



Companion Guide: Electronic Data Interchange Reports and Acknowledgements

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Revision History

Document Version Number	CO	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
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			Table 3.4	Professional error codes and descriptions	
Version 3.9	834	January 2006	Table 3.4	Add First Steps professional error codes and descriptions	Systems/ Publications
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Section 1: Introduction

Overview

The *Companion Guide - Electronic Data Interchange Reports and Acknowledgements* contains information specific to the *997 Functional Acknowledgement*, 837D, 837I, and 837P *Biller Summary Reports* (BSRs), and the *X12 276 Reject Report*. These reports must be downloaded and reviewed to verify acceptance or rejection of electronic data interchange (EDI) data.

997 Functional Acknowledgement

The *997 Functional Acknowledgement* is an X12 transaction that acknowledges the receipt of the batch transaction and reports the acceptance or rejection of a functional group, transaction set, or segment. The IHCP returns the 997 within two hours of the batch submission.

Biller Summary Report

The Biller Summary Report (BSR) is created to report the results of pre-adjudication edit checking to verify two levels of compliance, Health Insurance Portability and Accountability Act (HIPAA) compliance and Indiana Health Coverage Programs (IHCP)-specific compliance of 837D, 837I, and 837P transactions. BSRs are produced for each file received from a trading partner that contains an 837 transaction. The IHCP returns the BSR within two hours of the batch submission.

276 Reject Report

The *X12 276 Reject Report* provides information about the claim status requests containing errors that prevented processing.

Section 2: Acknowledgements

997 Functional Acknowledgement – Outbound

The Indiana Health Coverage Programs (IHCP) generates an outbound 997 to acknowledge all inbound transactions received in batch mode. Interactive transactions do not report the acceptance of an interactive inbound transaction and generate an outbound 997 only when the interactive inbound transaction rejects for compliance errors. The software used by the IHCP is Sybase, Inc.'s ECMAP™ with a Health Insurance Portability and Accountability Act (HIPAA) toolkit extension. ECMAP's method for creating 997 acknowledgements is to run data through a compliance map. The compliance map is defined to validate the EDI data against the complete standard transaction set definition or to validate EDI data against a specific subset of the standard transaction.

The IHCP's direction was to take the standard HIPAA compliance maps created by ECMAP without modifications. If transactions contain errors, the entire ST-SE is rejected. Any additional functional groups within the ISA-IEA are accepted provided data meets compliance rules.

997 Functional Acknowledgement – Inbound

The IHCP expects a functional acknowledgment in response to all outbound transactions created in batch mode. The IHCP does not expect a functional acknowledgment in response to the interactive outbound transaction created by the IHCP. The software used by the IHCP is Sybase, Inc.'s ECMAP with an HIPAA toolkit extension. Sybase, Inc., has not yet developed an automated method for reconciliation of the acknowledgements to the outbound X12. The process is being developed and requirements will be published later.

The following tables define the data elements of the 997 Functional Acknowledgement.

Table 2.1 – Inbound, Transaction Set Header

Segment Name	Transaction Set Header
Segment ID	ST
Loop	N/A
Usage	Required
Segment Notes	
Example	ST*997*54321~

Table 2.2 – Inbound, Element ID (ST01-ST02)

Element ID	Usage	Guide Description/Valid Values	Comments
ST01	R	Transaction Set Identifier Code 997 – Functional Acknowledgement	
ST02	R	Transaction Set Control Number	This number is assigned locally matches the value in the corresponding SE segment.

Table 2.3 – Inbound, Functional Group Response Header

Segment Name	Functional Group Response Header
Segment ID	AK1
Loop	N/A
Usage	Required
Segment Notes	This segment responds to the functional group information in the interchange envelope.
Example	AK1 *HC*8215~

Table 2.4 – Inbound, Element ID (AK101-AK102)

Element ID	Usage	Guide Description/Valid Values	Comments
AK101	R	Functional Identifier Code HC – Health Care Claim (837) HS – Eligibility, Coverage or Benefit Inquiry (270) HR – Health Care Claim Status Request (276) HI – Health Care Services Review Information (278)	This is only a list of identifier codes used for 997s generated by the IHCP in response to inbound transactions.
AK102	R	Transaction Set Control Number	This data element contains the value from the GS06 data element from the GS segment of the original file being acknowledged.

Table 2.5 – Inbound, Transaction Set Response Header

Segment Name	Transaction Set Response Header
Segment ID	AK2
Loop	AK2
Usage	Situational
Segment Notes	This segment starts the acknowledgment of a transaction set. If there are no errors at the transaction set level, this segment is not returned.
Example	AK2*837*252525~

Table 2.6 – Inbound, Element ID (AK201-AK202)

Element ID	Usage	Guide Description/Valid Values	Comments
AK201	R	Functional Identifier Code 837 – Health Care Claim 270 – Eligibility, Coverage or Benefit Inquiry) 276 – Health Care Claim Status Request 278 – Health Care Services Review Information	This is only a list of identifier codes used for 7s generated by the IHCP in response to inbound transactions.
AK202	R	Transaction Set Control Number	This data element contains the value from the ST02 data element from the ST segment of the original file being acknowledged.

