276/277 Fallon Health Companion Guide

Health Care Claim Status

Request and Response 276/277 Companion Guide

Refers to the ASC X12N 276/277 Technical Report Type 3 Guide (Version 005010X212)

Companion Guide Version Number: 1.1

PREFACE

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA Clarifies and specifies the data content when exchanging electronically with Fallon Health. Transmissions based on this companion guide, used in tandem with the X12N Technical Report Type 3 Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Technical Report Type 3 Guides.

276/277 Fallon Health Companion Guide

Table of Contents

1. INTRODUCTION

Scope

Providers, billing services and clearinghouses are advised to use the ASC X12N 276/277 (005010X212) Implementation Guide as a basis for their submission of Claims Status inquiries. This companion document should be used to clarify the CORE Buisness rules for 276/277 data content requirements, batch and real-time acknowledgement, connectivitiy, response time, and system availability, specifically for submissions through Fallon or clearinghouses. This document is intended for use with CAQH CORE compliant systems. For additional information on building a CORE compliant system go to http://www.caqh.org

Overview

The Health Insurance Portability and Accountability Act–Administration Simplification (HIPAAAS) requires Fallon and all other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services.

This guide is designed to help those responsible for testing and setting up electronic Claim transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Fallon. This guide supplements (but does not contradict) requirements in the ASC X12N 276/277 (version 005010X212) implementation. This information should be given to the provider's business area to ensure that claim status inquiry responses are interpreted correctly.

References

- The ASC X12N 276/277 (version 005010X212) Technical Report Type 3 guide for Health Care Claim Status Request and Response has been established as the standard for claim status transactions and is available at http://www.wpc-edi.com
- Fallon Provider Portal containing documentation on transactions for providers is located at http://www.fchp.org/providers/provider-tools/electronic-data-submission.aspx

Technical Requirements

Fallon supports the 276/277 ASC X12N version 005010X212 for claim status requests and responses. Providers wishing to receive the 277 must support this version. We support both Real Time and batch transactions.

Real Time 276s have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed), and one claim loop. Typical turnaround time is within 20 seconds during which the portal connection is held open.

Batch 276s also have a single ST/SE loop, one information source, one information receiver, one subscriber loop, and one dependent loop (when needed) and one claim loop. Batch 277s can take up to 10 hours to process a response. A single 277 is created for each 276 submitted.

Fallon requires the following naming convention for all production files submitted: XXMMDDYYV1.276 and XXMMDDYYV1.277 (10-character maximum). The first two letters are used to identify trading partner, then two-digit month, two-digit day, two- digit year, version number, and production file indicator. If multiple files are to be sent on the same day, then version numbers would need to be sent as part of the file naming convention.

2. TESTING

Testing with Fallon

Fallon recommends that Trading Partners submit three successful and unique 276 submissions and receive the associated 277 responses in order to obtain approval from Fallon to promote to Production. Providers must coordinate with Fallon so that the necessary patient test data is available.

Fallon provides testing support Monday through Friday, 8:00AM to 5:00PM EST. We utilize Claredi for running test files for SNIP level I and II testing.

3. CONNECTING AND COMMUNICATING

Implementing EDI transactions with Fallon Contact an EDI Coordinator at:

Fallon Health: 1-866-275-3247, option 6, or e-mail edi.coordinator@fallonhealth.org

Set-up for direct submission to Fallon:

Providers wishing to request a claim status directly to Fallon in the EDI 276 format should contact an EDI Coordinator at 1-866-275-3247 or via e-mail to edi.coordinator@fallonhealth.org. The information necessary for implementation will be provided and an enrollment packet in PDF format can be obtained from the Fallon website at fallonhealth.org/providers/provider-tools/provider-tools-registration.aspx

Set-up for submission to Fallon via a clearinghouse

Providers wishing to submit a claim status to Fallon via a clearinghouse should contact the clearinghouse directly and provide them with our Payor ID number. A Payor ID number is required for claim submissions that go through a clearinghouse and is used to route your claims to the correct health plan for payment. Our contracted clearinghouses and associated Payor IDs are listed below:

- **Change Healthcare** (formerly Emdeon and WebMD)

Call 1-800-845-6592 or visit their website: changehealthcare.com.

