ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for the HIPAA 277 Unsolicited Encounter Status Transactions

Version 1.3
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Revision History

Date	Version	Description	Author
	1.0	Draft document for Unsolicited (277U) Encounter Status Transactions	AHCCCS Information Services Division
05/01/2006	1.1	Draft updates	AHCCCS Information Services Division
06/20/2008	1.2	Included the Health plan Paid Amount and the Allowed/Approved Amount fields to the 277U Supplemental File Specifications table Updated the file name syntax and file path for 277U and 277U Supplemental 277U Supplemental file specifications – Included CRN status 'AV' to correspond to PMMIS status codes	AHCCCS Information Services Division
03/01/2009	1.3	2008-0287 PMMIS/277U Status Codes	AHCCCS Information Services Division

Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, trading partners, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 837 and NCPDP Encounter Transactions
- *277 Unsolicited Encounter Status Transactions*

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both AHCCCS and its providers are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 277 Health Care Payer Unsolicited Claim Status Transactions that is specific to AHCCCS and AHCCCS trading partners. AHCCCS uses the unsolicited version of the 277 Transaction to inform submitting health plans of the statuses of encounters that have been adjudicated by AHCCCS. For this transaction, the document describes the data sent electronically to AHCCCS health plans and other trading partners in response to encounter submissions.

Intended Users

Companion Documents are intended for the technical staffs of health plans and other entities that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from an AHCCCS perspective.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the AHCCCS environment and interchange conventions for batch Unsolicited 277 (277U) Encounter Status Transactions. It also provides trading partners with specific information on the fields and values on 277U transactions received from AHCCCS.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

The Unsolicited Encounter/Claim Status Transaction differs from other X12 and NCPDP Transactions in that HIPAA Transaction and Code Set Rules do not yet mandate it. Rather, it is an X12 Transaction that AHCCCS uses to support implementation of 837 and NCPDP Transactions for encounters by returning information to health plans on encounters accepted and adjudicated by AHCCCS.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Data interchange conventions applicable to the transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides more specific information relating to the transaction included in this Companion Document including: ▪ A statement of the purpose of transaction specifications for electronic interchanges between AHCCCS and other HIPAA covered entities. ▪ Detailed specifications that show how AHCCCS expects to populate data elements in the 277 Unsolicited Encounter Status Transactions when AHCCCS uses transaction data elements in ways that are not fully described by the HIPAA Implementation Guide.

2. 277 Unsolicited Encounter Status Transactions

2.1 Transaction Overview

Encounter Status Transactions

AHCCCS uses the ASC X12 277 Health Care Payer Unsolicited Claim Status Transaction to inform contracted health plans of the statuses of the encounters that they have submitted to AHCCCS. Encounters that have been accepted by AHCCCS and adjudicated by the AHCCCS Pre-Paid Medical Management Information System (PMMIS) are reported on the Unsolicited 277 Transaction. Encounters that have been pended or denied by PMMIS as well as approved encounters are included.

Following periodic PMMIS batch encounter adjudication, AHCCCS returns to each plan a 277U Status Transaction with information on each adjudicated encounter. 277U Transactions can be downloaded to health plan systems as HIPAA compliant transactions. In either mode, claim status responses carry identification and status information as well as service data. HIPAA Status Category and Status Codes tell 277U receivers when encounters are approved or denied by AHCCCS and when they are pended for correction and require modification. For each health plan, encounters are in 277 sequence by Servicing Provider ID, AHCCCS Recipient ID, and Encounter Reference Number.

As a result of some AHCCCS MCOs (Managed Care Organizations) desiring additional data not found in 277U, AHCCCS created a 277U Supplemental File.

As is noted below, the 277 Unsolicited Encounter Status Transactions replaced the pre-HIPAA Adjudicated Encounter File. AHCCCS encounter correction procedures remain as is and are not affected by the 277U.

Files Replaced or Impacted

277 Unsolicited Encounter Status Transactions

Replaced Files
Pre-HIPAA Adjudicated Encounter File

Impacted Files
None

2.2 277 Unsolicited Encounter Status Transaction

Standard Implementation Guide

The standard Implementation Guide for the 277 Transaction Set is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N Implementation Guide for the Health Care Payer Unsolicited Claim Status Transactions. The Implementation Guide for the 277U is not yet final. The version adopted by AHCCCS and used in preparation of this document is:

- ASC X12N 277 (003070X070) dated May 2003

An Addenda to this Guide has not been published. AHCCCS MCOs may either purchase the 277U Implementation Guide or rely on AHCCCS specifications.