Table 2.7 – Inbound, Data Segment Note

Segment Name	Data Segment Note
Segment ID	AK3
Loop	AK2/AK3
Usage	Situational
Segment Notes	This segment reports segment and looping errors in the submitted transaction.
Example	AK3*NM1*16*2010BA*8~

Table 2.8 – Inbound, Element ID (AK301-AK304)

Element ID	Usage	Guide Description/Valid Values	Comments
AK301	R	Segment ID Code	This data element lists the two or three byte segment ID that contains the error, such as <i>ST</i> , <i>SBR</i> .
AK302	R	Segment Position in Transaction Set	This data element contains the sequential position of the segment ID identified in AK301. This count begins with 1 for the <i>ST</i> segment and increments by 1 from that point.
AK303	S	Loop Identifier Code	This data element identifies the loop where the erroneous segment resides.
AK304	S	Segment Syntax Error Code See code list in the <i>IG</i>	This data element describes the type of error encountered.

Table 2.9 – Inbound, Data Segment Note

Segment Name	Data Segment Note
Segment ID	AK4
Loop	AK2/AK3
Usage	Situational
Segment Notes	This segment reports data element and composite errors in the submitted transaction.
Example	AK4*9**67*1~

Table 2.10 – Inbound, Element ID (AK401-AK405)

Element ID	Usage	Guide Description/Valid Values	Comments
AK401	R	Position in Segment	This is a composite data element.
AK401-1	R	Segment Position in Transaction Set	This data element contains the sequential position of the simple data element or composite data structure. This count begins with 1 for the initial element and increments by 1 from that point.
AK401-2	S	Component Data Element Position in Composite	This data element identifies within the composite structure where the error occurs.

(Continued)

AK403	S	Data Element Reference Number	This is the <i>Data Element Dictionary</i> reference number associated with the erroneous data element or composite.
AK404	R	Data Element Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK405	S	Copy of Bad Data Element	

Table 2.11 – Inbound, Transaction Set Response Trailer

Segment Name	Transaction Set Response Trailer
Segment ID	AK5
Loop	AK2/AK3
Usage	Required
Segment Notes	This segment acknowledges the acceptance or rejection of a transaction and any report errors.
Example	AK5 *R *5~

Table 2.12 – Inbound, Element ID (AK501-AK506)

Element ID	Usage	Guide Description/Valid Values	Comments
AK501	R	Transaction Set Acknowledgment Code A – Accepted R – Rejected	
AK502	S	Transaction Set Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK503	S	Transaction Set Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK504	S	Transaction Set Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK505	S	Transaction Set Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK506	S	Transaction Set Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.

Table 2.13 – Inbound, Functional Group Response Trailer

Segment Name	Functional Group Response Trailer
Segment ID	AK9
Loop	N/A
Usage	Required
Segment Notes	This segment acknowledges the acceptance or rejection of a functional group and report the number of transaction sets originally included, received, and accepted.
Example	AK9*P*1*1*0~

Table 2.14 – Inbound, Element ID (AK901-AK909)

Element ID	Usage	Guide Description/Valid Values	Comments
AK901	R	Functional Group Acknowledgment Code A – Accepted P – Partially Accepted, at least one transaction set was rejected R – Rejected	
AK902	S	Number of Transaction Sets Included	This data element contains the value from the GE01 data element from the GE segment of the original file being acknowledged.
AK903	S	Number of Received Transaction Sets	
AK904	S	Number of Accepted Transaction Sets	
AK905	S	Functional Group Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK906	S	Functional Group Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK907	S	Functional Group Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK908	S	Functional Group Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.
AK909	S	Functional Group Syntax Error Code See code list in <i>IG</i>	This data element describes the type of error encountered.

Table 2.15 – Inbound, Transaction Set Trailer

Segment Name	Transaction Set Trailer
Segment ID	SE
Loop	N/A
Usage	Required
Segment Notes	
Example	SE*997*54321~

Table 2.16 – Inbound, Element ID (SE01-SE02)

Element ID	Usage	Guide Description/Valid Values	Comments
SE01	R	Number of Included Segments	This is the total number of segments included in this acknowledgment. This value includes the ST and SE segments.
SE02	R	Transaction Set Control Number	This number is assigned locally and matches the value in the preceding ST segment.

