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# **FMMIS 277U Health Care Payer Unsolicited Claim Status Companion Guide 005010 X228**

**Version 1.3**

**December 20, 2011**

**Florida Medicaid Management Information System Fiscal  
Agent Services Project**

Disclaimer: The information contained in this Companion Guide is subject to change. EDI submitters are advised to check the EDI-Submission Information page on the "My Medicaid Florida" Web site ([www.mymedicaid-florida.com](http://www.mymedicaid-florida.com)) for the latest updates before and after go-live of version 5010.

## Document Information Page

<b>Required Information</b>	<b>Definition</b>
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## Amendment History Page

### Summary of Change

<b>Document Version #</b>	<b>Modified Date</b>	<b>Modified By</b>	<b>Section, Page(s) and Text Revised</b>
Version 1.0	1/27/2011	Carl Bunche	Creation of document - 1st Draft
Version 1.1	3/17/2011	Carl Bunche	Updated HL03 data element: <ul style="list-style-type: none"> <li>Replaced code value '22' with 'PT' (Patient).</li> </ul> Updated TRN01 data element: <ul style="list-style-type: none"> <li>Replaced code value '2' with '1' (Current Transaction Trace Numbers).</li> </ul>
Version 1.2	6/29/2011	Reid O'Kelley	Removed references to Remove Access Servicer (RAS).
Version 1.2	7/7/2011	Daniel Gray	The following changes were made: <ul style="list-style-type: none"> <li>Updated page number references to the 5010 Implementation Guide.</li> <li>Updated New/updated policy information regarding NPI in Section 6.</li> </ul>
Version 1.3	12/20/2011	Daniel Gray	The following changes were made: <ul style="list-style-type: none"> <li>Removed 'T' as a valid option in "ISA15" on page 5-2; and</li> <li>Clarified NPI only billing rules in item 2 of "X12N 277U Business Scenarios - Outbound Transactions" on page 6-1.</li> </ul>

## 4010-5010 Change Log

This section specifies X12N 277U fields that have changed with the implementation of version 5010 (as it pertains to Florida Medicaid). Note: New 5010 information is **highlighted** in the body of this document.

CG Page	Loop ID	Reference	Name	4010 Value	5010 Change
5-2		ISA11	Repetition Separator	N/A	Added: This field is now a repetition separator which is a delimiter and not a data element. This field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different than the data element separator, component element separator and the segment terminator. The 4010 name was Interchange Control Standards Identifier.
5-2		ISA12	Interchange Control Version Identifier	00401	Updated: Changed to "00501."
5-3		GS08	Version/Release/ Industry Identifier Code	003070X070	Updated: Changed to "005010X228"
5-4		ST03	Implementation Convention Reference	N/A	Added: Must be identical to the value in GS08, which is 005010X228.
7-3	2000D	HL03	Hierarchical Level Code	22	Changed: Replaced '22' with the code value of 'PT' (Patient).
7-3	2100D	NM108	Identification Code Qualifier	MR	Changed: Replaced 'MR' with the code value of 'MI' (Member Identification).
7-3	2200D	TRN01	Payer Claim Control Number	2	Changed: Replaced '2' with the code value of '1' (Current Transaction Trace Numbers).
7-4	2200D	REF01-REF02	Payer Claim Control Number	1K	Removed: This segment was removed because the information is reported in Loop 2200D, TRN02 segment.
7-4	2200D	REF01-REF02	Medical Record Number	EA	Removed: This segment was removed to meet 5010 277U (version 228) compliance.

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<b>CG Page</b>	<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>4010 Value</b>	<b>5010 Change</b>
7-5	2200D	DTP	Claim Received Date		Added: This segment was added to show the date the claim was received by Florida Medicaid.
7-5	2200D	SVC01-1	Product/Service ID Qualifier	ND	Changed: Replaced 'ND' with the code value of 'N4' (National Drug Code).

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# 1 Introduction

The following is intended to be a companion document to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Payer Unsolicited Claim Status, ASC X12N 277 (005010X228).

This transaction is not a Health Insurance Portability and Accountability Act (HIPAA) covered transaction. The authors of the HIPAA covered Transaction for the Remittance Advice (835) do not recommend including information about suspended claims from the adjudication system in the remittance advice. For financial accounting purposes, the authors recommend that the remittance advice process, which generates the 835 transaction set, only contain information pertaining to finalized claims. For that reason, the Agency for Health Care Administration (AHCA) is utilizing this 277 Health Care Payer Unsolicited Claim Status to communicate pended claim information in an electronic format to fee-for-service providers.

