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MVP Health Care

# Testing and Implementation Guide

*ANSI X12 277U Version 4040X167  
Health Care Unsolicited Claim Status*

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## VERSION CHANGE LOG

<b>Version 1.0 Original</b>	<b>Published June 02, 2005</b>
<b>Modifications to segments</b>	<b>June 14, 2005</b>
<b>Modifications to descriptions</b>	<b>July 24, 2005</b>
<b>Added Category Status Code descriptions</b>	<b>August 10, 2005</b>
<b>Added in Servicing Provider NPI</b>	<b>April 12, 2007</b>
<b>Updated with new logo</b>	<b>April 27, 2009</b>
<b>Updated Subscriber HL code</b>	<b>June 15, 2009</b>

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## INTRODUCTION

In an effort to reduce the administrative costs, as a supplement to the ANSI X12N 837 Health Care Claim: Professional transaction and Institutional transaction, MVP Health Care has implemented the ANSI ASC X12 4040 277U unsolicited claim status transaction. This companion guide only addresses the business use of the 277 Unsolicited Claim Acknowledgment. The purpose of this transaction is to provide a system (application) level acknowledgement of electronic claims.

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## PURPOSE

The purpose of this document is to provide data requirements and content for receivers of MVP Health Care version of the 277 – Health Care Payer Unsolicited Claim Status Transaction (ANSI ASC X12 4040). This companion guide focuses on use of the 277 as an acknowledgement to receipt of claim submission(s).

**This companion guide is to be used in conjunction with the ANSI X12N implementation guide.** This companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at [www.wpc-edi.com](http://www.wpc-edi.com).

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## CLAIM SYSTEM ACKNOWLEDGEMENT

The first level of acknowledgement by MVP Health Care for the ANSI ASC X12 837 transactions will be the ANSI ASC X12 Functional Acknowledgement (997) transaction. The 997 transaction is designed to notify the submitter of the receiver's ability or inability to process the entire 837 transaction based on HIPAA syntax and structure rules.

The second level of acknowledgement by MVP Health Care for the ANSI ASC X12 837 transaction will be the 277 Health Care Payer Unsolicited Claim Status. This is a system (application) acknowledgement of the business validity and acceptability of the claims. The application acknowledgement identifies claims accepted for adjudication and those that are not accepted. The 277 is the only notification of pre-adjudication claim status. Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system and therefore never reported on the paper remittance or in the ANSI ASC X12 Health Care Claim Payment/Advice (835) transaction. Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to the claims processing guidelines. Final adjudication of claims is reported in the ANSI ASC X12 Health Care Claim Payment/Advice (835) transaction.

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## SPECIAL CONSIDERATIONS

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### Request Transactions Supported

This section is intended to identify the type and version of the ASC X12 Health Care Claim: Professional transaction and Institutional transaction that MVP will respond with an ASC X12 277U Unsolicited Claim Status.

- |   |
|---|
| • 837 Health Care Claim: Professional – <b>ASC X12N 837 (004010X098A1)</b>  |
| • 837 Health Care Claim: Institutional – <b>ASC X12N 837 (004010X096A1)</b> |

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### Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan (MVP).

- |   |
|---|
| • 277U Unsolicited Claim Status – <b>ASC X12N 277U (004040X167)</b>   |
| • 997 Functional Acknowledgement – <b>ASC X12N 837 (004010X098A1)</b> |
| • 997 Functional Acknowledgement – <b>ASC X12N 837 (004010X096A1)</b> |

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### Communication Specifications

MVP will transmit the 277U Unsolicited Claim Status in batch mode to its trading partners.

**Status Code List**

The 277U, Unsolicited Claim Status transaction is used to provide claim level acceptance and rejections for basic business edits.

