Pennsylvania PROMISe™ Companion Guide

Unsolicited 277

Claim Status Response

Version 5010

June 2011 – Version 1.1

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Table of Contents

Overview 2

Companion Guide Instructions 2

Revisions to the Companion Guide 3

PROMIS*e*™ Specific HIPAA Data Elements 4

Appendix A – Unsolicited 277 Reconciliation Information 16

Overview

The Pennsylvania Department of Public Welfare's HIPAA-compliant Provider Reimbursement and Operations Management Information System (PROMIS*e*™) has adopted the new version 5010 X12 standards. These standards are in compliance with the CMS mandate effective January 1, 2012.

This Companion Guide contains information for interpreting unsolicited 277 transactions which are sent to notify managed care organizations (MCOs) about the status of their encounter data

Companion Guide Instructions

See appendix A "Unsolicited 277 Reconciliation" for information to aid in determining the status of encounter transactions.

Revisions to the Companion Guide

To aid the provider community in organizing these Companion Guides and the revisions that may occur, this document will have a revision schedule and notification process.

The initial release of this Companion Guide is September 2010. The first release reflects all the known information as of this date. However, as the implementation phases of PROMIS*e*™ progress, updates and releases of new information may be forthcoming.

Revision Process:

For each new release of this Companion Guide, the information that has been changed since the previous version will be located in this section of the guide. If a revision is made to a data element, it will be detailed in the Revision(s) Description section in the table containing the element. DPW will clearly define the change that was made so it can be integrated into your process.

Updated releases of the Transaction Guide will be posted on the DPW website. You are encouraged to check this site regularly.

Revision(s) Description	9/1/2010 – Original 5010 Version 06/2011 – Version 1.1 PROMISe™ specific HIPAA Data Elements section • Header – BHT06: Transaction Type Code – Removed text from the "Description of 5010 Change" column. Also, the 'test' ID for element ISA06: Sender ID was changed to '445562154'. • Loop 2220D – Service Line Information "title row" incorrectly indicated loop 2200D, and was corrected to state 2220D • Loop 2220D – DTP01: Date/Time Qualifier – "5010 values" column – replaced '232' with '472' Appendix A, Section 3.0: • In the exception box under Status P2 (Suspend); the Error Status Codes '911 & 999' were added. • Updated the text for **"P2:484"** changing 'claim detail' to 'claim header'

PROMIS*e*™ Specific HIPAA Data Elements

Unsolicited 277 CLAIM STATUS

General: The unsolicited 277 claim status transaction will be used to notify managed care organizations (MCOs) about the status of their encounter data. All encounter data 837 submissions accepted into the system will generate an unsolicited 277 transaction. When no information is provided in the PROMIS*e*™ Specific Information column in the matrix below indicates the information to be returned will be specific to the record being returned.

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMIS*e*™ Specific Information
C.3	ISA01: Authorization Information Qualifier			"00"
	ISA02: Authorization Information			10 spaces
	ISA03: Security Information Qualifier			"00"
	ISA04: Security Information			10 spaces
	ISA05: Interchange ID Qualifier			"ZZ"
	ISA06: Interchange Sender ID			Production - 345529167 Testing - 445562154
	ISA07: Interchange ID Qualifier			"ZZ"
	ISA08: Interchange Receiver ID			PROMIS*e*™ assigned receiver ID
	ISA09: Interchange Date			
	ISA10: Interchange Time			
	ISA11: Interchange Control Standards Identifier		New usage as repeating data separator	PROMIS*e*™ will use the suggested caret (^) character.
	ISA12: Interchange Control Version Number	"00501"	Changed for 5010	
	ISA13: Interchange Control Number			
	ISA14: Acknowledgment Requested			
	ISA15: Usage Indicator			