Example of 997 Functional Acknowledgement

Figure 2.1 illustrates an 837 transaction rejected due to a missing subscriber ID.

```

ST*997*54321~
AK1*HC*8215~
AK2*837*252525~
AK3*NM1*16*2010BA*8~
AK4*9**67*1~
AK5*R*5~
AK9*P*1*1*0~
SE*997*54321~
    
```

Figure 2.1 – 997 Functional Acknowledgement, 837 Transaction Rejected, Missing Subscriber ID

Section 3: Biller Summary Report

Format of Report

The first section of the *Biller Summary Report* (BSR) contains the reporting of claims that are rejected due to Health Information Portability and Accountability Act (HIPAA) compliance errors. This section displays the patient account numbers of the claims that are rejected, unless the entire file is rejected. If the entire file is rejected, the BSR reflects that information. For files with multiple transactions, only the transaction in error is rejected. However, the entire transaction is rejected, even though only one claim is in error. When a transaction is rejected at the HIPAA-compliance level, the trading partner should review additional information about the rejections in the 997 Functional Acknowledgement.

The second section of the BSR displays results of the Indiana Health Coverage Programs (IHCP)-specific pre-adjudication editing. This section contains submission date and time, provider number or numbers, number of claims accepted, number of claims rejected, dollar amount billed, and detailed information about **all** rejected claims.

Rejected claims contain errors that prevent them from continuing through the claim processing cycle. For claims with multiple details, the **entire** claim is rejected, even though only one service line is in error. The fact that a claim is accepted does not guarantee payment of the claim. It only means that it contained the basic information needed for processing.

Purpose of Report

Trading partners should download and view the BSR, as claims that are rejected are not processed and will not appear on the provider's remittance advice. Trading partners can correct errors immediately, and resubmit the claim, or claims.

BSRs are created after each transmission session. Trading partners that transmit 837 transactions directly can download the report within two hours from their transmission.

Informational Code 804

Claims displayed on the BSR with an informational code of 804 will be processed under a default Legacy Provider Identifier (LPI) and service location requested by the billing provider. Only claims submitted with NPI only can be processed with a default LPI and service location. For additional information about the default processing option view the NPI section of the www.indianamedicaid.com web site.

General Error Codes

The following tables list the possible error codes and descriptions received on the BSR.

Table 3.1 – Biller Summary Report, General Error Codes and Descriptions

Error Code	Error Description
X01	Shadow claim submitted by a non-MCO entity
X02	MCOs may not submit chargeable claims to IHCP. Please resubmit 837 with BHT06 = RP indicating reporting or encounter claim.
100	EDI file – Empty
101	EDI file – Not <i>ASC X12N</i> (does not begin with <i>ISA</i>)
102	EDI file – <i>ISA</i> segment has incorrect length
103	EDI file – <i>ISA01</i> is not <i>00</i>
104	EDI file – <i>ISA02</i> is not ' ' (10 spaces)
105	EDI file – <i>ISA03</i> is not <i>00</i>
106	EDI file – <i>ISA04</i> is not ' ' (10 spaces)
107	EDI file – <i>ISA05</i> is not <i>ZZ</i>
108	EDI file – <i>ISA06</i> does not match the assigned Trading Partner ID
109	EDI file – <i>ISA07</i> is not <i>ZZ</i>
110	EDI file – <i>ISA08</i> is not <i>IHCP</i>
111	EDI file – <i>ISA12</i> is not <i>00401</i>
112	EDI file – <i>ISA15</i> is not <i>T</i> or <i>P</i> (depending on the environment)
113	EDI file – <i>GS</i> segment does not follow the <i>ISA</i>
114	EDI file – <i>GS</i> does not contain the correct number of elements
115	EDI file – <i>GS</i> element separator does not match <i>ISA</i> element separator
116	EDI file – <i>GS</i> segment terminator does not match <i>ISA</i> segment terminator
117	EDI file – <i>GS02</i> does not match the assigned Trading Partner ID
118	EDI file – <i>GS03</i> is not <i>IHCP</i>
119	EDI file – <i>GS07</i> is not <i>X</i>
120	EDI file – <i>GS08</i> is not <i>004010X096A1</i> , <i>004010X097A1</i> , or <i>004010X098A1</i>
121	EDI file – Trading partner not authorized for the transaction
122	EDI file – Character 4 of the <i>ISA</i> segment (element separator) is blank
123	EDI file – <i>ISA06</i> , Trading Partner ID, is blank
124	EDI file – <i>ISA13</i> , Interchange Control Number does not match <i>IEA02</i>
125	EDI file – <i>ISA16</i> , component element separator, is blank
126	EDI file – Character 106 of the <i>ISA</i> segment (segment terminator) is blank
127	Invalid Interchange Content (missing <i>IEA</i>)
128	Invalid Interchange Content (<i>CLM</i> prematurely terminated)