<ul style="list-style-type: none"> <li>The following error codes are possible in the 277U</li> </ul>		
<b>A1</b>	<b>19</b>	Entity acknowledges receipt of claim/encounter.
<b>A3</b>	<b>30</b>	Subscriber/ Patient name mismatched.
<b>A3</b>	<b>33</b>	Subscriber/Patient id not found.
<b>A3</b>	<b>85</b>	MVP is not the policyholder's primary insurance carrier
<b>A3</b>	<b>88</b>	Patient not eligible/not approved for dates of service.
<b>A3</b>	<b>116</b>	Claim submitted to incorrect payer.
<b>A3</b>	<b>158</b>	Patient date of birth mismatch
<b>A3</b>	<b>481</b>	Claim/submission format is invalid: Multiple providers billed.
<b>A3</b>	<b>510</b>	Future date of service
<b>A6</b>	<b>145</b>	provider specialty/taxonomy code.
<b>A6</b>	<b>189</b>	Facility admission date
<b>A7</b>	<b>228</b>	Type of bill for UB claim
<b>A7</b>	<b>231</b>	Hospital admission type.
<b>A7</b>	<b>234</b>	Patient status.
<b>A7</b>	<b>249</b>	Place of service.
<b>A7</b>	<b>255</b>	Diagnosis code.
<b>A7</b>	<b>402</b>	Claim amount must be greater than zero
<b>A7</b>	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
<b>A7</b>	<b>454</b>	Procedure code for services rendered.
<b>A7</b>	<b>455</b>	Revenue code for services rendered.
<b>A7</b>	<b>460</b>	NUBC Condition Code(s)
<b>A7</b>	<b>461</b>	NUBC Occurrence Code(s) and Date(s)
<b>A7</b>	<b>462</b>	NUBC Occurrence Span Code(s) and Date(s)
<b>A7</b>	<b>488</b>	Diagnosis code(s) for the services rendered.
<b>A7</b>	<b>562</b>	National Provider Identifier (NPI)
<b>A7</b>	<b>634</b>	Remark Code
<b>A8</b>	<b>128/562/145</b>	Taxonomy not on file for tax id/NPI affiliation
<p><b>Note:</b>  A1 - The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.</p> <p>A3 - Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.</p> <p>A6 - Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.</p> <p>A7 - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.</p> <p>A8 - Acknowledgement / Rejected for relational field in error.</p> <p><b>Note:</b> The codes and descriptions above are as the writing of this document. Although we will endeavor to keep this guide current, some changes may occur. If this does occur, please visit <a href="http://www.wpc-edi.com">www.wpc-edi.com</a> for a complete list and detailed explanation please visit.</p>		

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### Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde

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### Implementation of Claim Status Receipt

- Please refer to the 837 Companion Guide's implementation of claim submission steps to implement the receipt of Claim Status.



**MVP Requirements for the ANSI 277U Transaction - Health Care Unsolicited Claim Status**

Required?	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
R	<b>ISA</b>	INTERCHANGE CONTROL HEADER		
R	1	AUTHORIZATION INFORMATION QUALIFIER	00	NO AUTHORIZATION INFORMATION PRESENT
R	2	AUTHORIZATION INFORMATION		BLANK
R	3	SECURITY INFORMATION	00	NO SECURITY INFORMATION PRESENT
R	4	SECURITY INFORMATION		BLANK
R	5	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	6	INTERCHANGE SENDER ID	141650868	SENDER TAX ID
R	7	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	8	INTERCHANGE RECEIVER ID		RECEIVER TAX ID
R	9	INTERCHANGE DATE	YYMMDD	DATE OF INTERCHANGE
R	10	INTERCHANGE TIME	HHMM	TIME OF INTERCHANGE
R	11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	US EDI COMMUNITY OF ASC X12
R	12	INTERCHANGE CONTROL VERSION NUMBER	00404	VERSION NUMBER
R	13	INTERCHANGE CONTROL NUMBER		MUST MATCH IEA02
R	14	ACKNOWLEDGEMENT REQUESTED	0	NO ACKNOWLEDGEMENT REQUESTED
R	15	USAGE INDICATOR	P OR T	PRODUCTION OR TEST
R	16	COMPONENT ELEMENT SEPARATOR	:	COMPOSITE DELIMITER
R	<b>GS</b>	FUNCTIONAL GROUP HEADER		
R	1	FUNCTIONAL IDENTIFIER CODE	HN	HEALTH CARE CLAIM STATUS NOTIFICATION (277)
R	2	APPLICATION SENDER'S CODE	141650868	MVP HEALTH PLAN
R	3	APPLICATION RECEIVER'S CODE		CODE FOR RECEIVER
R	4	DATE	CCYYMMDD	FUNCTIONAL GROUP CREATION DATE
R	5	TIME	HHMM	CREATION TIME
R	6	GROUP CONTROL NUMBER		MUST MATCH GE02
R	7	RESPONSIBLE AGENCY CODE	X	ACCREDITED STANDARDS COMMITTEE X12
R	8	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004040X167	VERSION CODE