AHCA also utilizes this 277 Health Care Payer Unsolicited Claim Status to communicate paid and denied claim information to Managed Care Organizations. Those organizations will not receive the 835 transaction for paid and denied claims.

## 1.1 Purpose

Additionally, all required segments within the 277 transactions must always be sent back to the submitter by the payer. This transaction provides fee-for-service providers' status information for pended claims and managed care organizations status information for paid and denied claims. The business application of the 277U also augments the use of the Health Care Claim Status Request and Response paired transaction by providing the Internal Control Numbers (ICN) assigned to claims for trading partners to specifically inquire upon.

Unsolicited Health Care Payer Claim Status response is sent weekly in a batch file for fee-for-service providers, and daily for managed care organizations along with any claim transaction in which a Medicaid provider ID or National Provider Identifier (NPI) is unidentifiable.

Even though the use of the 277U was not included in the *Transactions and Code Set Final Regulations*, AHCA and HP Enterprise Services (HP) have elected to support the 277 Health Care Payer Unsolicited Claim Status Version 5010, Version 228, Implementation Guideline.

## 1.2 Minimum Mandated Processing Requirements

The business purpose described herein is not a HIPAA-mandated business purpose and thus is agreed upon between willing trading partners. AHCA requirements are as follows:

1. Information Source Identifier (77027);
2. Information Receiver Identifier (Trading Partner as assigned by the HP EDI area);
3. Service Provider Identifier (NPI or Medicaid Provider ID);
4. Beneficiary Identifier (Recipient Number);
5. Claim Dates of Service (Header and/or Detail); and
6. Header Claim Submitted Charges.

The claim status segment is required at the header of the claim. Therefore, a header status is always given. Within the status segment, there are certain minimum requirements.

1. The status data element defined in the 277U Transaction Set is a composite data structure that consists of three difference data elements. It is repeated a total of three times within the STC segment. Each status data element consists of the following three data elements:
  - a. Health Care Claim Status Category Code – The overall category for where the claim currently is in processing (e.g., P2 – Pending/In Process – The Claim is suspended pending review).
  - b. Health Care Claim Status Code – Detailed information as to the reason the claim being in the category defined in the category code (e.g., 450 – Awaiting spend down determination).
  - c. Entity Identifier – The identity of the entity from which additional information about the claim has been requested if the claim is pended for additional information (e.g., QC – Patient).
2. The status effective date is always sent within this segment at the Claim Header level. This consists of the last date that the claim adjudicated in the system.
3. The Action Code is always sent at the Claim Header level. This directs the receiver of the transaction as to what actions are required on their part.
4. The claim header submitted charge is always sent at the Claim Header level.
5. A free-form text area is available for specific messages related to the Health Care Claim Status Code 448. The code 448 is not currently utilized, thus STC12 will not be populated.

## 1.3 Implementation Timeline for the HIPAA 5010 standard

Per Federal mandate, beginning on **January 1, 2012**, any electronic transaction files submitted by providers to a payer must be in the new HIPAA standard 5010 X12 format.

In the interest of providing a needed transition period between the current HIPAA 4010 standard and the incoming HIPAA 5010 standard, starting on **July 11, 2011**, Florida Medicaid accepts electronic medical transactions in *both* the current 4010 X12 and the new 5010 X12 format.

In line with the Federal mandate, this transition period ends on **December 31, 2011**, and all files submitted after that date *must* be in the new 5010 X12 standard format.

## 2 Transmission and Data Retrieval Methods

HP supports several types of data transport depending upon the trading partner's need. Providers and their representatives can submit and receive data via the Web Portal and Value Added Networks (VANs)/Switch Vendors for interactive transactions.

1. Web Portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web Portal.
2. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at <http://www.mymedicaid-florida.com>.

Information available includes:

1. Trading Partner Testing Procedures (Ramp Manager) for all new trading partners, or trading partners adding a new transaction; and
2. Web Upload/Download instructions for submitters uploading/downloading via the secure Web Portal.