Unsolicited 277 Transaction

For each health plan that receives them, 277U Encounter Status Transactions are organized in a hierarchical manner by servicing provider, health plan member, encounter, and service line. A 2000D Claim Submitter Level Loop appears for each member and two 2200D Claim Submitter Trace Number Loops for each encounter. Each 2000D Loop and loops subservient to it carry recipient identification and demographic information and claim status, service, and payment information. Two 2200D Loops are created for each encounter. This allows AHCCCS to return both the AHCCCS CRN and the Health Plan CRN. The 2220D Loop Service Line information is not used for pended encounters.

The combinations of HIPAA compliant Status Category and Status Codes that AHCCCS uses on the 277U reflect encounter processing categories determined by PMMIS. Complete translation of PMMIS encounter error codes is not attempted. To give encounter submitters data not provided on the 277 Transaction, AHCCCS creates a 277U Supplemental File to accompany 277U Transactions. Refer to Section 4.4, 277U Supplemental File, for more information.

Further information on the Status Category and Status Codes used by AHCCCS in the 277U Transaction can be found in Section 5.2, 277 Unsolicited Encounter Status Transactions Specifications.

Related Transactions	The 277 Unsolicited Encounter Status Transaction is similar in design and data content to the response component of the 276/277 Claim Status Request and Response Transaction Set. As used by AHCCCS, however, the 277U is quite distinct and serves as a separate business function. It transmits data on encounters to health plans rather than data on fee-for-service claims to providers.
Transmission Schedules	277U files will be available from the AHCCCS FTP server following encounter processing.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Cisco Systems Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS Electronic Claim Submission and Electronic Remittance Advice Requirements document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance related questions about electronic data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

3.2 Directory and File Naming Conventions

FTP Directory Naming Convention

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Current FTP Directory file naming conventions are as follows:

FTP\HP\Encounter\(HPIDin\HPIDout)\(Prod\Test)

- HP – The 3-character Health Plan acronym assigned by AHCCCS.
- Encounter – The default directory indicating Encounter Transactions.
- HPIDin – The default directory name that includes the 6 digit Health Plan ID indicating inbound data.
- HPIDout – The default directory name that includes the 6 digit Health Plan ID indicating outbound data.
- Prod – The default directory name indicating it is the production environment.
- Test – The default directory name indicating it is the test environment.

File Naming Convention

277U Encounter Status Transaction

The 277U Encounter Status Transaction is produced at the end of the Encounter cycle, and it contains all adjudicated and pending encounters. Refer to Section 5.2, 277U Encounter Status Transaction Specifications, for more information.

AZU277-nnnnnn-YYMMDD.TXT

- AZ is the state code.
- U to indicate Unsolicited.
- 277 is the Transaction code.
- nnnnnn is the Health Plan ID.
- YYMMDD is the process date.
- TXT is the file extension.

4. Transaction Standards

4.1 General Information

HIPAA Requirements	HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. The 277U has not yet been mandated, however, AHCCCS has adopted the standard transaction.
Size of Transmissions/ Batches	The 277U Implementation Guide makes no recommendations as to the maximum transaction size.
Other Standards	Use of 277U Header and Service Line Data for Various Encounter Types Variations between use of 2200D (Header) and 2220D (Service Line) Loops for institutional and non-institutional encounter types are a major consideration for the 277U Transaction. All institutional encounters, both inpatient and outpatient, use a single header-level 2200D Loop. Line level data on institutional encounters is not included on the 277U. For non-institutional encounters (Professional, Dental, and Pharmacy), both header and line data (2200D and 2220D Loops) appears for every service line.

4.2 Batch Data Interchange Conventions

Overview of Data Interchange

When sending batch 277U Transactions to encounter submitters, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 277U Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B of Implementation Guides.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes appear in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Sender and Receiver Identification Numbers in ISA and GS Segments are assigned in Trading Partner Tables maintained by AHCCCS.

Envelope Specifications Table

Definitions of table column follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
The data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number (866004791)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		The three-character Health Plan acronym plus the Health Plan Tax ID (AAA860000000).
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00307	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	1	Interchange Acknowledgement Requested AHCCCS does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the AHCCCS translator will receive them and notify AHCCCS staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions: Segment Delimiter - “~’ (tilde – hexadecimal

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HN	Health Care Claim Status Notification (277)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		The three-character Health Plan acronym plus the six-digit Health Plan ID assigned by AHCCCS.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		003070X070 The 277U Transaction has no Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.3 Acknowledgment Procedures

Overview of Acknowledgment Processes

Although AHCCCS does not require receivers of the 277U Transaction to return electronic acknowledgements, it accepts and processes the following ASC X12 Transactions from 277U receivers:

- TA1 Interchange Acknowledgement Transactions
- 997 Functional Acknowledgement Transactions
- 824 Implementation Guide Reporting Transactions

Trading partners can use the TA1 Transaction to acknowledge receipt of transmissions or "interchanges" of X12 Transactions and to tell AHCCCS of problems in the ISA/IEA Interchange Envelope. A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors. The 824, with its substantial error handling capabilities, reports syntactical errors within the 277U Transaction received from AHCCCS.