Payor ID #22254

- **NEHEN**

  Call: 1-781-907-7210

  Website: nehen.org

  Email:members@nehen.org

- **Athena Health** (Billing Service)

  Call: 1-617-402-1000

  Website: athenahealth.com

FinThrive offers an accelerated registration process
Call: 1-800-390-7459
Website: Accelerated Deployment | FinThrive

Direct Connect is Available for Real Time 276 Transactions

Communication Methods Supported:
- The transport protocol is HTTPS over the Internet
- The message (payload) protocol can be either SOAP
- The content of the request and response is a standard X12N HIPAA transaction.

Technical standards and versions for HTTPS/SOAP are:
- HTTPS Version 1.1
- SOAP Version 1.2
- SSL Version 3
- WS-Security Version 1.x

Health Care Claim Status Request and Response Version 005010X212 Submissions & Response Pickups use MTOM to handle the file payloads.

Technical standards and versions for HTTPS are:
- HTTPS Version 1.1
- SSL Version 3
- Health Care Claim Status Request and Response Version 005010X212

CAQH SOAP – Fallon Health supports the use of HTTP SOAP + WSDL envelope standards as identified in CAQH CORE Phase II Connectivity standards (https://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270v5010.pdf). Fallon Health provides certificates to use in place of a user ID and password for SOAP upon completion of enrollment process.

SOAP Body Requirements

Element Name	Description
Payload Type	**X12_270_Request_005010X279A1**
Processing Mode	RealTime
Payload ID	Refer to Section 4.4.2 of the Phase II CORE 270: https://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf Example: e51d4fae-7dec-11d0-a765-00a0c91e6db3
Timestamp	Format is YYYY-MM-DDTHH:MM:SSZ. Refer to Section 4.4.2 of the Phase II CORE 270: https://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf Refer to - http://www.w3.org/TR/xmlschema11-2/%23dateTime for more information. Example: 2019-05-03T00:35:45+03:00
Sender ID	ISA06 value as assigned by Fallon Health
Receiver Id	ISA08 value as assigned by Fallon Health
CORERuleVersion	2.2.0
Payload	X12 request. This element must be digitally signed and the entire payload should be enclosed within a CDATA tag. **Note: No XML Exception characters (&, <, >) in the Payload XML message. When the XML exception characters are present in the Payload message, then they should be submitted with escape sequence.** **Example:** **& can be submitted in payload message as &** **< can be submitted in payload message as <** **> can be submitted in payload message as >**

Security

Fallon is dedicated to maintaining the confidentiality of personal health information. Fallon has adopted a mindset to safeguard member information as if it were our own. Associates are required to safeguard member privacy by using reasonable measures during all phases of the information-handling process: from collection and storage, to disclosure and disposal. This policy applies to the personally identifiable health information of all applicants and past or present members. Information may be in the form of data in storage or in transit, on paper or in electronic format.

Due to its sensitivity, the use and disclosure of PHI is restricted, except in circumstances where permitted or required by law or where appropriate authorization for use or disclosure is obtained. Access to PHI is limited to those with a business need to know the information for treatment, payment, or health care operations, or as otherwise permitted or required by law.

Associates with a business need to handle PHI must be identified and granted appropriate access in accordance with their department-level policies and procedures. Fallon maintains policies and procedures for the HIPAA compliant transfer of protected health information to external health care partners. These provisions include secure file transfer, encryption, password protection, secure fax, and other measures, as indicated based on the nature of the data being transferred.

System Availability

Fallon will be available to process Real Time and Batch transactions 24x7, except during routine maintenance windows. Routine Maintenance may be performed on Sundays.