### 2.1 File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three character file extension.

EDI allows for the upload/download of zipped or compressed files. Any data file contained within the zipped file must contain a valid three character file extension. The recommended extension is .txt or .dat. Zipped files must not contain directory folders or structures and should contain only individual files.

Note: Only one X12 transaction file is permitted in each zipped file. Any data file that is 5MB or larger is required to be zipped or compressed before transmitting it to EDI.

The Web Portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

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### **3 Transmission Responses**

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it goes through a 'front end' compliance check called a TA1. The TA1 is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit verifies the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction receives a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred are reported in a rejected acknowledgement. If the transaction contained no syntactical errors, a positive 997 response is generated and the transaction is passed on for processing.

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## **4 EDI Support**

The HP EDI Operations Team is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

The providers may reach EDI staff Monday through Friday 8:00 a.m. to 5:00 p.m. EST (Eastern Standard Time) at the EDI Helpdesk, (866) 586-0961.

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## 5 Control Segment Definitions for Florida Medicaid 277U Transactions

Note the page numbers listed below in each of the tables represent the corresponding page number in the X12N 277U HIPAA Implementation Guide [277U\_5010\_x228].

<b>X12N EDI Control Segments</b>
ISA - Interchange Control Header Segment
IEA - Interchange Control Trailer Segment
GS - Functional Group Header Segment
GE - Functional Group Trailer Segment
ST - Transaction Set Header
SE - Transaction Set Trailer
TA1 - Interchange Acknowledgement

### 5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

<b>277U Health Care Claim Status Request and Response</b>					
<b>Page</b>	<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/Value</b>	<b>Notes/Comments</b>
C.3	N/A	ISA	Interchange Control Header Segment		
C.4	N/A	ISA01	Authorization Information Qualifier	00	'00' – No Authorization Information Present
C.4	N/A	ISA02	Authorization Information		[space fill]
C.4	N/A	ISA03	Security Information Qualifier	00	'00' – No Security Information Present
C.4	N/A	ISA04	Security Information		[space fill]
C.4	N/A	ISA05	Interchange ID Qualifier	ZZ	'ZZ' – Mutually Defined
C.4	N/A	ISA06	Interchange Sender ID	77027	'77027' left justified and space filled. Florida Medicaid Sender ID.
C.5	N/A	ISA07	Interchange ID Qualifier	ZZ	'ZZ' – Mutually Defined

277U Health Care Claim Status Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.5	N/A	ISA08	Interchange Receiver ID		Trading Partner ID as supplied by Florida Medicaid, left justified and space filled.
C.5	N/A	ISA09	Interchange Date		The date format is YYMMDD.
C.5	N/A	ISA10	Interchange Time		The time format is HHMM.
C.5	N/A	ISA11	Repetition Separator	^	'^'
C.5	N/A	ISA12	Interchange Control Version Number	00501	'00501' – Control Version Number
C.5	N/A	ISA13	Interchange Control Number		Interchange Unique Control Number – Must be identical to IEA02
C.6	N/A	ISA14	Acknowledgement Requested	1, 0	'1' – Acknowledgement Requested  '0' – No Acknowledgement Requested
C.6	N/A	ISA15	Usage Indicator	P	'P' – Production Data
C.6	N/A	ISA16	Component Element Separator	:	'.' – Component Element Separator

## 5.2 IEA - Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

277U Health Care Claim Status Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.10	N/A	IEA	Interchange Control Trailer		
C.10	N/A	IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10	N/A	IEA02	Interchange Control Number.		Must be identical to the value in ISA13

## 5.3 GS - Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

277U Health Care Claim Status Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.7	N/A	GS	Functional Group Header		
C.7	N/A	GS01	Functional ID Code	HN	'HN' – Health Care Claim Status Notification (277)
C.7	N/A	GS02	Application Sender's Code	77027	'77027' left justified and space filled. Florida Medicaid Sender ID.
C.7	N/A	GS03	Application Receiver's Code		Trading Partner ID as supplied by Florida Medicaid, left justified and space filled.
C.7	N/A	GS04	Date		The date format is CCYYMMDD.
C.8	N/A	GS05	Time		The time format is HHMM.
C.8	N/A	GS06	Group Control Number		Must be identical to GE02.
C.8	N/A	GS07	Responsible Agency Code	X	'X' – Responsible Agency Code
C.8	N/A	GS08	Version/ Release/ Industry ID Code	005010X22 8	Version/ Release/ Industry Identifier Code

## 5.4 GE - Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

277U Health Care Claim Status Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.9	N/A	GE	Functional Group Header		
C.9	N/A	GE01	Number of Transaction Sets Included		Number of included Transaction Sets

277U Health Care Claim Status Request and Response					
Page	Loop ID	Reference	Name	Code/Value	Notes/Comments
C.9	N/A	GE02	Group Control Number		Must be identical to the value in GS06.