Extensive syntactical problems are not anticipated because AHCCCS applies translator edits to outgoing as well as incoming transactions and corrects any problems revealed by the translator prior to transmission. Discrepancies are possible, however, due to variations in sender and receiver edits.

AHCCCS Interchange Flow Diagrams for the 277U appear later in this section. The transaction is built from PMMIS, processed by the AHCCCS translator and posted to the AHCCCS FTP Server, to be downloaded by receiving health plans.

TA1 Interchange Acknowledgement Transaction

The TA1 is really a segment of fixed-length fields rather than a full-blown X12 Transaction. In the X12 environment, the TA1 can be used to either acknowledge receipt of a valid transmission or file by a trading partner and/or to tell the trading partner of interchange errors. The TA1 does not cover data within functional envelopes or X12 transactions.

Detailed information on TA1 data elements appears in Appendix B of all HIPAA Implementation Guides.

997 Functional Acknowledgement Transaction

Like the TA1, the 997 Functional Acknowledgment Transaction is designed to both acknowledge receipt of a valid functional group of X12 Transactions or to report on some types of syntactical errors. Functional groups consist of one or more X12 Transactions as defined by GS/GE Functional Envelopes within ISA/IAE Interchanges. AHCCCS is prepared to receive 997 Transactions as acknowledgements of valid functional groups of 277U Transactions and as reports of transaction errors.

Details on the format and syntax of the 997 Transaction can be found in Appendix B of each Transaction Set's Standard Implementation Guide.

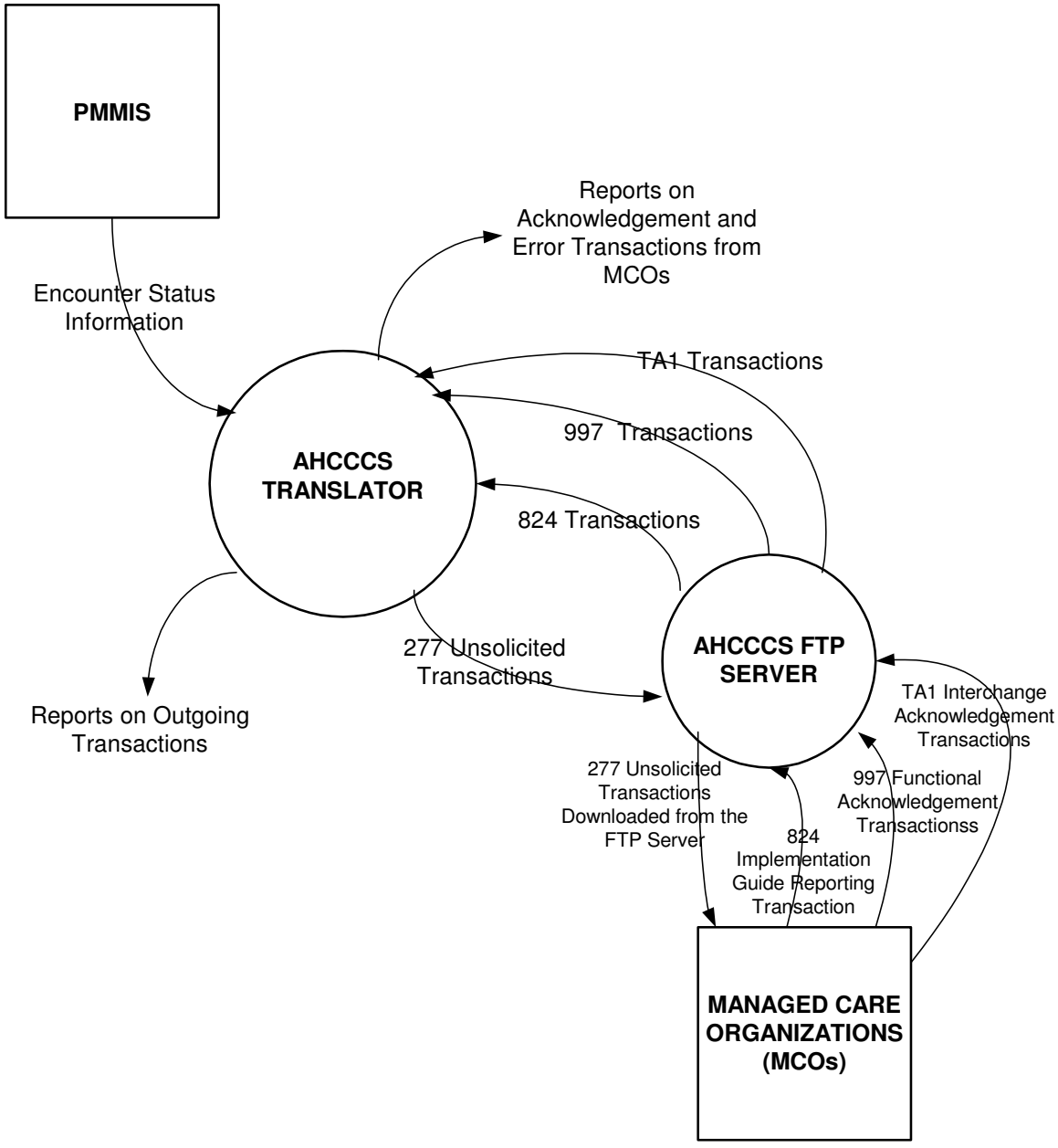
824 Implementation Guide Reporting Transaction