Trading partners may receive rejection messages indicating that Fallon is unable to respond to their transactions. It is recommended that transactions submitted during this time be sent in Batch mode.

Maintenance

Routine downtime is scheduled weekly from 6 PM to 11 PM on Thursdays and 8 AM to 12 PM on Sundays to support maintenance and enhancements for all EDI transactions. Non-routine downtime will be communicated via email at least one week in advance. Emergency unscheduled downtime will be communicated to trading partners via email within one hour following the determination that emergency downtime is needed.

4. FALLON PROVIDER SUPPORT

If you cannot find the answers to your questions within this Companion Guide, please use the contact information below to reach our EDI Support team.

Fallon EDI Support : Phone: 1-866-275-3247 (Option 6)

Email : edi.coordinator@fallonhealth.org

EDI Support is available Monday through Friday, 8:00 AM to 5:00 PM EST, excluding the following major holidays:
New Year's Day (1/1)
Presidents Day (3 Monday in February) Memorial Day (Last Monday in May) Independence Day (7/4)
Labor Day (1st Monday in September) Thanksgiving Day (4th Thursday in November) Day after Thanksgiving Day
Christmas Day (12/25)

Fallon Provider Portal:

Fallon Provider Portal provides information regarding our Products, Policies and Procedures, FAQs, as well as Companion Guides for various electronic transactions. Please refer to the online documentation for the most up-to-date materials.

Fallon Website: http://www.fchp.org/providers.aspx

5. Fallon 276/277 PATIENT INFORMATION

Fallon processes 276 requests for Fallon members.

Identification Number Requirements

Fallon members IDs contain 13 numeric characters.
Note: Member IDs should not contain hyphens, spaces, or any special characters

Name Normalization

In accordance with CAQH CORE requirements and under the recommendation of the Massachusetts Administration Simplification Workgroup, Fallon normalizes the patient's last name and first name from the submitted 276 request and compares them to a normalized version of the patient information contained in Fallon's membership files. When making name comparisons:

- The match will not be case-sensitive
- All special characters within the basic character set are ignored:
  "!", "", "&", "", "(", ")", "*", "+", ",", "-", ".", "/", ":", ";", "?", "=" and space
- Special characters "&","<",">" should be submitted as shown below.
  & can be submitted in payload message as &
  < can be submitted in payload message as <
  > can be submitted in payload message as >

- All of the following character strings are ignored when they are:
- At the beginning of the data element and followed by a space, comma, or forward slash
- At the end of the data element and preceded by a space, comma, or forward slash

JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ

Patient Relationship

Subscriber Submitted as Dependent
If the patient is a dependent in Fallon's membership files, but was submitted in the Subscriber loop on the 276 request (2100C), the patient will be returned in the appropriate loop on the 277 response (2100D). Fallon will also return the corrected Subscriber information on the 2100C loop.

Dependent Submitted as Subscriber
If the patient is a subscriber in Fallon's membership files, but was submitted in the Dependent loop on the 276 request (2100D), the patient will be returned in the appropriate Subscriber loop on the 277 response (2100C).

6. Fallon276/277 CLAIM STATUS INFORMATION

Fallon Match Criteria

Fallon recommends submitting a Claim Status inquiry 30 days after a claim has been submitted for processing and a remittance has not been received.

Fallon evaluates certain data elements from the 276 request to use in finding a matching claim(s).

The following data elements must match the data elements submitted on the claim:
- Billing Provider's NPI (2100C NM109)
- Patient's Subscriber ID# (2100D/E NM109)
- Patient's Subscriber LastName# (2100D/E NM103)
- Patient's Dependent First LastName# (2100E NM104)
- Patient's Date of Birth (2100D/E DMG02)
- Date(s) of Service (2200D/E DTP03)

Fallon performs a "flexible" match by evaluating all matching claims found within the date of service range submitted.