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	ISA16: Component Element Separator			
C.7	GS01: Functional Identifier Code			
	GS02: Application Sender's Code			
	GS03: Application Receiver's Code			
	GS04: Functional Group Creation Date			
	GS05: Functional Group Creation Time			
	GS06: Group Control Number			
	GS07: Responsible Agency Code			
	GS08: Version/Release/Industry Identifier Code	"005010X212"	Changed transaction set value for 5010 version.	
106	ST01: Transaction Set Identifier Code	"277"		
	ST02: Transaction Set Control Number			
	ST03: Implementation Convention Reference	"005010X212"	New Data Element	
107	BHT01 Hierarchical Structure Code	"0010"		
	BHT02: Transaction Set Purpose Code	"08"		
	BHT03: Reference Identification			
	BHT04: Date			
	BHT05: Time	Required	Usage changed from not used to required	
	BHT06: Transaction Type Code	"DG"		
	Loop 2000A: Information Source Level			
109	HL01: Hierarchical ID Number			
	HL03: Hierarchical Level Code	"20"		
	HL04: Hierarchical Child Code	"1"		
	Loop 2100A: Payer Name			
111	NM101: Entity Identifier Code	"PR"		

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	NM102: Entity Type Qualifier	"2"		
	NM103: Name Last or Organization Name			"Pennsylvania Dpt of Public Welfare"
	NM108: Identification Code Qualifier	"PI", "XV"	Changed qualifier codes	"PI" will be used.
	NM109: Identification Code			"236003113"
113	PER: Payer Contact Information			PROMIS*e*™ will not use this segment
	Loop 2000B: Information Receiver Level			
116	HL01: Hierarchical ID Number			
	HL02: Hierarchical Parent ID Number			
	HL03: Hierarchical Level Code	"21"		
	HL04: Hierarchical Child Code	"1"		"1"
	Loop 2100B: Information Receiver Name			
118	NM101: Entity Identifier Code	"41"		
	NM102: Entity Type Qualifier	"1", "2"		"2"
	NM103: Name Last or Organization Name	Required when needed to identify the information receiver. If not required by this implementation guide, do not send.	Usage changed from required to situational	PROMIS*e*™ will not use this data element
	NM104: Name First	Required if NM102 is a "1" and the first name is required to identify the information receiver. If not required by this implementation guide, do not send.	Usage change	PROMIS*e*™ will not use this data element
	NM105: Name Middle	Required if NM102 is a "1" and additional name information is required to identify the information receiver. If not required by this implementation guide, do not send.	Usage change	PROMIS*e*™ will not use this data element
	NM108: Identification Code Qualifier	"46"	Changed Qualifier code	

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	NM109: Identification Code			
120	TRN : Information Receiver Trace Identifier			PROMIS*e*™ will not use this segment at this level
121	STC: Information Receiver Status Information			PROMIS*e*™ will not use this segment at this level
	Loop 2000C: Service Provider Level			
124	HL01: Hierarchical ID Number			
	HL02: Hierarchical Parent ID Number			
	HL03: Hierarchical Level Code	"19"		
	HL04: Hierarchical Child Code	"1", "0"	Changed valid values	"1"
	Loop 2100C: Provider Name			
126	NM101: Entity Identifier Code	"1P"		
	NM102: Entity Type Qualifier	"1", "2"		
	NM103: Name Last or Organization Name	Required when the last name is needed to identify the provider. If not required by this implementation guide, it may be provided at sender's discretion, but cannot be required by the receiver.		
	NM104: Name First	Required if NM102 = "1" and provider has a first name		
	NM105: Name Middle	Required if NM102 = "1" and provider has a middle name or initial		
	NM106: Name Suffix	Recommended if NM102 = "1" and provider has a name suffix.		PROMIS*e*™ is not using this data element
	NM108: Identification Code Qualifier	"SV", "FI", "XX"		
	NM109: Identification Code			
129	Loop 2200C: Provider of Service Trace Number			PROMIS*e*™ will not use this segment at this level
132	Loop 2200B: Provider Status			PROMIS*e*™ will not use