The 824 Transaction reports on deviations from Implementation Guide standards. These deviations can involve format conventions at transaction, segment, and data element levels as well as presence of required segments and elements and validity of element values defined in the transaction's Implementation Guide. The 824 can use both standard HIPAA compliant code sets and proprietary code sets to report errors.

AHCCCS anticipates 824 Transactions from receivers of 277U Transaction when receiver software detects syntactical errors within the 824's domain. As with the TA1, trading partners that return 824 error Transactions to AHCCCS should not make use of any data within the affected interchange. AHCCCS will correct and retransmit all data within the interchange.

A final Implementation Guide for the 824 Transaction has been published and is available at cost from the Washington Publishing Company (http://www.wpc-edi.com).

AHCCCS Interchange Flow for 277U Transaction



5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the data elements and code set values that pass between AHCCCS and its trading partners. In some cases the values specified are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to AHCCCS requirements.

For example, in the Subscriber Number Loop of a transaction in the Implementation Guide, Element NM109 is defined as an alphanumeric identification element that is between 1 and 30 characters long. In the Transaction Specifications, NM109 is defined as the member's AHCCCS ID. The length and format of the field are based on the characteristics of the AHCCCS Recipient ID rather than on the variable field size defined for the transaction by the more generic Implementation Guide.

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction. AHCCCS has taken the same approach to its data requirements as it has for mandated transactions.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 277U Encounter Status Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify and describe the data elements used in the AHCCCS 277U Encounter Status Transaction. These elements tell encounter submitters the results of the periodic AHCCCS encounter adjudication process. Approved, pended and denied encounters are included.

A 277U Supplemental File accompanies the 277U Transaction for encounter submitters that request it. The Supplemental File carries encounter status data that is not supported by the 277U, including, for encounters denied by AHCCCS, the detailed Denial Reason Codes generated by PMMIS. More information can be found in Section 4.4, 277U Supplemental File.

Status Category and Status Codes

The 277U Transaction uses HIPAA compliant Health Care Claim Status Category and Health Care Claim Status Codes to show the statuses of selected encounters and service lines. For institutional encounters, statuses are reported at the invoice level. Professional, dental, and pharmacy statuses are reported at the service level line.

On the 277U Transaction, institutional encounters populate data in only the header-level 2200D Loop without use of the 2220D Service Line Loop. Professional, dental, and pharmacy encounters are "split" when they have more than one payment line. They are represented on the 277U by data in both 2200D and 2220D Loops with a separate header for each service line.

AHCCCS assigns four sets of Status Category/Status Code combinations at the institutional invoice or professional/dental/pharmacy service line level. Detailed information appears in the table below.

For each institutional invoice or professional/dental/pharmacy service line submitted during the previous month and accepted by AHCCCS, the system generates an appropriate HIPAA compliant Status Category/Status Code combination for the 277U Transaction.

STATUS CODES USED BY AHCCCS ON THE 277 ENCOUNTER STATUS TRANSACTION					
PMMIS Adjudication Status Code	**Current Description**	**HC Claim Status Category Code**	**Description**	**HC Claim Status Code**	**Description**
11	In Process	P1	Pending/In Process – The Claim or Encounter is in the Adjudication System	02	More detailed information in letter.
31	Adjudicated/ Approved	F0	Finalized – The Claim or Encounter has completed the adjudication cycle and no more action will be taken	641	Service adjudication or payment date
32	Adjudicated/ Voided Original	F3	Finalized/Revised – Adjudication information has been changed	686	The Claim or Encounter has completed the adjudication cycle and the entire claim has been voided
33	Adjudicated/ Replaced Original	F3	Finalized/Revised – Adjudication information has been changed	641	Service adjudication or payment date
41	Adjudicated/ Denied by AHCCCS	F2	Finalized/Denial – The Claim/Line has been denied	23	Returned to entity
43	Adjudicated/ Denied by Plan	F0	Finalized – The Claim or Encounter has completed the adjudication cycle and no more action will be taken	585	Denied Charge or Non-covered Charge