## 5.5 ST - Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

277U Health Care Claim Status Request and Response				
Loop ID	Reference	Name	Code/Value	Notes/Comments
N/A	ST	Transaction Set Header		
N/A	ST01	Transaction Set Identifier Code	277	277 – Health Care Information Status Notification
N/A	ST02	Transaction Set Control Number		Transaction Control Number
				Increment by 1 when multiple transaction sets are submitted.  Must be identical to SE02.
N/A	ST03	Implementation Convention Reference		Must be identical to the value in GS08.

## 5.6 SE - Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments [including the beginning (ST) and ending (SE) segments]. This segment may be thought of traditionally as the claim trailer record.

277U Health Care Claim Status Request and Response				
Loop ID	Reference	Name	Code/Value	Notes/Comments
N/A	SE	Transaction Set Trailer		
N/A	SE01	Number of Included Segments		Total number of segments included in Transaction Set including ST and SE

<b>277U Health Care Claim Status Request and Response</b>				
<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/Value</b>	<b>Notes/Comments</b>
N/A	SE02	Transaction Set Control Number		Must be identical to the value in ST02

## 5.7 Valid Delimiters

The delimiters documented below is used for Florida Medicaid, unless otherwise requested by a trading partner.

<b>Definition</b>	<b>ASCII</b>	<b>Decimal</b>	<b>Hexadecimal</b>
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A
Repetition Separator	^	94	5E

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## 6 X12N 277U Business Scenarios - Outbound Transactions

This section contains Payer-specific business rules and limitations for the 277U Claim Status Response transactions.

1. Subscriber, Insured = Recipient in the Florida Medicaid Eligibility Verification System:

The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each program or Managed Care Organization.

2. Provider Identification = NPI or Medicaid ID (Providers without an NPI only):

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the implementation of a National Provider Identifier (NPI). Most health care providers must register with the National Plan and Provider Enumeration System and receive a unique NPI. The intent of the HIPAA regulations was to require all health plans to convert their claims processing systems to use only the NPI for claims processing and reporting for providers required to obtain an NPI. Because of the complexities of this conversion by health care plans and providers, the use of the NPI has not yet been strictly enforced. However, Medicaid claims submitted on and after **January 1, 2011**, have new requirements for the use of the NPI.

Beginning on **January 1, 2011**, the NPI is required on all electronic claim transactions and paper claims from providers who qualify for an NPI. Florida Medicaid still accepts transactions containing the Provider's Medicaid ID, but any qualifying claims that lack the NPI are denied.

Starting on **May 1, 2011**, Florida Medicaid no longer accepts electronic claim transactions (837D, 837I, and 837P) containing the Florida Medicaid ID submitted by providers who qualify for an NPI. Any electronic claims sent by qualifying providers on or after **May 1, 2011** that contain the provider's Florida Medicaid Provider ID are denied, even if they also contain the NPI.

Please note that paper claims are not affected by this change.

For all non- healthcare providers where an NPI is not assigned, the claim must contain the Florida Medicaid Provider Number with the appropriate loops within the REF segment where REF01 equals G2.

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## 7 X12N 277U Loop and Data Element Specific Information for Florida Medicaid

This section specifies X12N 277U fields for which Florida Medicaid has specific requirements.

277 Health Care Payer Unsolicited Claim Status				
Loop ID	Reference	Name	Code/Value	Notes/Comments
N/A	BHT	Beginning of Hierarchical Transaction		
N/A	BHT03	Reference Identification		RA (Remittance Number)
N/A	BHT06	Transaction Type Code	NO	NO – Notice
2000A	HL	Information Source Level		
2000A	H L01	Hierarchical ID number	1	The first HL01 value will be „1“ and each HL will increment by one throughout the transaction set.
2000A	H L02	Hierarchical Parent ID Number	0	0 - Hierarchical Parent ID Number
2000A	H L03	Hierarchical Level Code	20	20 - Information Source
2000A	H L04	Hierarchical Child Code	1	1 - Additional subordinate HL data segments exist in this structure
2100A	NM1	Payer Name		
21 00A	NM103	Name Last or Organization Name	See Notes	„STATE OF FLORIDA MEDICAID“
21 00A	NM108	Identification Code Qualifier	PI	„PI“ – Payer Identifier
21 00A	NM109	Identification Code	77027	„77027“ – Florida Medicaid Electronic Payer ID
2000B	HL	Information Receiver Level		
2000B	H L01	Hierarchical ID Number	See Notes	Incremented by ‘1’ from the previous HL segment in the Transaction Set.

