMM 95044 AH DE Commercial HMO AH NJ Commercial HMO AH DE APOS AH Mercy (Family Planning Only) AH NJ APOS 93688 AH DE PPO AH DE CMM 60061 AH NJ PPO AH NJ CMM 95044 AH DE Commercial HMO AH NJ Commercial HMO AH DE APOS AH Mercy (Family Planning Only) AH NJ APOS 93688 AH DE PPO AH DE CMM 60061 AH NJ PPO AH NJ CMM 95044 AH DE Commercial HMO AH NJ Commercial HMO AH DE APOS AH Mercy (Family Planning Only) AH NJ APOS |

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Segment: **NM1** Patient Name
 Loop: **2010CA Patient Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|----------------------------|--|
| NM109 | Patient Primary Identifier | Enter the value from the subscriber's identification card (ID Card), including alpha characters. Spaces, dashes and other special characters that may appear on the ID Card are for readability and appearance only, are not part of the identification code, and therefore should not be submitted in this transaction. |

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Segment: **CLM** Health Claim Information
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|---|--|
| CLM01 | Claim Submitter's Identifier (Patient Control Number) | Do not enter values more that 20 characters. |

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Segment: **PRV** Referring Provider Specialty Information
 Loop: **2310A Referring Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|--|
| PRV01 | Provider Code | Enter value: (choose one) RF for Referring |
| PRV02 | Reference Identification Qualifier | Enter value: ZZ for Mutual Defined Health Care Provider Taxonomy Code list |
| PRV03 | Reference Identification | Enter value: Provider Taxonomy Code |

Segment: **NM1** Rendering Provider Name
 Loop: **2310B Rendering Provider Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|--------------------------------|---|
| NM101 | Entity Identifier Code | Enter code value: 82 (Rendering Provider) |
| NM102 | Entity Type Qualifier | Enter code value: (choose one) 1 (Person) 2 (Non Person Entity) |
| NM103 | Name Last or Organization Name | Enter value: Rendering Provider last or Organization Name |
| NM104 | Name First | Value: Requesting Rendering Provider's first name |
| NM108 | Identification Code Qualifier | Enter code value: (choose one) XX - Health Care Financing Administration National Provider Identifier |
| NM109 | Identification Code | Enter the appropriate Rendering Provider National Provider ID (NPI). |

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Segment: **PRV** Rendering Provider Specialty Information
 Loop: **2310B Rendering Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|--|
| PRV01 | Provider Code | Enter value: (choose one) PE for Performing |
| PRV02 | Reference Identification Qualifier | Enter value: ZZ for Mutual Defined Health Care Provider Taxonomy Code list |
| PRV03 | Reference Identification | Enter value: Provider Taxonomy Code |

Segment: **REF** Rendering Provider Secondary Identification
 Loop: **2310B Rendering Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| REF01 | Reference Identification Qualifier | Enter code value: G2 for AH Products 1C for Medicare Crossover Claims 1D for Family Planning Claims |
| REF02 | Reference Identification | Enter the appropriate rendering provider identification number. |

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Segment: **NM1** Service Facility Location
Loop: **2310D Service Facility Location**
Level: **Detail**
Usage: Situational by Implementation Guide
Business **AH requires submission with only the following data**
Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-----------------------------------|--|
| NM101 | Entity Identifier Code | Enter code value: 77 Service Location FA Facility |
| NM102 | Entity Type Qualifier | Enter code value: (choose one) 2 (Non Person Entity) |
| NM103 | Name Last or Organization Name | Enter value: Laboratory or Organization Name |
| NM108 | Identification Code Qualifier | Enter code value: (choose one) XX - Health Care Financing Administration National Provider Identifier |
| NM109 | Identification Code | Enter the appropriate National Provider ID (NPI). |

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Segment: **REF** Service Facility Location Secondary Identification
 Loop: **2310D Service Facility Location**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| REF01 | Reference Identification Qualifier | Enter code value: G2 for AH Products 1C for Medicare Crossover Claims 1D for Family Planning Claims |
| REF02 | Reference Identification | Enter the appropriate service facility provider identification number. |

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Segment: **LIN** Drug Identification
 Loop: **2410 – Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business: **AH requires submission the use of Loop ID 2410 to specify**
 Rule: **billing/reporting for drugs provided that may be part of the**
service(s) described in SV1.