Transaction Specifications Table

277U Encounter Status Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	277	Health Care Claim Status Notification
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		A number assigned by AHCCCS that is unique within the functional group (GS/GE) and interchange (ISA/ISE) envelopes
N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	00010	Information Source, Information Receiver, Provider of Service, Subscriber, Dependant
N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	08	Status
N/A	BHT	BHT03	Originator Application Transaction Identifier	An identification number that identifies a transaction within the originator's applications system		A unique number generated by AHCCCS to identify the 277U Transaction that is different from the number assigned to all other 277U Transactions. For the 277U Transaction, BHT03 consists of the Health Plan ID (X[6]), the TSN (X[3]), Date (CCYYMMDD), and a Transaction Sequence Number (N[3]).
N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 277U Transaction is created in CCYYMMDD format.
N/A	BHT	BHT06	Transaction Type Code	Code specifying the type of transaction	TH	Receipt Acknowledgement Advice
2000A	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	1	Always "1" for the initial HL Segment
2000A	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	20	Information Source
2000A	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100A	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The organization name of the payer

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's Identification Number
2100A	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax ID
2000B	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	2	The HL Segment within the 2000B Information Receiver Level Loop is always for the second HL Segment in the transaction.
2000B	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	1	The level of the HL Segment to which this HL Segment is subordinate.
2000B	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	21	Information Receiver
2000B	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	41	Submitter
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100B	NM1	NM103	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		For AHCCCS, the information receiver is an organization with a single name. NM103 in this loop is an organization name for the receiving health plan.
2100B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
2100B	NM1	NM109	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query		The six-digit AHCCCS Health Plan ID, the three-digit Transmission Submitter Number (TSN).

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000C	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	3 - nnn	For AHCCCS, this is the third, servicing provider level HL Level within the 277U Transaction. For 277U Transactions, with any number of servicing providers within a health plan network, the value of HL01 in Loop 2000C beings with 3 and increases by 1 for each servicing provider. The second servicing provider should have a 2000C/HL01 value of 4, the third a value of 5, and so forth.
2000C	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	2	For AHCCCS, the 2000C Service Provider Level Loop is always subordinate to the 2000B Information Receiver Loop.
2000C	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	19	Provider of Service
2000C	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional Subordinate Data Segment in the Hierarchical Structure
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	1P	Provider
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100C	NM1	NM103	Provider Last or Organization Name	The last name of the provider of care or name of the provider organization submitting a transaction or related to the information provided in or request by the transaction		The name of the encounter's servicing provider.
2100C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	XX SV	National Provider ID Number Service Provider Number
2100C	NM1	NM109	Provider Identifier	Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider		The NPI number after May 22, 2007 as mandated by HIPAA. Prior to then or for those providers who do not have an NPI, the six-character AHCCCS Provider ID and two-character Location Code of the servicing provider on the encounter.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000D	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	4 - nnn	For AHCCCS, this is the final HL Level within the 277U Transaction. For interactive requests, HL01 in the 2000D Loop will always have a value of 4. 277U Transactions can have any number of recipient claim status requests; the value of HL01 in Loop 2000D begins with 4 and increases by 1.
2000D	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	3	For AHCCCS, the 2000D Subscriber Loop is always subordinate to the 2000C Service Provider Loop.
2000D	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	22	Subscriber
2000D	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	0	No subordinate HL Segment in this hierarchical structure A subordinate segment would be at the dependent level – not used by AHCCCS.
2100D	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100D	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		The patient's Last Name
2100D	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		The patient's First Name
2100D	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		The patient's Middle Name or Initial
2100D	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	Member Identification Number
2100D	NM1	NM109	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		The member's AHCCCS ID