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	Information			this segment at this level
133	HL01: Hierarchical ID Number			
	HL02: Hierarchical Parent ID Number			
	HL03: Hierarchical Level Code	"22"		
	HL04: Hierarchical Child Code	"0", "1"		"0"
	Loop 2100D: Subscriber Name			
135	NM101: Entity Identifier Code	"IL" - Insured or Subscriber	Changed qualifier for this data element.	
	NM102: Entity Type Qualifier	"1", "2"		"1"
	NM103: Name Last or Organization Name	Required when NM102 = "1" and the first name is needed to identify the subscriber. If not required by this implementation guide, do not send.	Usage change	PROMISe™ will use this data element.
	NM104: Name First	Required when NM102 = "1" and the first name is needed to identify the subscriber. If not required by this implementation guide, do not send.	Usage change	PROMISe™ will use this data element.
	NM105: Name Middle	Required when NM102 = "1" and additional name information is needed to identify the subscriber. If not required by this implementation guide, do not send.	Usage change	PROMISe™ will use this data element, if the subscriber has a middle name.
	NM107: Name Suffix	Required when NM102 = 1 and the person has a name suffix that is known. If not required by this implementation guide, do not send.	Usage Change	PROMISe™ does not use this data element.
	NM108: Identification Code Qualifier	"MI", "24", "ZZ"		"MI"
	NM109: Identification Code			Subscriber's RID

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	Loop 2200D: Claim Status Tracking Number			
137	TRN01: Trace Type Code	"2" - Referenced Transaction Trace Numbers. Required if Subscriber is the Patient. Not used if Subscriber is not the Patient	Usage change	"2'"
	TRN02: Reference Identification	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.	Usage change	PROMIS*e*™ will send Patient Account Number as TRN02.
138	STC01: Health Care Claim Status	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	SCT01-1: Claims Status Category Code	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	SCT01-2: Claim Status Code	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	STC01-3: Entity Identifier Code	Required if Subscriber is the Patient and additional detail applicable to the claim status is needed to clarify the status and the payer's system supports this level of detail. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element, if applicable, since the subscriber is the patient.
	STC01-4: Code List Qualifier Code	Required when using a National Council for Prescription Drug Programs Reject/Payment Code in STC01-2 for status related to a pharmacy claim. If not required by this implementation guide, do not send.		PROMIS*e*™ is not using this data element component.

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	STC02: Date	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	STC04: Monetary Amount	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	STC05: Monetary Amount	Required if Subscriber is the Patient. Not used if Subscriber is not the Patient. Amount must be zero if adjudication process is not complete.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	STC06: Date	Required if Subscriber is the Patient and payment determination is complete. Not used if Subscriber is not the Patient.		PROMIS*e*™ will send this data element since the subscriber is the patient.
	STC08: Date	Required if Subscriber is the Patient, adjudication is complete, and there is a dollar payment to the provider of service. Not used if the Subscriber is not the Patient.		
	STC09: Check Number	Required if Subscriber is the Patient, adjudication is complete, the entire claim was paid using a single check or EFT. Not used with Pending or Rejected claims. Not used if Subscriber is not the Patient.		
	STC10: Health Care Claim Status			PROMIS*e*™ will send this data element, if applicable, since the subscriber is the patient.
	STC10-1: Claim Status Category Code			
	STC10-2 Claim Status Code			
	STC10-3 Entity Identifier Code			

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	STC10-4: Code List Qualifier Code	"RX" Required when using a National Council for Prescription Drug Programs Reject/Payment Code in STC01-2 for status related to a pharmacy claim. If not required by this implementation guide, do not send.		PROMIS*e*™ is not using this data element component.
	STC11: Health Care Claim Status			PROMIS*e*™ will send this data element, if applicable, since the subscriber is the patient.
	STC11-1: Claim Status Category Code			
	STC11-2: Claim Status Code			
	STC11-3: Entity Identifier Code			
	STC11-4: Code List Qualifier Code	"RX" Required when using a National Council for Prescription Drug Programs Reject/Payment Code in STC01-2 for status related to a pharmacy claim. If not required by this implementation guide, do not send.		PROMIS*e*™ is not using this data element component.
149	REF01: Reference Identification Qualifier	"1K"		
	REF02: Payer Claim Control Number			If the encounter is identified as a duplicate the value in this segment will be the current ICN that denied for duplicate, a dash, and then the ICN of the previously paid encounter that caused the duplicate.