Table 3.1 – Biller Summary Report, General Error Codes and Descriptions

Error Code	Error Description
129	Invalid Interchange Content (element separator after CLM header missing)
130	Invalid Test Indicator Value (ISA15 is <i>P</i> and the environment is not <i>production</i>)
131	Invalid Test Indicator Value (ISA15 is <i>T</i> and the environment is <i>production</i>)
132	Non-compliant transaction, claim count provided.
133	The transmitted file does not contain claim data (missing CLM segment).
240	Member not enrolled with HIP ESP for dates of service
241	Duplicate original HIP ESP claim (duplicate other payer ICN)
242	HIP ESP claim with different original/replacement ICNs
243	HIP ESP void claim submitted, original claim not found
244	HIP ESP void/replacement submitted, original claim previously voided
245	HIP ESP replacement claim submitted, original claim not found
246	HIP ESP replacement claim is a duplicate of the original
250	HIP claim submitted for member not enrolled in Medicaid
251	HIP claim submitted for member not eligible for HIP for dates of service
258	Billing NPI tied to multiple LPis.
259	Billing NPI not tied to an LPI.
260	Billing NPI must be submitted.
274	MCO submitted claim without a valid Payer ID.
275	Only claims with this following Status can be voided: Paid, Suspended, Resubmit, CCF, Queue.
276	This Claim Type cannot be Voided (<i>P</i> , <i>Q</i>).
278	Claims with this Status cannot be replaced (<i>J</i>).
279	This Claim Type cannot be replaced (<i>P</i> , <i>Q</i>).
281	Provider submitted Attachment Control Numbers that are not unique for SAK. Provide for this Provide/Service Location/Claim CAN combination.
283	MCO void/replacement request past filing limit.
284	MCO ID – state region, billing provider/service location and/or recipient information sent on request does not match with the MCO ID – state region, billing provider/service location and/or recipient information on the original claim provided.
285	Replacement request past filing limit. Please resubmit as a manual request.
286	Billing Provider – service location and/or recipient information sent on request does not match with the Billing Provider – service location and/or recipient information on the original claim provided.
287	Voids can only be submitted for non-denied claims.
288	Mismatch in claim type submitted vs. the claim type for the given ICN
289	A void/replacement was already processed for this claim, please submit a void/replacement for the most current claim.

Table 3.1 – Biller Summary Report, General Error Codes and Descriptions

Error Code	Error Description
290	Provider submitted a replacement or void for a claim that was not found. Please identify claim to be voided or replaced and initiate another void or replacement if necessary.
291	A replacement was submitted for a claim that was previously voided. Please submit as an original claim.
293	CAS – Invalid Adjustment Reason Code
296	The patient must be the same as the subscriber
900	Missing billing provider number
902	Invalid billing provider number
903	Missing or invalid provider service location
911	Missing or invalid MCO/region for shadow claim
998	Internal Error, Output from Parse/Mapper does not match the expected length for the number of Details provided.
999	Claim was written to the bad directory Contact the EDI Solutions Helpdesk at 317-488-5061 or 1-877-877-5182

Dental Claim Error Codes

Table 3.2 – Biller Summary Report, Dental Error Codes and Descriptions

Error Code	Error Description
294	Invalid data submitted for COB TPL claim.
297	Diagnosis codes must be consecutive 1 - 4 contain no blanks.
298	PWK06 – Attachment Control Numbers were not unique
299	More than the maximum detail records were received
301	SV302 – Line Item Charge Amount was negative
302	SV306 – Procedure Count was negative
303	Number of details sent was negative
304	CLM02 – Total Claim Charge Amount was negative
305	Net Charge (Total Charge – TPL) was negative
306	AMT02 (Loop 2320) – Payer Paid Amount was negative
401	SV302 – Line Item Charge Amount was received in an invalid format
402	SV306 – Procedure Count was received in an invalid format
403	Number of details sent was received in an invalid format
404	CLM02 – Total Claim Charge Amount was received in an invalid format
405	Net Charge (Total Charge – TPL) was received in an invalid format
406	AMT02 (Loop 2320) – Payer Paid Amount was received in an invalid format