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R	<b>ST</b>	TRANSACTION SET HEADER		
R	1	TRANSACTION SET IDENTIFIER CODE	277	HEALTH CARE CLAIM STATUS NOTIFICATION
R	2	TRANSACTION SET CONTROL NUMBER		MUST MATCH SE CONTROL NUMBER
R	3	IMPLEMENTATION CONVENTIONAL REFERENCE	004040X167	
R	<b>BHT</b>	BEGINNING OF HIERARCHICAL TRANSACTION		
R	1	HIERARCHICAL STRUCTURE CODE	0010	INFORMATION SOURCE
R	2	TRANSACTION SET PURPOSE CODE	08	STATUS
R	3	REFERENCE IDENTIFICATION	CCYYMMDD	NUMBER USED TO IDENTIFY TRANSACTION BY ORIGINATOR
R	4	DATE	CCYYMMDD	TRANSACTION SET CREATION DATE
R	5	TIME	HHMMSS	TIME
R	6	TRANSACTION TYPE CODE	DG	INDICATION THAT THIS IS RECEIPT ACKNOWLEDGEMENT ADVICE
	<b>2000A</b>			
R	HL	HIERARCHICAL LEVEL 2000A - <b>INFO SENDER LEVEL</b>		
R	1	HIERARCHICAL ID NUMBER	1	UNIQUE NUMBER ASSIGNED BY THE SENDER
NOT USED	2	HIERARCHICAL PARENT ID NUMBER		NOT USED
R	3	HIERARCHICAL LEVEL CODE	20	INFORMATION SOURCE
R	4	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUB HL DATA SEGMENT IN HIER STRUCTURE
	<b>2100A</b>			
R	NM1	PAYER NAME 2100A		
R	1	ENTITY IDENTIFIER CODE	PR	PAYER
R	2	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	3	ORGANIZATION NAME	MVP HEALTH CARE	PAYER NAME
NOT USED	4	NAME FIRST		NOT USED
NOT USED	5	NAME MIDDLE		NOT USED
NOT USED	6	NAME PREFIX		NOT USED
NOT USED	7	NAME SUFFIX		NOT USED
R	8	IDENTIFICATION CODE QUALIFIER	PI	MVP ID
R	9	IDENTIFICATION CODE	141650868	MVP's TAX ID

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	<b>2200A</b>			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200A		
R	1	TRACE TYPE CODE	1	REFERENCED TRANSACTION TRACE NUMBER
R	2	REFERENCE IDENTIFICATION		MVP HEALTH CARE EXTERNAL CORE SYSTEM NUMBER.
	<b>2000B</b>			
R	HL	HIERARCHICAL LEVEL 2000B - <b>INFO RECEIVER LEVEL</b>		
R	1	HIERARCHICAL ID NUMBER	2	UNIQUE NUMBER ASSIGNED BY SENDER
R	2	HIERARCHICAL PARENT ID NUMBER	1	PARENT HL TO HL01
R	3	HIERARCHICAL LEVEL CODE	21	INFORMATION RECEIVER
R	4	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL
	<b>2100B</b>			
R	NM1	INFORMATION RECEIVER NAME 2100B		
R	1	ENTITY IDENTIFIER CODE	41	SUBMITTER
R	2	ENTITY TYPE QUALIFIER	2	NON-PERSON ENTITY
R	3	ORGANIZATION NAME		ORGANIZATION NAME
S	4	NAME FIRST		FIRST NAME
NOT USED	5	NAME MIDDLE		NOT USED
NOT USED	6	NAME PREFIX		NOT USED
NOT USED	7	NAME SUFFIX		NOT USED
R	8	IDENTIFICATION CODE QUALIFIER	46	FEDERAL TAX ID
R	9	IDENTIFICATION CODE		VENDOR TAX ID
	<b>2200B</b>			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200B		
R	1	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	2	REFERENCE IDENTIFICATION		VALUE OF THE BHT03 DATA ELEMENT FROM THE SUBMITTED 837 CLAIM FILE

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	<b>2000C</b>			
R	HL	HIERARCHICAL LEVEL 2000C - <b>SERVICE PROVIDER LEVEL</b>		
R	1	HIERARCHICAL ID NUMBER	3	UNIQUE NUMBER ASSIGNED BY SENDER
R	2	HIERARCHICAL PARENT ID NUMBER	2	PARENT HL TO HL01
R	3	HIERARCHICAL LEVEL CODE	19	PROVIDER OF SERVICE
R	4	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	<b>2100C</b>			
R	NM1	PROVIDER NAME 2100C		
R	1	ENTITY IDENTIFIER CODE	85	BILLING PROVIDER
R	2	ENTITY TYPE QUALIFIER	1,2	PERSON, ORGANIZATION
R	3	NAME LAST		LAST NAME, ORGANIZATION NAME
S	4	NAME FIRST		FIRST NAME
NOT USED	5	NAME MIDDLE		NOT USED
NOT USED	6	NAME PREFIX		NOT USED
NOT USED	7	NAME SUFFIX		NOT USED
R	8	IDENTIFICATION CODE QUALIFIER	XX	BILLING PROVIDER NPI
R	9	IDENTIFICATION CODE		BILLING PROVIDER NPI
	<b>2000D</b>			
M	HL	HIERARCHICAL LEVEL 2000D- <b>PATIENT LEVEL</b>		
R	1	HIERARCHICAL ID NUMBER	4	UNIQUE NUMBER ASSIGNED BY SENDER
R	2	HIERARCHICAL PARENT ID NUMBER	3	PARENT HL TO HL01
R	3	HIERARCHICAL LEVEL CODE	PT	PATIENT
R	4	HIERARCHICAL CHILD CODE	0	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	DMG			
R	1	DATE PERIOD TIME FORMAT QUALIFIER	D8	DATE IN FORMAT: CCYYMMDD
R	2	DATE TIME PERIOD	CCYYMMDD	BIRTH DATE
R	3	GENDER CODE	F, M, U	GENDER