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
150	REF01: Reference Identification Qualifier	"BLT" For institutional claims when Subscriber is the Patient Required on institutional claims when different than the value submitted on the 276 request. If not required by this implementation guide, maybe be provided at the sender's discretion but cannot be required by the receiver.	Usage change	
	REF02: Institutional Bill Type Identification	Required if different from type of bill submitted on the 276. May be sent at payer's discretion.	Usage change	PROMIS*e*™ will send the type of bill for institutional encounters.
151	REF01: Reference Identification Qualifier	Constant "EJ" - Patient Account Number. Required when the Patient Account Number was submitted on the 276 request or when available on claims location in the information source's system. If not required by this implementation guide, do not send.	New Segment	
	REF02: Patient Control Number		New Segment	PROMIS*e*™ will send Patient Account Number as REF02
152	REF01: Reference Identification Qualifier	Constant "XZ" - Pharmacy Prescription Number. Required when the Pharmacy Prescription Number was submitted on the 276 request or when available on claims location in the information source's system. If not required by this implementation guide, do not send.	New Segment	

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	REF02: Pharmacy Prescription Number		New Segment	PROMISe™ will send the prescription number for drug encounters.
153	REF: Voucher Identifier			This segment is not applicable to encounter data
154	REF: Claim Identification Number for Clearinghouses and Other Transmission Intermediaries			PROMISe™ will not use this segment
155	DTP01: Date/Time Qualifier	"232" Required if Subscriber is the Patient and claim is Institutional. Not used if Subscriber is not the Patient. Not required if Subscriber is the Patient and claim is not Institutional and Service Line Dates are used.	Usage Change	PROMISe™ will send From and To Date of Service the same as we currently do
	DTP02: Date Time Period Format Qualifier	"RD8" Required if Subscriber is the Patient and claim is Institutional. Not used is Subscriber is not the Patient. Not required if Subscriber is the Patient and claim is not institutional and Service Line Dates are used.	Usage Change	PROMISe™ will send From and To Date of Service the same as we currently do
	DTP03: Claim Service Date	Required if Subscriber is the Patient and claim is Institutional. Not used is Subscriber is not the Patient. Not required if Subscriber is the Patient and claim is not institutional and Service Line Dates are used.	Usage Change	PROMISe™ will send From and To Date of Service the same as we currently do
	Loop 2220D: Service Line Information			
157	SVC01: Composite Medical Procedure Identifier			
	SVC01-1: Product/Service ID Qualifier			

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	SVC01-2: Produce/Service ID			
	SVC01-3: Procedure Modifier			
	SVC01-4: Procedure Modifier			
	SVC01-5: Procedure Modifier			
	SVC01-6: Procedure Modifier			
	SVC02: Monetary Amount			
	SVC03: Monetary Amount			
	SVC04: Product/Service ID			
	SVC07: Quantity			
162	STC01: Health Care Claim Status			
	STC01-1: Claim Status Category Code			
	STC01-2: Claim Status Code			
	STC01-3: Entity Identifier Code			
	STC02: Date			
	STC10: Health Care Claim Status			
	STC10-1: Claim Status Category Code			
	STC10-2: Claim Status Code			
	STC10-3: Entity Identifier Code			
	STC11: Health Care Claim Status			
	STC11-1: Claim Status Category Code			
	STC11-2: Claim Status Code			
	STC11-3: Entity Identifier Code			
171	REF01: Reference Identification Qualifier	"FJ"		
	REF02: Service Line Identification			
172	DTP01: Date/Time Qualifier	"472"		
	DTP02: Date Time Period Format Qualifier	"RD8"		