Institutional Claim Error Codes

Table 3.3 – Biller Summary Report, Institutional Error Codes and Descriptions

Error Code	Error Description
265	MCO denied claims cannot be replaced
271	Void and replacement claims from COBA are not accepted.
272	Invalid Type of Bill
273	There are multiple Medicare payers.
274	Invalid MCO Payer ID in NM109 of loop 2330B.
277	Crossover adjustment amounts (deductible, coinsurance, and blood deductible amounts) at the detail do not balance with the header crossover adjustment amounts.
280	Crossover A claims must contain crossover amounts (Medicare paid, deductible, coinsurance, and blood deductible amounts) at the header level.
292	Received Shadow Claim indicating the MCO denied all details.
295	Invalid data submitted for COB crossover claim.
297	Diagnosis codes must be consecutive 1 - 4 contain no blanks.
298	PWK06 – Attachment Control Numbers were not unique
299	More than the maximum detail records were received for a non Medicare claim
301	HI01-5 – Value Code Associated Amount was negative (first occurrence)
302	HI01-5 – Value Code Associated Amount was negative (second occurrence)
303	HI01-5 – Value Code Associated Amount was negative (third occurrence)
304	HI01-5 – Value Code Associated Amount was negative (fourth occurrence)
305	HI01-5 – Value Code Associated Amount was negative (fifth occurrence)
306	HI01-5 – Value Code Associated Amount was negative (sixth occurrence)
307	HI01-5 – Value Code Associated Amount was negative (seventh occurrence)
308	HI01-5 – Value Code Associated Amount was negative (eighth occurrence)
309	HI01-5 – Value Code Associated Amount was negative (ninth occurrence)
310	HI01-5 – Value Code Associated Amount was negative (10th occurrence)
311	HI01-5 – Value Code Associated Amount was negative (11th occurrence)
312	HI01-5 – Value Code Associated Amount was negative (12th occurrence)
313	SV205 – Service Unit Count was negative
314	SV203 – Line Item Charge Amount was negative
315	Medicare Paid Amount (sum of SVD02 segments) was negative
316	Sum of CAS segments at service level when indicating coinsurance – Co Insurance Adjustment Amount Total was negative
317	Sum of CAS segments at service level when indicating deductible – Deductible Adjustment Amount Total was negative
318	Sum of CAS segments at service level when indicating blood deductible – Blood Deductible Adjustment Amount Total was negative
319	CTP04 – National Drug Unit Count was negative

Table 3.3 – Biller Summary Report, Institutional Error Codes and Descriptions

Error Code	Error Description
320	QTY02 – Claim Days Count was negative
321	CLM02 – Total Claim Charge Amount was negative
322	AMT02 – Patient Amount Paid was negative
323	AMT02 – Estimated Claim Due Amount was negative
324	Sum of AMT02 – Total Medicare Paid Amount was negative
326	Sum of AMT02 – Other Payer Patient Paid Amount was negative
327	Field amt_due_est3 from the INTTRL record was negative
328	Sum of CAS segments at claim level when indicating deductible – Deductible Adjustment Amount was negative
329	Sum of CAS segments at claim level when indicating coinsurance – Coinsurance Adjustment Amount was negative
330	Sum of CAS segments at claim level when indicating blood deductible – Blood Deductible Adjustment Amount was negative
331	Field amt_tpl_paid from the DETAIL record was negative
332	Field cde_revenue from the DETAIL record has invalid data
416	Sum of CAS segments when indicating coinsurance – Co Insurance Adjustment Amount Total was received in an invalid format
417	Sum of CAS segments when indicating deductible – Deductible Adjustment Amount Total was received in an invalid format
418	Sum of CAS segments when indicating blood deductible – Blood Deductible Adjustment Amount Total was received in an invalid format
419	CTP04 – National Drug Unit Count was received in an invalid format
420	QTY02 – Claim Days Count was received in an invalid format
421	CLM02 – Total Claim Charge Amount was received in an invalid format
422	AMT02 – Patient Amount Paid was received in an invalid format
423	AMT02 – Estimated Claim Due Amount was received in an invalid format
424	Sum of AMT02 – Total Medicare Paid Amount was received in an invalid format
426	Sum of AMT02 – Other Payer Patient Paid Amount was received in an invalid format
428	Sum of CAS segments when indicating deductible – Deductible Adjustment Amount was received in an invalid format
429	Sum of CAS segments when indicating coinsurance – Coinsurance Adjustment Amount was received in an invalid format
430	Sum of CAS segments when indicating blood deductible – Blood Deductible Adjustment Amount was received in an invalid format

Professional Claim Error Codes

Table 3.4 – Biller Summary Report, Professional Error Codes and Descriptions

Error Code	Error Description
263	First Steps claim Prior Authorization number missing or less than 10 characters
264	First Steps claim Prior Authorization number is invalid
265	MCO Denied claims cannot be replaced
266	Detail from/to dates of service must be the same for First Steps claims
267	Cannot void or replace a First Steps claim that is suspended.
268	Cannot void or replace a First Steps claim whose Medicaid claim is pending void or pending replacement.
269	First Steps replacement request rejected for filing limit.
270	First Steps replacement rejected due to original claim encountering a filing limit error.
271	Void and replacement claims from COBA are not accepted.
273	There are multiple Medicare payers.
274	Invalid MCO Payer ID in NM109 of loop 2330B.
277	Crossover adjustment amounts (deductible, coinsurance, and psych amounts) at the detail do not balance with the header crossover adjustment amounts.
292	Received Shadow Claim indicating the MCO denied all details.
295	Invalid data submitted for COB crossover claim.
297	Diagnosis codes must be consecutive 1 - 4 contain no blanks.
298	PWK06 – Attachment Control Numbers were not unique
299	More than the maximum detail records were received for a non Medicare claim
301	SV104 – Service Unit Count was negative
302	SV102 – Line Item Charge Amount was negative
303	SVD02 – Service Line Paid Amount was negative
304	Sum of CAS segments at service level when indicating coinsurance – Coinsurance Adjustment Amount was negative
305	Sum of CAS segments at service level when indicating deductible – Deductible Adjustment Amount was negative
306	Sum of CAS segments at service level when indicating psych adjustment – Psych Adjustment Amount was negative
307	CTP04 – National Drug Unit Count was negative
308	CLM02 – Total Claim Charge Amount was negative
309	Net Charge (Total charges – (TPL + Medicare paid)) was negative
310	AMT02 – Payer Paid Amount was negative
311	AMT02 – Patient Paid Amount was negative
312	Medicare Paid Amount (Sum of Payer Paid Amount segments) was negative
313	Sum of CAS segments at claim level when indicating coinsurance – Coinsurance Adjustment Amount was negative