The following data elements will be used as filters (if submitted) to return more specific claim(s):
- Payer Claim Control Number (REF01 = "1K")

If the 276 request includes a Fallon ICN (Internal Control Number) and that ICN matches a claim with all the criteria in section 6, only that claim will be returned on the 277 response.

- Patient Control Number (REF01 = “EJ”)

If the 276 request includes a Patient Account Number and that Patient Account Number matches a claim with all the criteria in section 6, only that claim will be returned on the 277 response.

277 Claim Level Information

- Fallon provides information regarding the status of your claim(s). Please see Appendix A for Fallon’s most common Claim Level STC code values.
- If multiple matching claims are identified, each claim will be returned in a separate 2200D/E segment on the 277 response.
- When a 277 response indicates that a claim is finalized, Fallon recommends referencing the 835 Health Care Claim Payment/Advice for more detailed information regarding the adjudication of your claim.

277 Claim Line Information

- Fallon provides information regarding the status of each claim line. Please see

Appendix B for Fallon’s most common Line Level STC code values.

- If a matching claim has multiple claim lines, each claim line will be returned in a separate 2220D/E segment on the 277 response.

277 Error Responses

Some scenarios may result in an error 277 response. Please see Appendix C for a list of error responses.

8 .7. 999 ACKNOWLEDGEMENT FOR HEALTH CARE INSURANCE

276 Claim Status Requests submitted to Fallon must be HIPAA compliant.

Fallon will issue a 999 Acknowledgment for Health Care Insurance (005010X231A1) when a 276 request (Batch or Real Time) fails validation of WEDI SNIP Type 1 and 2 HIPAA edits. Fallon sends a positive acknowledgement for successful 276 batch requests, but does not return a positive acknowledgment for real time requests (the 277 acts as the acknowledgment).

The purpose of the 999 Acknowledgment (Reject) is to identify critical errors within the 276 request based on the ASC X12N 276 (version 005010X212) Technical Report Type 3 guide. The submitter should review the 999 to determine what errors occurred.

8 . 276 DATA SPECIFICATIONS*

***Note:** All Data must be submitted in UPPER CASE. Leading spaces must be omitted. Trailing spaces must be omitted unless necessary to fulfill a minimum field length.

Header Data

Segment ID	Element ID	Data Element Name	Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"
	06	Interchange Sender ID	Value assigned by system
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	Value assigned by system
	14	Acknowledgment Requested	"0" (numeric)
	15	Interchange Usage Indicator	P – Production Requests T – Test Requests
GS		**Functional Group Header**	
	02	Application Sender's Code	Value assigned by system
	03	Application Receiver's Code	Value assigned by system
	08	Version/Release/Industry	"005010X212"

		Identifier Code	
BHT		**Beginning of Hierarchical Trans.**	
	02	Transaction Set Purpose Code	“13”

Loop Specific Data

Loop ID	Segment/ Element ID	Data Element Name	Business Rule
2100A	**NM1**	**Information Source Name**	
	01	Entity Identifier Code	“PR”
	03	Name Last or Organization Name	“FCHP”
	08	Identification Code Qualifier	“PI”
	09	Identification Code	“700”
2100B	**NM1**	**Information Receiver Name**	
	05	Information Receiver Name	Required
2100C	**NM1**	**Service Provider Name**	
	08	Identification Code Qualifier	“XX”
	09	Identification Code	The NPI of the Billing Provider that was submitted on the claim
2000D	**DMG**	**Subscriber Demographic Information**	
	02	Subscriber Birth Date	Required when the patient is the Subscriber
2100D	**NM1**	**Subscriber Name**	
	03	Subscriber Last Name	Required
	04	Subscriber First Name	Required if known
	08	Identification Code Qualifier	“MI”

	09	Identification Code	Required: This is the patient's member ID# (13 numerical characters) that displays on the insurance card.
2200D	**REF**	**Payer Claim Control Number**	**Use only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	If used, this is the Claim # (if known)