TR3 Page	Field Name	5010 Values, Functions	Description of 5010 Change	PROMISe™ Specific Information
	DTP03: Service Line Date			
173	Dependent Level			PROMIS*e*™ Does not use this hierarchical level
213	SE01: Number of Included Segments (Industry: Transaction Segment Count)			
	SE02: Transaction Set Control Number			
C.9	GE01: Number Transaction Sets Included			
	GE02: Group Control Number			
C.10	IEA01: Number of Included Functional Groups.			
	IEA02: Interchange Control Number			

Appendix A – Unsolicited 277 Reconciliation Information

1.0 Purpose of appendix:

The intention of this appendix is to provide information for the accurate reconciliation of HIPAA version 5010, U277 files from PROMIS*e*™. The document is being provided at this time specifically to highlight the changes that will occur when HIPAA 5010 is implemented. For this reason, several examples will be shown to illustrate the difference between HIPAA versions 4010 and 5010.

Documentation available:

National Electronic Data Interchange Transaction Set Implementation Guide, "Health Care Claim Status Request and Response 276/277"

2.0 Overview

PROMIS*e*™ will generate a HIPAA U277 transaction record for all managed care records sent via HIPAA 837 transaction. Because the HIPAA U277 transaction is sent in response to the HIPAA 837 transaction, without the use of the HIPAA 276 claim status request, it is referred to as an "*unsolicited 277"* or U277.

Transition Information

HIPAA version 4010 allows the return of up to three (3) statuses at the claim header and each claim detail on the HIPAA U277. A status is generated for each edit/audit (ESC or error status code) the 837 transaction record sets in PROMISe at the header and each detail. It is possible to set more than 3 edit/audits on the header and each detail, however, the HIPAA U277 transaction allows the return of only three. In the event more than three statuses are generated, they will be sent in the order as follows: all denial statuses first, followed by all suspended statuses, followed by all paid statuses.

To reconcile the U277 the receiver will run an algorithm at the header and each detail to determine the separate statuses of the header and each detail. A final algorithm is run on the determined statuses of the header and detail to determine the status of the encounter.

In the HIPAA 5010 version, the U277 will continue to display up to three ESCs at the header and at the detail in the same order. What has changed is that the category code for each ESC must be in the same "family" for all edits on the header or same service line. All category codes on a header or service line must be all "P", pended or "F" final.

2.1 HIPAA Claim Category Codes

As used by Encounters in PROMISe™

F0 Finalized Paid – Represents an ESC that is paid/approved.

F2 Finalized Denial – Represents an ESC that is denied or suspended.

P2 Pending/In Process – Represents an ESC that causes the encounter to suspend.

P0 ***NEW*** Pending/Paid – Represents an ESC that is paid/approved.

2.2 HIPAA Claim Status Codes

As used by Encounters in PROMISe™

Following the Category Code on the U277 is a number known as the Status Code. The Status Code will crosswalk to a specific PROMIS*e*™ ESC so the submitter can determine any corrections needed.

Column Definitions of the U277 Crosswalk

A column will be added to the crosswalk to give the specific disposition for each edit. This is needed because the U277 Category Code will depend on the final status of the header or line.

U277 Category Code – The possible responses that can be returned on the U277 for a specific Status Code.

Disp – The actual disposition of the PROMIS*e*™ ESC setting.

U277 Status Code - The HIPAA Status Code to be cross walked to the PROMIS*e*™ ESC number.

PROMISe ESC Number – The number in PROMIS*e*™ that corresponds to the U277 Status Code and the Error Status Code Description.

Error Status Code Description – A short description of the condition within the transaction record that caused the ESC to set.

U277 Category Code	Disp.	U277 Status Code	PROMIS*e*™ ESC Number	Error Status Code Description
F0/P0	Pay & List	84	340	REVENUE CODE IS INVALID FOR THIS TYPE OF BILL
F2/P2	Deny	86	354	GROSS PATIENT PAY IS INVALID
F2/P2	Suspend	4271	417	CLAIM ADJ REASON CD MISSING (HEADER)

2.3 The Major Difference between U277 version 4010 and 5010

On version 4010 the Category Code indicates the status of the ESC. On version 5010 the Category Code indicates the status of the header or service line. See the transition examples next.