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D 1st occurrence	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	2	Referenced Transaction Trace Numbers The 2200D Loop, although it is called the "C Submitter's Identifier Loop" in the 277U Implementation Guide, is the loop that carrier header-level data for both institutional and non-institutional encounters. Two 2200D Loops will be created. The first occurrence of the 2200D Loop will contain the AHCCCS CRN in element REF02. The second occurrence of the 2200D Loop will contain the Health Plan CRN in element REF02.
2200D 1st occurrence	TRN	TRN02	Trace Number	Identification number used by originator of the transaction		Patient Account Number matches CLM01 from all 837 Transactions.
2200D 1st occurrence	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D 1st occurrence	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D 1st occurrence	STC	STC02	Status Information Effective Date	The date that the status information provided is effective		The AHCCCS Encounter Processing Date in YYMMDD format
2200D 1st occurrence	STC	STC03	Action Code	Code indicating type of action	NA	No Action Required Actions taken to correct pended encounters are separate from the 277U Transaction. Health plans receive separate Pended Encounter Files to facilitate encounter correction.
2200D 1st occurrence	STC	STC04	Total Claim Charge Amount	The sum of all charges included within this claim		The amount charged by the provider for all services on the claim that generated this encounter.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D 1st occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1K	Payer's Claim Number
2200D 1st occurrence	REF	REF02	Payer Claim Control Number	A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)		In the first occurrence of the 2200D Loop, this REF Segment carries the 14-digit Claim Reference number assigned by AHCCCS.
2200D 1st occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the specific type of bill or claim	BLT	Billing Type This REF Segment is used on institutional claims only
2200D 1st occurrence	REF	REF02	Bill Type Identifier	A code indicating the specific type of bill or claim		The Institutional claim's UB-92 Type of Bill Code
2200D 1st occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	EA	Medical Record Identification Number
2200D 1st occurrence	REF	REF02	Medical Record Number	A unique number assigned to patient by the provider to assist in retrieval of medical records		When available, the Medical Record Number with which the claim used by the health plan to generate an encounter is associated.
2200D 1st occurrence	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2200D 1st occurrence	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D 1st occurrence	DTP	DTP03	Date Time Period	Expression of a date. A time. Or range of dates, times or dates and times		On institutional encounters, the first and last Dates of Service. Dates of Service appear only at the service line level for professional, dental, and pharmacy encounters.
2200D 1st occurrence				Service Line Information Loop		This loop will not be present for encounters in a pend status.
2220D 1st occurrence	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	AD HC ND	American Dental Association Codes Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes National Drug Code The “AD” value is for dental service lines, the “HC” value for professional service lines, and the “ND” value for pharmacy service lines.
2220D 1st occurrence	SVC	SVC01-2	Service Identification Code	A code from a recognized coding scheme identified by a qualifier that describes the service rendered		On dental encounter lines, the ADA Procedure Code. On professional and outpatient lines, the HCPCS Procedure Code. On pharmacy lines, the NDC Code.
2220D 1st occurrence	SVC	SVC01-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the first Procedure Modifier on a professional service line.
2220D 1st occurrence	SVC	SVC01-4	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the second Procedure Modifier on a professional service line.
2220D 1st occurrence	SVC	SVC01-5	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the third Procedure Modifier on a professional service line.
2220D 1st occurrence	SVC	SVC01-6	Procedure Modifier	This identifies special circumstances related to the performance of a service		If present, the fourth Procedure Modifier on a professional service line.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D 1st occurrence	SVC	SVC02	Line Item Charge Amount	Charges related to this service		For professional, dental, and pharmacy service lines, the amount charged by the provider for the service.
2220D 1st occurrence	SVC	SVC03	Line Item Charge Amount	The actual amount paid to the provider for this service line		For professional, dental, and pharmacy service lines, the amount paid by the health plan for the service.
2220D 1st occurrence	SVC	SVC07	Quantity	Numeric value of quantity		The Units of Service for the service line.
2220D 1st occurrence	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		An STC01-1 value is generated, in combination with a value for STC01-2, for every professional, dental, or pharmacy service line reported on a 277U Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section. For institutional encounters, Status Codes appear in the encounter level 2200D Loop.
2220D 1st occurrence	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		AN STC01-2 value is generated, in combination with a value for STC01-1, for every professional, dental, or pharmacy service line reported on a 277U Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2220D 1st occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	FJ	Line Item Control Number
2220D 1st occurrence	REF	REF02	Line Item Control Number	Identifier assigned by the submitter/provider to this line item		The AHCCCS Claim Reference Number (CRN) Suffix assigned to the service line.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D 1st occurrence	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2220D 1st occurrence	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	A range of line item Service Dates in CCYYMMDDCCYYMMDD format. Both from and through dates are included even when they are the same.
2220D 1st occurrence	DTP	DTP03	Service Line Date	Date of service of the identified service line on the claim		Service line Begin and End Dates of Service for non-institutional encounters
2200D 2nd occurrence	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	2	Referenced Transaction Trace Numbers The 2200D Loop, although it is called the “C Submitter’s Identifier Loop” in the 277U Implementation Guide, is the loop that carrier header-level data for both institutional and non-institutional encounters. Two 2200D Loops will be created. The first occurrence of the 2200D Loop will contain the AHCCCS CRN in element REF02. The second occurrence of the 2200D Loop will contain the Health Plan CRN in element REF02.
2200D 2nd occurrence	TRN	TRN02	Trace Number	Identification number used by originator of the transaction		Patient Account Number matches CLM01 from all 837 Transactions.
2200D 2nd occurrence	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D 2nd occurrence	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D 2nd occurrence	STC	STC02	Status Information Effective Date	The date that the status information provided is effective		The AHCCCS Encounter Processing Date in YYMMDD format
2200D 2nd occurrence	STC	STC03	Action Code	Code indicating type of action	NA	No Action Required Actions taken to correct pended encounters are separate from the 277U Transaction. Health plans receive separate Pended Encounter Files to facilitate encounter correction.
2200D 2nd occurrence	STC	STC04	Total Claim Charge Amount	The sum of all charges included within this claim		The amount charged by the provider for all services on the claim that generated this encounter.
2200D 2nd occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	1K	Payer's Claim Number
2200D 2nd occurrence	REF	REF02	Payer Claim Control Number	A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN)		The second occurrence of the 2200D Loop contains the Health Plan CRN.
2200D 2nd occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the specific type of bill or claim	BLT	Billing Type This REF Segment is used on institutional claims only
2200D 2nd occurrence	REF	REF02	Bill Type Identifier	A code indicating the specific type of bill or claim		The Institutional claim's UB-92 Type of Bill Code
2200D 2nd occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	EA	Medical Record Identification Number