276/277 Fallon Health Companion Guide

2200D	**REF**	**Patient Control Number**	**Use only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"EJ"
	02	Reference Identification	If used, this is the patient's Patient Account # that was submitted on the claim
2200D	**AMT**	**Claim Submitted Charges**	**Use only if the patient is the Subscriber**
	02	Total Claim Charge Amount	Total claim charge amount that was submitted on the claim
2200D	**DTP**	**Claim Service Date**	**Use only if the patient is the Subscriber**
	03	Date Time Period	Claim date(s) of service that was submitted on the claim
2000E	**DMG**	**Dependent Demographic Information**	
	02	Dependent Birth Date	Required when the patient is a dependent
2100E	**NM1**	**Dependent Name**	
	03	Dependent Last Name	Required when the patient is a dependent
	04	Dependent First Name	Required when the patient is a dependent, if known
2200E	**TRN**	**Claim Status Tracking Number**	
	01	Trace type code	Required: Identifies which transaction is being referenced
	02	Reference Identification	Required: Provides unique identification for the transaction
2200E	**REF**	**Payer Claim Control Number**	
	01	Reference Identification Qualifier	"1K'
	02	Reference Identification	If used, this is the Claim # (if known)
2200E	**REF**	**Patient Control Number**	
	01	Reference Identification Qualifier	"EJ"
	02	Reference Identification	If used, this is the patient's Patient Account # that was submitted on the

			claim
2200E	**AMT**	**Claim Submitted Charges**	
	02	Total Claim Charge Amount	Total Claim charge that was submitted on the claim
2200E	**DTP**	**Claim Service Date**	
	03	Date Time Period	Claim date(s) of service that was submitted on the claim

9.277 DATA SPECIFICATIONS

Header Data

Segment ID	Element ID	Data Element Name	Business Rule
ISA		**Interchange Control Header**	
	05	Interchange ID Qualifier	"ZZ"
	06	Interchange Sender ID	ISA08 value from 276 request
	07	Interchange ID Qualifier	"ZZ"
	08	Interchange Receiver ID	ISA06 value from 276 request
	09	Interchange Date	Processed Date (in EST)
	10	Interchange Time	Processed Time (in EST)
GS		**Functional Group Header**	
	02	Application Sender's Code	GS03 value from 276 request
	03	Application Receiver's Code	GS02 value from 276 request
	04	Date	Processed Date (in EST)
	05	Time	Processed Time (in EST)
BHT		**Beginning of Hierarchical Transaction**	
	04	Date	Processed Date (in EST)
	05	Time	Processed Time (in EST)

Loop Specific Data

lement IDLoop ID	Segment/ Element ID	Data Element Name	Business Rule
2100A	**NM1**	**Payer Name**	
	01	Entity Identifier Code	"PR"
	03	Name Last or Organization Name	"FCHP"
	08	Identification Code Qualifier	"PI"
	09	Identification Code	"700"
2100B	**NM1**	**Information Receiver Name**	
	05	Information Receiver Name	Required
2100D	**NM1**	**Subscriber Name**	
	03	Subscriber Last Name	Subscriber's last name from the membership files.
	04	Subscriber First Name	Subscriber's first name from the membership files.
	05	Subscriber Middle Initial	Subscriber's middle initial from the membership files.
	09	Subscriber Primary Identifier	Required: This is the patient's member ID# (13 numerical characters) that displays on the insurance card.
2200D	**STC**	**Claim Level Status Information**	**Used only if the patient is the Subscriber**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim
	02	Status Information Effective Date	If the claim is finalized, this is the date the claim finalized. If the claim is pending or an error is encountered, this is the date the 277 was processed (in EST).