Table 3.4 – Biller Summary Report, Professional Error Codes and Descriptions

Error Code	Error Description
314	Sum of CAS segments at claim level when indicating deductible – Deductible Adjustment Amount was negative
315	Sum of CAS segments at claim level when indicating psych adjustment – Psych Adjustment Amount was negative

Sort Sequence

- Primary – Claim Type Number
- Secondary – Provider Number

Distribution

Table 3.5 – Biller Summary Report, Distribution

To	Media	Copies	Frequency
Providers	Electronic	1	As needed
Software Vendors	Electronic	1	As needed

Detailed Field Descriptions

Table 3.6 – Biller Summary Report, Field Descriptions

Field	Description
Trading Partner Name	Name of submitting trading partner
Submission Time	HH:MM and MM/DD/YY from the translated file
ISA Trade Partner	Interchange trading partner ID from the ISA envelope
Submission Type	Submission method and type of claim submitted electronically
ISA Control Number	Interchange control number from the ISA envelope
Version	X12 version number from the ISA envelope
GS Control Number	Group control number from the ISA envelope
MCO Number	MCO number (if error)
MCO Error Code	MCO error code (if error)
Provider Number	IHCP provider number
Provider Error Code	IHCP provider error code
Received Claims	Number of claims accepted for further processing
Provider Total Billed Amount	Total dollar amount billed by provider
Rejected Claims	Number of claims rejected for errors that prevented processing
Provider Accepted Billed Amount	Total dollar amount of claims accepted from the provider for further

Table 3.6 – Biller Summary Report, Field Descriptions

Field	Description
	processing
Member	First five characters of the member's last name and the first character of the member's first name, separated by a comma and up to four spaces
RID	Twelve-digit member identification number
DOS	From and to dates of service on the claim
Patient Acct. No.	Provider's account number assigned to the member
Bill Amt.	Total dollar amount billed on the claim. Decimals are implied but not shown. The last two characters in the field indicate cents.
Err Cod	Detail error that caused the claim to reject that are only Provider errors. Up to three occurrences are reported. On claims with three or more errors, the third error code is 999. 000 represents no error code and indicates that this information is only displayed for rejected claims.
ISA Control Number (ISA Totals)	Interchange control numbers for this ISA envelope
Total Claims Received (ISA Totals)	Total number of claims received for this ISA envelope, including both compliant and non-compliant claims
X12 Non-Compliant Claims Rejected (ISA Totals)	Total number of non-compliant claims received for this ISA envelope, claims not passing X12 compliance check
X12 Compliant Accepted (ISA Totals)	Total number of compliant claims received for this ISA envelope, claims passing X12 compliance check
Total X12 Compliant Billed Amount (ISA Totals)	Total dollar amount of all X12 compliant claims received in this ISA envelope
Total X12 Compliant Accepted Billed Amount (ISA Totals)	Total dollar amount of X12 compliant claims accepted for further processing in this ISA envelope
Total X12 Compliant Claims Accepted (ISA Totals)	Total number of X12 compliant claims accepted for further processing for this ISA envelope
Total X12 Compliant Claims Rejected (ISA Totals)	Total number of X12 compliant claims rejected for this ISA envelope
Total Claims Received (Sender Totals)	Total number of claims received for this transmission, including both compliant and non-compliant claims
X12 Non-Compliant Claims Rejected (Sender Totals)	Total number of non-compliant claims received for this transmission, claims not passing X12 compliance check
X12 Compliant Accepted (Sender Totals)	Total number of compliant claims received for this transmission, claims passing X12 compliance check
Total X12 Compliant Billed Amount (Sender Totals)	Total dollar amount of all X12 compliant claims received for this transmission
Total X12 Compliant Accepted Billed Amount (Sender Totals)	Total dollar amount of X12 compliant claims accepted for further processing for this transmission
Total X12 Compliant Claims Accepted (Sender Totals)	Total number of X12 compliant claims accepted for further processing for this transmission
Total X12 Compliant Claims Rejected (Sender Totals)	Total number of X12 compliant claims rejected for this transmission

Biller Summary Report Layout (Compliant and Non-compliant Data)