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2200D 2nd occurrence	REF	REF02	Medical Record Number	A unique number assigned to patient by the provider to assist in retrieval of medical records		When available, the Medical Record Number with which the claim used by the health plan to generate an encounter is associated.
2200D 2nd occurrence	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2200D 2nd occurrence	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD
2200D 2nd occurrence	DTP	DTP03	Date Time Period	Expression of a date. A time. Or range of dates, times or dates and times		On institutional encounters, the first and last Dates of Service. Dates of Service appear only at the service line level for professional, dental, and pharmacy encounters.
2200D 2nd occurrence				Service Line Information Loop		This loop will not be present for encounters in a pend status.
2220D 2nd occurrence	SVC	SVC01-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	AD HC ND	American Dental Association Codes Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes National Drug Code The “AD” value is for dental service lines, the “HC” value for professional service lines, and the “ND” value for pharmacy service lines.
2220D 2nd occurrence	SVC	SVC01-2	Service Identification Code	A code from a recognized coding scheme identified by a qualifier that describes the service rendered		On dental encounter lines, the ADA Procedure Code. On professional and outpatient lines, the HCPCS Procedure Code. On pharmacy lines, the NDC Code.
2220D 2nd occurrence	SVC	SVC01-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		If present, the first Procedure Modifier on a professional service line.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D 2nd occurrence	SVC	SVC01-4	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the second Procedure Modifier on a professional service line.
2220D 2nd occurrence	SVC	SVC01-5	Procedure Modifier	This identifies special circumstances related to the performance of the service.		If present, the third Procedure Modifier on a professional service line.
2220D 2nd occurrence	SVC	SVC01-6	Procedure Modifier	This identifies special circumstances related to the performance of a service		If present, the fourth Procedure Modifier on a professional service line.
2220D 2nd occurrence	SVC	SVC02	Line Item Charge Amount	Charges related to this service		For professional, dental, and pharmacy service lines, the amount charged by the provider for the service.
2220D 2nd occurrence	SVC	SVC03	Line Item Charge Amount	The actual amount paid to the provider for this service line		For professional, dental, and pharmacy service lines, the amount paid by the health plan for the service.
2220D 2nd occurrence	SVC	SVC07	Quantity	Numeric value of quantity		The Units of Service for the service line.
2220D 2nd occurrence	STC	STC01-1	Health Care Claim Status Category Code	Code indicating the category of the associated claim status code		An STC01-1 value is generated, in combination with a value for STC01-2, for every professional, dental, or pharmacy service line reported on a 277U Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section. For institutional encounters, Status Codes appear in the encounter level 2200D Loop.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D 2nd occurrence	STC	STC01-2	Health Care Claim Status Code	Code conveying the status of a claim		AN STC01-2 value is generated, in combination with a value for STC01-1, for every professional, dental, or pharmacy service line reported on a 277U Transaction. Four combinations of Status Category and Status Codes identify adjudication statuses equivalent to the statuses maintained in PMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2220D 2nd occurrence	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	FJ	Line Item Control Number
2220D 2nd occurrence	REF	REF02	Line Item Control Number	Identifier assigned by the submitter/provider to this line item		The AHCCCS Claim Reference Number (CRN) Suffix assigned to the service line.
2220D 2nd occurrence	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service
2220D 2nd occurrence	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	A range of line item Service Dates in CCYYMMDDCCYYMMDD format. Both from and through dates are included even when they are the same.
2220D 2nd occurrence	DTP	DTP03	Service Line Date	Date of service of the identified service line on the claim		Service line Begin and End Dates of Service for non-institutional encounters
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		The number of segments in the transaction, including ST and SE segments.
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		The same control number that appears in ST02.