Transition Examples

These examples illustrate the difference in the category code to be returned between the HIPAA 4010 version and the 5010 version.

Example 1.

Service Ln. or Header	ESC Adjudication in PROMISe	Return on 4010 version U277	Return on 5010 version U277	Notes
0000	Deny	F2:333	F2:333	In this example, a service line or header has 3 ESCs setting with 3 different disposition results in PROMISe. In the 4010 version U277 the plan can use the category code to determine the disposition of each edit. In the 5010 version all category codes must be in the same “family”, either all final or all pended. The status of this header or detail is denied. Note that status codes will continue to set and will crosswalk to the PROMISe specific edit.
0000	Suspend	P2:123	F2:123	
0000	Pay & List	F0:234	F0:234	

Example 2.

Service Ln. or Header	ESC Adjudication in PROMISe™	Return on 4010 version U277	Return on 5010 version U277	Notes
0000	Pay & List	F0:333	P0:333	In this example, a service line or header has 3 ESCs setting with 2 different disposition results in PROMIS*e*™. In the 4010 version U277 the plan can use the category code to determine the disposition of each edit. In the 5010 version all category codes must be in the same “family”, either all final or all pended. The status of this header or detail is suspended. Note that status codes will continue to set and will crosswalk to the PROMIS*e*™ specific edit.
0000	Suspend	P2:123	P2:123	
0000	Pay & List	F0:234	P0:234	

3.0 Algorithm 1

Resolving Multiple Statuses at the Claim Header or Claim Detail

In the event multiple statuses are set at the claim header or claim detail, it will need to be determined if the combined statuses require action.

Status F2 [Deny] – If any of the three returned statuses is F2, the header or detail has denied, regardless of any F0 status set. The header or detail must be corrected for all F2 statuses.

There is one exception to the deny rule. If the U277 is in response to a void request on a previously paid encounter, the void response will indicate F0 at the header and F2:21 at the service line. The U277 response for a void request will be:

- F0:293 for Behavioral Health encounters or
- F0:335 for Physical Health encounters

at the claim header. The service line will be returned with the default deny, which is the same for Behavioral and Physical Health encounters, F2:21. This response indicates the void transaction is successful and requires no action.

Status P2 [Suspend] – If any of the three returned statuses is P2, the header or detail has suspended, regardless of any P0 status returned. The header or detail must be corrected for all P2 statuses.

There is one exception to the suspend rule. PROMISe™ sets two suspend edits at the header (#911 and #999) that cannot be corrected by the MCO. The suspended encounter will be resolved by PROMISe™ without intervention from the MCO. These responses are:

- P2:220 for Behavioral Health encounters and CCR encounters
- P2:251 for Physical Health encounters
- P2:484 for both Behavioral Health, CCR, and Physical Health encounters

at the claim header. Regardless of any other status on the transaction record, these two suspend statuses take precedence. If either one has set, the record has been suspended. The record will be reprocessed without MCO intervention and you will receive a U277 with an updated status after the reprocessing.

Status F0 [Paid/approved] – If all three (3) returned statues are F0, the header or detail is paid/approved. This status requires no action.

Status P0 [Paid/approved] – This status can only set in conjunction with a P2 status and indicates the ESC is pay and list. The header or detail must be corrected for all P2 statuses.

4.0 Algorithm 2

This **has not changed** from HIPAA version 4010 to version 5010.

Handling Multiple Statuses for the Transaction Record

The claim header and claim detail(s) together comprise the transaction record. Once an actionable status has been determined at the claim header or claim detail, the resolution for the transaction record must be determined.

Rules for Resolving Multiple Statuses on the Transaction Record

If the header denies ** [An F2 set at the claim header]

**and all the details approve to pay, the transaction record denies.

**and any of the details suspend, the transaction record denies.

If the header suspends ** [A P2 set at the claim header]
**and any of the details pay or suspend, the transaction record suspends.