	04	Total Claim Charge Amount	The total claim charged amount
	05	Claim Payment Amount	The total claim payment amount
	06	Adjudication Finalized Date	If the claim is finalized, this is the date the claim finalized
2200D	**REF**	**Payer Claim Control Number**	**Used only if the patient is the Subscriber**
	01	Reference Identification Qualifier	"1K"

	02	Reference Identification	The claim #
2200D	**REF**	**Patient Control Number**	**Used only if the patient is the Subscriber**
	01	Reference Identification Qualifier	'EJ" is returned if the patient's Patient Account Number was submitted on the 276 request
	02	Reference Identification	This is the submitted patient's Patient Account #
2200D	**DTP**	**Claim Service Date**	**Used only if the patient is the Subscriber**
	03	Claim Service Period	The date(s) of service for the claim
2220D	**SVC**	**Service Line Information**	**Used only if the patient is the Subscriber**
	01-1	Product of Service ID Qualifier	"AD" if Dental claim "HC" if Professional claim OR if institutional claim line was submitted with HCPCS code "NU" if institutional claim line was submitted without HCPCS code
	01-2	Procedure Code	If SVC01-1 is "AD", this is the ADA Code If SVC01-1 is "HC", this is the HCPCS Code If SVC01-1 is "NU", this is the Revenue

	01-3 01-4 01-5	Procedure Code Modifiers	Code Up to 3 Procedure Code Modifiers (if used)
	02	Claim Line Charge Amount	The claim line charged amount
	03	Claim Line Payment Amount	The claim payment amount
	04	Revenue Code	If Institutional claim line was submitted with HCPCS Code, this is the Revenue Code
	07	Units of Service Count	The claim line units of service

2220D	**STC**	**Service Line Status Information**	**Used only if the patient is the Subscriber**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim line
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable)
			for the claim line
	02	Status Information Effective Date	If the claim is finalized, this is the date the claim finalized. If the claim is pending, this is the date the 277 was processed (in EST)
2220D	**DTP**	**Service Line Date**	**Used only if the patient is the Subscriber**
		Service Line Date	The date(s) of service for the claim line
2100E	**NM1**	**Dependent Name**	**Used only if the patient is a Dependent**
	03	Dependent Last Name	Dependent's last name from the membership files.
	04	Dependent First Name	Dependent's first name from the membership files.
	05	Dependent Middle Initial	Dependent's middle initial from the membership files.
2200E	**TRN**	**Claim Status Tracking Number**	
	01	Trace type code	Required: Identifies which transaction is being referenced
	02	Reference Identification	Required: Provides unique identification for the transaction
2200E	**STC**	**Claim Level Status Information**	**Used only if the patient is a Dependent**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim

	02	Status Information Effective Date	If the claim is finalized, this is the date the claim finalized. If the claim is pending or an error is encountered, this is the date the 277 was processed (in EST)
	04	Total Claim Charge Amount	The total claim charged amount
	05	Claim Payment Amount	The total claim payment amount
	06	Adjudication Finalized Date	If the claim is finalized, this is the date the claim finalized
2200E	**REF**	**Payer Claim Control Number**	**Used only if the patient is a Dependent**
	01	Reference Identification Qualifier	"1K"
	02	Reference Identification	The claim #
2200E	**REF**	**Patient Control Number**	**Used only if the patient is a Dependent**
	01	Reference Identification Qualifier	"EJ" is returned if the patient's Patient Account Number was submitted on the 276 request
	02	Reference Identification	This is the submitted patient's Patient Account #
2200E	**DTP**	**Claim Service Date**	**Used only if the patient is a Dependent**
	03	Claim Service Period	The date(s) of service for the claim
2200E	**SVC**	**Service Line Information**	**Used only if the patient is a Dependent**
	01-1	Product of Service ID Qualifier	"AD" if Dental claim "HC" if Professional claim OR if institutional claim line was submitted with HCPCS code "NU" if institutional claim line was submitted without HCPCS code
	01-2	Procedure Code	If SVC01-1 is "AD", this is the ADA Code If SVC01-1 is "HC", this is the HCPCS Code If SVC01-1 is "NU", this is the Revenue Code