<b>277 Health Care Payer Unsolicited Claim Status</b>				
<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/ Value</b>	<b>Notes/Comments</b>
2000B	H L02	Hierarchical Parent ID number	See Notes	The value in this data element will reference the Parent HL01 at the Information Source Level.
2000B	H L03	Hierarchal Level Code	21	'21' – Information Receiver
2000B	H L04	Hierarchical Child Code	1	'1' – Additional subordinate HL data segments exist in this structure
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	41	'41' – Submitter
2100B	NM102	Entity Type Qualifier	2	'2' – Non-Person Entity
21 00B	NM1 08	Identification Code Qualifier	46	'46' – Electronic Transmitter Identification Number
21 00B	NM1 09	Identification Code	See notes	Trading Partner ID supplied by Florida Medicaid
2000C	HL	Service Provider Level		
2000C	HL01	Hierarchical ID number	See Notes	Incremented by '1' from the previous HL segment in the Transaction Set.
2000C	HL02	Hierarchical Parent ID number	2	The value in this data element will reference the Parent HL01 at the Information Source Level.
2000C	HL03	Hierarchical Level code	19	'19' – Provider of Service
2000C	HL04	Hierarchical Child Code	1	'1' – Additional subordinate HL data segments exist in this structure
2100C	NM1	Provider Name		
21 00C	NM1 02	Entity Type Qualifier	1, 2	1 – Person Entity 2 – Non-Person Entity
2100C	NM103	Name Last or Organization Name	See Notes	When NM102 = '2', Provider Organization Name as stored on Florida Medicaid Provider File When NM102 = '1', Provider Last Name as stored on Florida Medicaid Provider File

<b>277 Health Care Payer Unsolicited Claim Status</b>				
<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/ Value</b>	<b>Notes/Comments</b>
2100C	NM104	Name First	See Notes	When NM102 = '1', Provider First Name as stored on Florida Medicaid Provider File
21 00C	NM1 08	Identification Code Qualifier	SV, XX	SV – Service Provider Number XX – National Provider Identifier
21 00C	NM1 09	Identification Code	See Notes	If NM1 08=SV, then this will contain the Provider's Medicaid ID number If NM108=XX, then this will contain the Provider's NPI.
2000D	HL	Subscriber Level		
2000D	HL01	Hierarchical ID Number	See Notes	Hierarchical ID Number
2000D	HL02	Hierarchical Parent Code	See Notes	Parent ID Number
2000D	HL03	Hierarchical Level Code	PT	Subscriber Information
2000D	HL04	Hierarchical Child Code	0	'0' – No subordinate HL segment in this hierarchical structure
2100D	NM1	Subscriber Name		
21 00D	NM1 01	Entity Identifier Code	QC	'QC' - Patient
2100D	NM102	Entity Type Qualifier	1	'1' – Person
21 00D	NM1 03	Name Last or Organization Last Name	See Notes	Medicaid Recipient's last name
2100D	NM104	Name First	See Notes	Medicaid Recipient's first name
2100D	NM108	Identification Code Qualifier	MI	'MI' - Member Identification Number
2100D	NM109	Identification Code	See Notes	Recipient's 10-digit Medicaid ID number
2200D	TRN	Claim Status Tracking Number		
2200D	TRN01	Trace Type Code	1	'1' - Current Transaction Trace Numbers
2200D	TRN02	Reference Identification	See Notes	Payer Claim Control Number that was received on the original claim.