**and all details deny, the transaction record denies.

If the header approves to pay ** [Only F0 statuses set]
**and all the details deny, the transaction record denies.

**and one or more of the details approve to pay and one or more of the details denies, the transaction record goes to paid history and the denied details will need to be resubmitted as a new transaction record.

**and any of the details suspend, the transaction record suspends

HIPAA Status Codes Used for Default

When a header is paid or denied by virtue of what occurred at the detail, or the detail is paid or denied by virtue of what occurred at the header, or likewise, when the encounter is suspended by virtue of what has occurred at the header or detail, default HIPAA Statuses are used.

F0:107 is the default paid code.

F2:21 is the default deny code.

P2:21 is the default suspend code.

A default code is used *only when no other edit has set* at the header or detail to communicate the paid, deny, or suspend status.

5.0 Examples of Transaction Record Resolution

This **has not changed** from HIPAA version 4010 to version 5010.

1	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Deny	Deny	A valid detail without a valid header does not constitute an entire transaction record. Resubmit entire transaction record as a new day claim with corrected header. The denied encounter will not be used for auditing.
	Detail(s)	Pay		

2	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Deny	Deny	A suspended detail without a valid header does not constitute an entire transaction record. Resubmit entire transaction as a new day claim with corrected header and detail. The denied encounter will not be used for auditing.
	Detail 1	Suspend		

3	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Deny	Deny	A valid detail without a valid header does not constitute an entire transaction record. Resubmit entire transaction record as a new day claim with corrected header and details. The denied encounter will not be used for auditing.
	Detail 1	Deny		
	Detail 2	Suspend		

4	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Deny	A claim header without a valid detail does not constitute an entire transaction record. Resubmit entire transaction record as a new day claim with corrected detail. The denied encounter will not be used for auditing.
	Detail 1	Deny		

5	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Suspend	The entire transaction record is in suspense. Resubmit the entire transaction record as a correction, claim frequency code 7, making corrections to both the suspended detail and the denied detail.
	Detail 1	Suspend		
	Detail 2	Deny		

6	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Paid/Approve d	A paid header plus a paid detail constitute an entire, paid transaction record. The paid transaction record is moved to recipient history. Resubmit the claim header and any denied, corrected details as a new day claim. The denied detail is not used for auditing.
	Detail 1	Pay		
	Detail 2	Deny		

7	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Suspend	The entire transaction record is in suspense. Resubmit the entire transaction record as a correction, claim frequency code 7, making corrections to the suspended detail.
	Detail 1	Suspend		

8	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Suspend	The entire transaction record is in suspense. Resubmit the entire transaction record as a correction, claim frequency code 7, making corrections to the suspended detail.
	Detail 1	Pay		
	Detail 2	Suspend		

9	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Suspend	Suspend	The entire transaction record is in suspense. Resubmit the entire transaction record as a correction, claim frequency code 7, making corrections to the header.
	Detail 1	Pay		

10	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Suspend	Deny	A valid header without a valid detail does not constitute an entire transaction record. Resubmit entire transaction record as a new day claim with corrected header and details. The denied encounter will not be used for auditing.
	Detail 1	Deny		
	Detail 2	Deny		

11	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Suspend	Suspend	The entire transaction record is in suspense. Resubmit the entire transaction record as a correction, claim frequency code 7, making corrections to the suspended header and denied detail.
	Detail 1	Pay		
	Detail 2	Deny		

12	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Suspend	Deny	A valid header without a valid detail does not constitute an entire transaction record. Resubmit entire transaction record as a new day claim with corrected header and detail. The denied encounter will not be used for auditing.
	Detail 1	Deny		

13	Status Placement	Status Determined	Transaction Record Status	Transaction Record Resolution
	Header	Pay	Paid/Approved	No actionable status codes have set. The transaction record will be moved to recipient history.
	Detail 1	Pay		
	Detail 2	Pay		