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|---------------------------------|--|
| LIN02 | Product/Service ID Qualifier | Enter Code Value: N4 (National Drug Code in 5-4-2 Format) |
| LIN03 | Product/Service ID | Enter Value: National Drug Code |

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Segment: **CPT** Pricing Information
 Loop: **2410 – Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires the submission of Loop ID 2410 provide a price specific to the NDC provided in LIN03 that is different from the price reported in SV102.**
 Rule:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| CPT03 | Unit Price | Enter Value: Drug Unit Price |
| CPT04 | Quantity | Enter Value: National Drug Unit Count |
| CPT05 | Composite Unit of Measure | |
| CPT05-1 | Unit or Basis for Measurement Code | Enter Code Value: F2 for International Unit GR for Gram ML for Milliliter UN for Unit |

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Segment: **REF** Reference Identification
 Loop: **2410 — Drug Identification**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires the submission of Loop ID 2410 if dispensing of**
 Rule: **the drug has been done with an assigned Rx number.**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| REF01 | Reference Identification Qualifier | Enter Code Value: XZ (Pharmacy Prescription Number) |
| REF02 | Reference Identification | Enter Value: Prescription Number |

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Segment: **NM1** Rendering Provider Name
 Loop: **2420A Rendering Provider Name**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission if the Rendering Provider NM1**
 Rule: **information is different than that carried in the 2310B**
(claim) loop and this particular service line has a different
Rendering Provider.

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|--------------------------------|---|
| NM101 | Entity Identifier Code | Enter code value: 82 (Rendering Provider) |
| NM102 | Entity Type Qualifier | Enter code value: (choose one) 1 (Person) 2 (Non Person Entity) |
| NM103 | Name Last or Organization Name | Enter value: Rendering Provider last or Organization Name |
| NM104 | Name First | Value: Rendering Provider first name |
| NM108 | Identification Code Qualifier | Enter code value: (choose one) XX - Health Care Financing Administration National Provider Identifier |
| NM109 | Identification Code | Enter the appropriate National Provider ID (NPI). |

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Segment: **REF** Rendering Provider Secondary Identification

Loop: **2420A Rendering Provider Name**

Level: **Detail**

Usage: Situational by Implementation Guide

Business: **AH requires submission if the Rendering Provider NM1 (claim) loop and this particular service line has a different Rendering Provider.**

Rule:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| REF01 | Reference Identification Qualifier | Enter code value: G2 for AH Products 1C for Medicare Crossover Claims 1D for Family Planning Claims |
| REF02 | Reference Identification | Enter the appropriate rendering provider identification number. |

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Segment: **CAS** Claims Level Adjustment
 Loop: **2320 Other Subscriber Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting a Coordination of Benefits at the claim level:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-------------------------------|---|
| CAS01 | Claims Adjustment Group Code | Enter code value: (choose one) CO (Contractual Obligations) CR (Corrections and Reversals) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility) |
| CAS02 | Claims Adjustment Reason Code | Enter value: Adjustment Reason Code |
| CAS03 | Claim Adjusted Amount | Enter value: Adjustment Amount |

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Segment: **AMT** COB Payer Paid Amount
 Loop: **2320 Other Subscriber Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business: **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting a Coordination**
of Benefits:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-----------------------|--|
| AMT01 | Amount Qualifier Code | Enter code value: D (Payer Amount Paid) |
| AMT02 | Monetary Amount | Enter value: Payer Paid Amount |

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Segment: **AMT** COB Patient Responsibility Amount
 Loop: **2320 Other Subscriber Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting a Coordination**
of Benefits:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-----------------------|---|
| AMT01 | Amount Qualifier Code | Enter code value: F2 (Patient Responsibility Actual) |
| AMT02 | Monetary Amount | Enter value: Patient Responsibility Amount |