<b>277 Health Care Payer Unsolicited Claim Status</b>				
<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/ Value</b>	<b>Notes/Comments</b>
2200D	TRN04	Reference Identification		If applicable, the value that was received on the original claim from SBR09.
2200D	STC	Claim Level Status Information		
2200D	STC01 -1, STC1 0-1 and STC1 1-1	Health Care Claim Status Category Code	See Notes	From Code List 507 Claim Status Category Codes are available at www.wpc-edi.com
2200D	STC01 -2, STC1 0-2 and STC1 1-2	Health Care Claim Status Code	See Notes	From Code List 507 Claim Status Category Codes are available at www.wpc-edi.com
2200D	STC01 -3, STC1 0-3 and STC1 1-3	Entity Identifier Code	See Notes	Used to clarify STC01 -2.
2200D	STC02	Status Information Effective Date	See Notes	Status Date of Claim. Format YYMMDD
2200D	STC03	Action Code	NA	'NA' – No Action Required
2200D	REF	Institutional Bill Type Identification		
2200D	REF01	Reference Identification Qualifier	BLT	'BLT' – Billing Type Note: This REF segment is only sent if the original claim was billed on an 837I transaction for EDI or UB92 or UB04 for Paper Claims.
2200D	REF02	Coverage Level Code	See Notes	'Type of Bill' that was present on the original claim
2200D	DTP	Claim Service Date		
2200D	DTP01	Date Time Qualifier	472	'472' – Service
2200D	DTP02	Date Time Period Format Qualifier	RD8	'RD8' – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
2200D	DTP03	Date Time Period	See Notes	The Date(s) associated with this claim for Header level information. The system will take the Earliest „From Date“ and the Latest „To Date“ and report that information.

277 Health Care Payer Unsolicited Claim Status				
Loop ID	Reference	Name	Code/ Value	Notes/Comments
2200D	DTP	Claim Received Date		
2200D	DTP01	Date Time Qualifier	050	'050' – Received
2200D	DTP02	Date Time Period Format Qualifier	D8	'D8' – Range of Dates Expressed in Format CCYYM M DD-CCYYMM DD
2200D	DTP03	Date Time Period	See Notes	The Date(s) associated with this claim for Header level information.
2200D	SVC	Service Line Information		
2200D	SVC01-1	Product/Service ID Qualifier	N4, AD, NU, HC	'N4' = National Drug Code 'AD' = American Dental Associates Code 'NU' = National Health Related Item Code 'HC' = Health Care Financing Administration Common Procedural Coding System
2200D	SVC01 -2	Product/Service ID	See Notes	Original submitted Code or final adjudicated service code.
2200D	SVC01 -3 to SVC01 -6	Procedure Modifier 1-4		Original submitted Code(s) or final adjudicated service code.
2200D	SVC04	Product/Service ID	See Notes	When both a HCPCS code and a NUBC Revenue code are associated with a line item, this data element will contain the Revenue Code.
2220D	STC	Claim Level Status Information		
2220D	STC01 -1, STC1 0-1 and STC1 1-1	Health Care Claim Status Category Code	See Notes	From Code List 507 Claim Status Category Codes are available at <a href="http://www.wpc-edi.com">www.wpc- edi.com</a>
2220D	STC01-2, STC10-2 and STC11-2	Health Care Claim Status Code	See Notes	From Code List 507 Claim Status Category Codes are available at <a href="http://www.wpc-edi.com">www.wpc- edi.com</a>
2200D	STC01 -3, STC1 0-3 and STC1 1-3	Entity Identifier Code	See Notes	Used to clarify STC01 -2.

<b>277 Health Care Payer Unsolicited Claim Status</b>				
<b>Loop ID</b>	<b>Reference</b>	<b>Name</b>	<b>Code/ Value</b>	<b>Notes/Comments</b>
2200D	REF	Institutional Bill Type Identification		
2200D	REF01	Reference Identification Qualifier	FJ	'FJ' – Line Item Control Number.
2200D	REF02	Coverage Level Code	See Notes	Value that was submitted on the original claim if submitted on the 837I, 837P or 837D transaction.
2200D	DTP	Service Line Date		
2200D	DTP03	Date Time Period	472	Only used when a Service line date is available on the claim. If only a „From Date. is available, the 'From Date' will equal the 'To Date'.

## **8 Frequently Asked Questions**

Please reference the following link:

[http://portal.flmmis.com/FLPublic/Provider\\_EDI/Provider\\_EDI\\_SubmissionInformation/tabId/66/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_SubmissionInformation/tabId/66/Default.aspx)

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