Indiana Health Coverage Programs Electronic Claims Submission Biller Summary Report			Run Date:	MM/DD/YY	
			Run Time:	HH:MM AM	
			Page:	99,999	
Trading Partner Name		Submission Time:	HH:MMAM	MM/DD/YY	
ISA Trade Partner: 999X		Submission Type:	XXXX	999X	
ISA Control Number 99999999		Version:	XXXXXX		
GS Control Number 999999999					
ISA X12 Non-compliant Claims (check 997):					
Patient Acct. No					

99999999999999999999					
99999999999999999999					
ISA X12 Compliant Claims:					
MCO Number	999999999X	MCO Error Code	999		
Provider Number:	999999999X	Provider Error Code:	999		
Received Claims:	9	Provider Total Billed Amount:	\$	99.99	
Rejected Claims:	9	Provider Accepted Billed Amount:	\$	99.99	
Member	RID	DOS	Patient Acct No	Bill Amt.	
				Err Cod	
-----	-----	-----	-----	-----	
Doe, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Membe, D	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Patie, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
MCO Number	999999999X	MCO Error Code	999		
Provider Number:	999999999X	Provider Error Code:	999		
Received Claims:	9	Provider Total Billed Amount:	\$	99.99	
Rejected Claims:	9	Provider Accepted Billed Amount:	\$	99.99	
Member	RID	DOS	Patient Acct No	Bill Amt.	
				Err Cod	
-----	-----	-----	-----	-----	
Doe, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Membe, D	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Patie, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
ISA Control Number: 999999999					
ISA Totals:					
Total Claims Received:		99			
X12 Non-compliant Rejected:		99			
X12 Compliant Accepted:		99			
Total X12 Compliant Billed Amount:		\$ 9999999.99			
Total X12 Compliant Accepted Billed Amount:		\$ 9999999.99			
Total X12 Compliant Claims Accepted:		9			
Total X12 Compliant Claims Rejected:		9			

Figure 3.1 – Biller Summary Report Layout (Compliant and Non-compliant Data)

Indiana Health Coverage Programs			Run Date:	MM/DD/YY
Electronic Claims Submission			Run Time:	HH:MM AM
Biller Summary Report			Page:	99,999
Trading Partner Name		Submission Time:	HH:MMAM	MM/DD/YY
ISA Trade Partner:	999X	Submission Type:	XXXX	999X
ISA Control Number	99999999	Version:	XXXXXX	
GS Control Number	99999999			
ISA X12 Non-compliant Claims (check 997):				
Patient Acct. No				

99999999999999999999				
99999999999999999999				
ISA X12 Compliant Claims:				
MCO Number	999999999X	MCO Error Code	999	
Provider Number:	999999999X	Provider Error Code:	999	
Received Claims:	9	Provider Total Billed Amount:	\$	99.99
Rejected Claims:	9	Provider Accepted Billed Amount:	\$	99.99
Member	RID	DOS	Patient Acct No	Bill Amt. Err Cod
-----	-----	-----	-----	-----
Doe, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
Membe, D	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
Patie, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
MCO Number	999999999X	MCO Error Code	999	
Provider Number:	999999999X	Provider Error Code:	999	
Received Claims:	9	Provider Total Billed Amount:	\$	99.99
Rejected Claims:	9	Provider Accepted Billed Amount:	\$	99.99
Member	RID	DOS	Patient Acct No	Bill Amt. Err Cod
-----	-----	-----	-----	-----
Doe, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
Membe, D	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
Patie, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	99999999999 999
ISA Control Number: 999999999				
ISA Totals:				
Total Claims Received:				99
X12 Non-compliant Rejected:				99
X12 Compliant Accepted:				99
Total X12 Compliant Billed Amount:		\$	9999999.99	
Total X12 Compliant Accepted Billed Amount:		\$	9999999.99	
Total X12 Compliant Claims Accepted:			9	
Total X12 Compliant Claims Rejected:			9	
Sender Totals:				
Total Claims Received:				99
X12 Non-compliant Rejected:				99
X12 Compliant Accepted:				99
Total X12 Compliant Billed Amount:		\$	9999999.99	
Total X12 Compliant Accepted Billed Amount:		\$	9999999.99	
Total X12 Compliant Claims Accepted:			9	
Total X12 Compliant Claims Rejected:			9	
**** End of Report ****				

Figure 3.2 - Biller Summary Report Layout (Compliant and Non-compliant Data)

Biller Summary Report Layout (All Non-compliant Data)