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	<b>2100D</b>			
R	NM1	PATIENT NAME 2100D		
R	1	ENTITY IDENTIFIER CODE	QC	PATIENT
R	2	ENTITY QUALIFIER	1	PERSON
R	3	NAME LAST		PATIENT LAST NAME
S	4	NAME FIRST		PATIENT FIRST NAME
S	5	NAME MIDDLE		PATIENT MIDDLE INITIAL
NOT USED	6	NAME PREFIX		NOT USED
NOT USED	7	NAME SUFFIX		NOT USED
S	8	IDENTIFICATION CODE QUALIFIER	MI	PATIENT IDENTIFICATION
S	9	IDENTIFICATION CODE		MVP MEMBER ID NUMBER
	<b>2200D</b>			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200D		
R	1	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	2	REFERENCE IDENTIFICATION		PATIENT ACCOUNT NUMBER
R	STC	CLAIM LEVEL STATUS 2200D		
R	1	HEALTH CARE CLAIM STATUS		
R	1-1	INDUSTRY CODE		ANSI CATEGORY CODE - <b>CODE SOURCE 507</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	1-2	INDUSTRY CODE		ANSI STATUS CODE - <b>CODE SOURCE 508</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	2	DATE	CCYYMMDD	EFFECTIVE DATE / PROCESS DATE
NOT USED	3	ACTION CODE		NOT USED
R	4	MONETARY AMOUNT		TOTAL CLAIM CHARGES
S	5	MONETARY AMOUNT		CLAIM PAYMENT AMOUNT
NOT USED	6	DATE		NOT USED
S	7	PAYMENT METHOD CODE	NON	NON-PAYMENT DATA
NOT USED	8	DATE		NOT USED
NOT USED	9	CHECK NUMBER		NOT USED

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S	10	HEALTH CARE CLAIM STATUS		
R	10-1	INDUSTRY CODE		ANSI CATEGORY CODE - <b>CODE SOURCE 507</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	10-2	INDUSTRY CODE		ANSI STATUS CODE - <b>CODE SOURCE 508</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
S	11	HEALTH CARE CLAIM STATUS		
R	11-1	INDUSTRY CODE		ANSI CATEGORY CODE - <b>CODE SOURCE 507</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	11-2	INDUSTRY CODE		ANSI STATUS CODE - <b>CODE SOURCE 508</b> <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
S	12	FREE FORM MESSAGE TEXT		DESCRIPTION OF ERROR MESSAGE
S	REF	PAYER CLAIM IDENTIFICATION NUMBER 2200D		
R	1	REFERENCE IDENTIFICATION QUALIFIER	1K	PAYER'S CLAIM NUMBER
R	2	REFERENCE IDENTIFICATION		MVP HEALTH CARE'S EXTERNAL SYSTEM REFERENCE NUMBER. <b>Note:</b> This is not the same as the claim number used for payment.
S	REF	PAYER CLAIM IDENTIFICATION NUMBER 2200D		
R	1	REFERENCE IDENTIFICATION QUALIFIER	EA	MEDICAL RECORD NUMBER
R	2	REFERENCE IDENTIFICATION		MEDICAL RECORD NUMBER
S	DTP	CLAIM SERVICE DATE 2200D		
R	1	DATE/TIME QUALIFIER	232	CLAIM STATEMENT PERIOD START
R	2	DATE PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD - CCYYMMDD
R	3	DATE TIME PERIOD		CLAIM SERVICE PERIOD
R	SE	TRANSACTION SET TRAILER		
R	1	NUMBER OF INCLUDED SEGMENTS		TOTAL NUM OF SEGMENTS INCLUDES ST AND SE
R	2	TRANSACTION SET CONTROL NUMBER		DATA VALUE IN SE02 MUST BE IDENTICAL TO ST02

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R	GE	FUNCTIONAL GROUP TRAILER		
R	1	NUMBER OF TRANSACTION SETS INCLUDED		NUMBER OF TRANSACTION SETS
R	2	GROUP CONTROL NUMBER		ASSIGNED BY SENDER
R	IEA	INTERCHANGE CONTROL TRAILER		
R	1	NUMBER OF INCLUDED FUNCTIONAL GROUPS		NUMBER OF FUNCTIONAL GROUPS
R	2	INTERCHANGE CONTROL NUMBER		ASSIGNED BY SENDER/MUST MATCH ISA13