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Segment: **NM1** Other Subscriber Name
 Loop: **2330A Other Subscriber Name**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment AH requires submission with only**
the following data elements for this segment when
submitting a Coordination of Benefits:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|--------------------------------|--|
| NM101 | Entity Identifier Code | Enter code value: IL (Insured or Subscriber) |
| NM102 | Entity Type Qualifier | Enter code value: (choose one) 1 (Person) 2 (Non Person Entity) |
| NM103 | Name Last or Organization Name | Enter value: Subscriber last or Organization Name |
| NM104 | Name First | Enter value: Subscriber's first name |
| NM108 | Identification Code Qualifier | Enter code value: MI (Member Identification Number) ZZ (Mutually Defined Healthcare Provider Taxonomy Code List) |
| NM109 | Identification Code | Enter value: Member Identification Number |

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Segment: **CAS** Claims Adjustment
 Loop: **2430 – Line Adjudication Information**
 Level: **Detail**
 Usage: Situational by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting a Coordination of Benefits at the line level:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|-------------------------------|---|
| CAS01 | Claims Adjustment Group Code | Enter code value: (choose one) CO (Contractual Obligations) CR (Corrections and Reversals) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility) |
| CAS02 | Claims Adjustment Reason Code | Enter value: Adjustment Reason Code at the line level |
| CAS03 | Claim Adjusted Amount | Enter value: Adjustment Amount |

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Segment: **CLM** Health Claim Information
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment:**

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|----------------------------|---|
| CLM05-3 | Claims Frequency Type Code | Enter code value: (choose one) 6 (Correction) 7 (Replacement) |

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Segment: **REF** Original Reference Number
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting an adjustment**
request:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|------------------------------------|---|
| REF01 | Reference Identification Qualifier | Enter code value: F8 (Original Reference Number) |
| REF02 | Original Reference Number | Enter value: The AH claim number |

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Segment: **NTE** Claim Notes
 Loop: **2300 Claim Information**
 Level: **Detail**
 Usage: Required by Implementation Guide
 Business **AH requires submission with only the following data**
 Rule: **elements for this segment when submitting an adjustment**
request:

Data Element Summary

| Ref Des | Element Name | Element Note |
|---------|----------------------|---|
| NTE01 | Notes Reference Code | Enter code value: ADD (To provide additional detail description for the adjustment). |
| NTE02 | Claim Note Text | Enter a detail description regarding the adjustment request. |

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Transaction Acknowledgements

TA1 Interchange Acknowledgement Transaction

All X12 file submissions are pre-screened upon receipt to determine if the ISA or IEA segments are unreadable or do not comply with the HIPAA Implementation Guide. If errors are found, AH will send a TA1 response transaction to notify the trading partner that the file cannot be processed. No TA1 response transaction will be sent for error-free files.

Example: Once the 837P is received by AH, the file is checked for HIPAA compliance. Within AH, a validation is performed on the ISA loop and the IEA loop information. If these segments are missing required elements or have a non-standard structure, the file will receive a full file reject and the TA1 response transaction will be sent to the trading partner.

997 Functional Acknowledgement

If the file submission passes the ISA/IEA pre-screening above, it is then checked for HIPAA compliance syntactical and content errors. When the compliance check is complete, a 997 will be sent to the trading partner informing them which claims in the file were accepted for processing or rejected.

Example: An X12 file has passed pre-screening, and is then checked against the HIPAA standard. Once the file has been processed against the HIPAA standard, a 997 is generated indicating which claims within the file have passed or failed syntactical/content errors. No further processing of the failed X12 transaction will occur.

Unsolicited 277

The Unsolicited 277 acknowledgment is used for the 837P. The Unsolicited 277 acknowledgment provides accepted or rejected claim status for each claim contained within the batch.

****It is important to note that:*

Only accepted claims are submitted to the claims adjudication system for processing and the outcome results will appear on the statement of remittance (SOR).

A detailed explanation of the reason for claim rejection is contained in the STC12 segment of the Unsolicited 277 transaction.

Example: A batch file is received with three 837P claims that pass compliance. During processing, the first claim rejects due to invalid member information, the second claim rejects due to an invalid procedure code, and the third claim is accepted with no errors. The Unsolicited 277 is generated and returns a status of one accepted claim and two rejected claims along with an explanation of the reasons the claims were rejected. In addition, the one accepted claim is submitted to the claims adjudication system for processing.