Indiana Health Coverage Programs		Run Date:	MM/DD/YY
Electronic Claims Submission		Run Time:	HH:MM AM
Biller Summary Report		Page:	99,999
Managed Care Organization One	Submission Time:	HH:MMAM	MM/DD/YY
ISA Sender: 999X	Submission Type:	XXXX	999X
ISA Control Number 99999999	Version:	XXXXXX	
GS Control Number 999999999			
X12 Error Code: 105			
ISA Control Number: 999999999			
ISA Totals:			
Total Claims Received:	99		
X12 Non-compliant Rejected:	99		
X12 Compliant Accepted:	0		
Total X12 Compliant Billed Amount:	\$	0.00	
Total X12 Compliant Accepted Billed Amount:	\$	0.00	
Total X12 Compliant Claims Accepted:		0	
Total X12 Compliant Claims Rejected:		0	
Sender Totals:			
Total Claims Received:	99		
X12 Non-compliant Rejected:	99		
X12 Compliant Accepted:	0		
Total X12 Compliant Billed Amount:	\$	0.00	
Total X12 Compliant Accepted Billed Amount:	\$	0.00	
Total X12 Compliant Claims Accepted:		0	
Total X12 Compliant Claims Rejected:		0	
**** End of Report ****			

Figure 3.3 – Biller Summary Report Layout (All Non-compliant Data)

Section 4: 276 Reject Report

Purpose of Report

The *X12 276 Reject Report* provides all electronic X12 senders the opportunity to review claim status request errors almost immediately after submission, and subsequent rejection, of the request file.

Table 4.1 – 276 Reject Report

Functional Area	Report Number	Job Name	Report Title
Electronic Claim Capture	N/A	N/A	X12 276 Reject Report

General Error Codes

Table 4.2 – 276 Reject Report, General Error Codes and Descriptions

Error Code	Error Description
101	Information Source: NM109 (Payer ID) must contain <i>IHCP</i>
102	Information Resource: NM108 (Receiver ID Qualifier) must contain <i>46</i> and NM109 (Receiver ETIN) must contain a valid value
201	Provider: NM108 (Provider ID Qualifier) must contain <i>SV</i> to indicate service provider number
301	Recipient: The subscriber must be the same as the patient. No dependent loops are allowed.
991	Service Line: Service level requests are not allowed for interactive transactions

Sort Sequence

- Primary – NONE

Distribution

Table 4.3 – 276 Reject Report Distribution

To	Media	Copies	Frequency
Providers	Electronic	1	As needed
Software Vendors	Electronic	1	As needed

Detailed Field Descriptions

Table 4.4 – 276 Reject Report Field Descriptions

Field	Description
Sender Name	Name of submitting trading partner
Submission Time	HH:MM and MM/DD/YY from the translated file
ISA Sender	Interchange sender ID from the ISA envelope
Media Type	Submission method from the ISA envelope
Version	X12 version number from the ISA envelope
GS Control Number	Group control number from the GS envelope
Provider Number	IHCP provider number
Sender Error Code	Sender error code
Sent Status Requests	Number of <i>requests for status</i> sent by this provider
Receiver Error Code	Receiver error code
Provider Error Code	IHCP provider error code
Rejected Status Requests	Number of <i>requests for status</i> rejected for errors that prevented processing
Member	First five characters of the IHCP member's last name and the first character of the IHCP member's first name, separated by a comma and zero to four spaces.
RID	Twelve-digit member identification number
DOS	From and to dates of service on the claim
Trace Number	Tracking number created and used by the provider
Billed Amt.	Total dollar amount received on the claim
Claim Error Code	Claim status request error code
ISA Control Number (ISA Totals)	Interchange control number for this ISA envelope
Total Status Requests Sent (ISA Totals)	Total number of <i>requests for status</i> sent in this ISA envelope, including accepted and rejected requests
Total Status Requests Rejected (ISA Totals)	Total number of <i>requests for status</i> rejected in this ISA envelope
Total Status Requests Sent (File Totals)	Total number of <i>requests for status</i> received for this transmission, including accepted and rejected requests
Total Status Requests Rejected (File Totals)	Total number of <i>requests for status</i> rejected for this transmission

276 Reject Report Layout

Indiana Health Coverage Programs			Run Date:		MM/DD/YY
Electronic Submission			Run Time:		HH:MM AM
276 Reject Report			Page:		99,999
Indiana Dentist		Submission Time:		HH:MMAM	MM/DD/Y Y
ISA Sender:	999999999	Version:		004010X097A1	
GS Control Number	9				
Provider Number:	999999999X	Sender Error Code		999	
Sent Status Requests:	9	Receiver Error Code:		999	
Rejected Status Requests:	9	Provider Error Code:		999	
Member	RID	DOS	Trace Number	Billed Amt.	Clm Err
Doe, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Membe, D	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
Patie, J	999999999999	MMDDYY-MMDDYY	99999999999999999999	999999999999	999
ISA Totals:					
ISA Control Number:		9999999999			
Total Status Requests Sent:		9			
Total Status Requests Rejected:		9			
File Totals:					
Total Status Requests Sent:		9			
Total Status Requests Rejected:		9			
**** End of Report ****					

Figure 4.1 – 276 Reject Report Layout

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