6. 277U Supplemental File

Supplemental File Summary

AHCCCS generates the 277U Supplemental File in conjunction with 277U Transactions. The Supplemental File supplies encounter data not carried by the 277U Transaction, including the Encounter Denial Codes generated by PMMIS. Pended encounters are handled separately by the AHCCCS Encounter Pend Correction Process and Pend Codes are not necessary in this context. The Supplemental File is available to 277U receivers that request it from AHCCCS.

In terms of claim level and line level information, the Supplemental File follows the structure of the AHCCCS 277 Transaction. Encounters are represented as header-level segments for institutional encounters and as single services with both header and line segments for professional, dental, and pharmacy encounters.

The 277U Supplemental File is a fixed-length sequential file with 143-byte records. It is more similar in structure to pre-HIPAA AHCCCS interface files than to the 277U Transaction. It has three record types:

- A single Header Record with identification information on the payer (AHCCCS) and the information receiver (the AHCCCS health plan)
- Multiple Encounter Records with supplemental data elements for each institutional encounter or non-institutional service line
- A single Trailer Record with identifiers and a control count

Data element level information on the 277U Supplemental File appears in the remainder of this section.

File Naming Convention

277U Supplemental File

AZS277-nnnnnn-YYMMDD.TXT

- AZ is the state code.
- S to indicate Supplemental.
- 277 is the Transaction code.
- nnnnnn is the Health Plan ID.
- YYMMDD is the process date.
- TXT is the file extension.

277U SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
HEADER RECORD – 1 record per 277U Transaction				
Header	Contractor ID	The Health Plan ID assigned by AHCCCS	6AN	
Header	Transmission Submitter Number (TSN)	A number assigned by AHCCCS to submitters of electronic transactions	3AN	
Header	Process Date	The date on which the Supplemental File is created	8AN	Format is CCYYMMDD.
Header	File Type Code		2AN	Value is “SU” for Adjudicated Encounter
Header	Filler	Filler	122AN	
Header	Record Type		2AN	Value is “T0”
ENCOUNTER RECORD – 1 or more records per 277U Transaction				
Encounter	AHCCCS CRN	The Claim Reference Number assigned to the encounter by AHCCCS	14AN	For institutional encounters reported at the invoice level, the final two CRN positions are “00”. For non-institutional encounters, reporting is by service line and the final two positions have a value of from “01” to “50”.
Encounter	RI Number	Reinsurance Claim Number	10AN	
Encounter	Filler	Filler	14AN	
Encounter	AHCCCS CRN Status	A mnemonic for the status assigned to the encounter or service line by AHCCCS	2AN	“AP” = Adjudicated/Approved “AV” – Adjudicated/Void “DE” = Voluntary Plan Delete “DN” = Auto Deny “PE” = Pended
Encounter	Form Type		1AN	Form Type identifies the form type assigned by AHCCCS during processing.
Encounter	Filler	Filler	17AN	
Encounter	Primary Diagnosis Code	The Primary or Principal Diagnosis Code for the institutional invoice or non-institutional service line	6AN	Primary diagnosis is the diagnosis identified as primary on the encounter.
Encounter	Category of Service	The AHCCCS Category of Service assigned to the encounter	2AN	Category of Service is assigned to the encounter at the line level for all but institutional encounters.
Encounter	Filler	Filler	17AN	
Encounter	HP Paid Amt	Health Plan Paid Amount	12AN	
Encounter	Appr Amt	Health Plan Allowed/Approved Amount	12AN	
Encounter	Denial Reason	The Denial Reason Code or Codes on denied encounters and service lines	4AN	

277U SUPPLEMENTAL FILE SPECIFICATIONS				
Record Type	**Field Name**	**Field Description**	**Field Length/ Usage**	**Comments**
Encounter	Health Plan CRN	The Claim Reference Number assigned by the Health Plan	30AN	MCO CRN should be 30 characters.
Encounter	Record Type		2AN	Value is “C1”
TRAILER RECORD – 1 record per 277U Transaction				
Trailer	Filler	Filler	9AN	
Trailer	Transmission Submitter Number (TSN)	The number assigned to the transaction submitter by AHCCCS	3AN	
Trailer	Filler	Filler	6AN	
Trailer	Current Year		2N	YY format
Trailer	Current Julian Date		3N	DDD format
Trailer	File Type Code		2AN	“AE” = Adjudicated Encounter
Trailer	# of Records on File		8N	
Trailer	Filler	Filler	108AN	
Trailer	Record Type		2AN	Value is “T9”