	01-3 01-4 01-5	Procedure Code Modifiers	Up to 3 Procedure Code Modifiers (if used)
	02	Claim Line Charge Amount	The claim line charged amount
	03	Claim Line Payment Amount	The claim payment amount
	04	Revenue Code	If Institutional claim line was submitted
			with HCPCS Code, this is the Revenue Code
	07	Units of Service Count	The claim line units of service
2200E	**STC**	**Service Line Status Information**	**Used only if the patient is a Dependent**
	01-1	Health Care Claim Status Category Code	The Claim Status Category Code for the claim line
	01-2	Health Care Claim Status Code	The Claim Status Code for the claim line
	01-3	Entity Identifier Code	The Entity Identifier Code (if applicable) for the claim line
	02	Status Information Effective Date	If the claim is finalized, this is the date the claim finalized. If the claim is pending, this is the date the 277 was processed (in EST)
2200E	**DTP**	**Service Line Date**	**Used only if the patient is a Dependent**
		Service Line Date	The date(s) of service for the claim line

10.APPENDICES

Appendix A – Claim Level STC Responses

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…
A2	20		Claim has been accepted into the adjudication system for processing
A4	35		Claim not found; system was not able to find any claims matching the criteria described in Section 6

Claim Status Category Code (STC01-1)	Claim Status Code (STC01-2)	Entity Identifier Code (STC01-1)	Means…

D0	35		Claim not found; system was not able to find any claims matching the criteria described in Section 6

A7	0		Claim has been accepted and rejected for invalid information as specified in the status details
P1	20		Claim is pending in the adjudication system for processing
F1	65		Claim has completed processing and has been paid
F2	585		Claim has completed processing and was denied charge or Non-covered charge; please see the claim remittance advice for additional information
F3	101		Claim has completed processing; adjudication information has been changed

Appendix B – Line Level STC Responses

Claim Status Category Code (STC01-1)	**Claim Status Code (STC01-2)**	**Entity Identifier Code (STC01-1)**	**Means…**
P1	20		Claim service line is pending in the adjudication system for processing
F1	65		Claim service line has completed processing and has been paid
F2	585		Claim service line has completed processing and was denied charge or Non-covered charge; please see the claim remittance advice for additional information

Appendix C – Claim Level Error Responses

E1	484		System unable to respond at the current time; processing system unavailable

Appendix D – Sample 276 Request

```
ISA*00*       *00*       *ZZ*TEST       *ZZ*FCHPPARTY     *061107*1547*^*00501*000001000*0*T*:~
GS*HS*TEST*54763*20061107*1547*1*X*005010X212A1~
ST*276*0046*005010X212~
BHT*0022*13*2003032815473002*20030328*1547~
HL*1**20*1~
NM1*PR*2*FallonCommunity*****PI*0006362~
HL*2*1*21*1~
NM1*41*2*PROVIDER NAME*****XX*9999999999~
HL*3*2*19*1~
NM1*1P*2*PROVIDERLAST*PROVIDERFIRST****FI*9999999999~
HL*4*3*22*0~
DMG*D8*YYYYMMDD*F~
NM1*IL*1*Subscriber LAST*Subscriber FIRST****MI*9999999999~
TRN*1*TRACE NUMBER~
AMT*T3*XXX~
DTP*472*RD8*YYYYMMDD-YYYMMDD~
SE*15*0001~
GE*1*1~
IEA*1*000001000~
```

Appendix E – Sample 277 Response – TBD

```
ISA*00*       *00*       *ZZ*ISA08     *ZZ*ISA06      *131111*1358*^*00501*000001420*0*T*:~
GS*HS*ISA08     *ISA06      *20131111*1358*1420*T*005010X212A1~
ST*277*0001*005010X212~
BHT*0010*08*123*20131113*175216*DG~
HL*1**20*1~
NM1*PR*2*FallonCommunity*****PI*0006362~
HL*2*1*21*1~
NM1*41*2*PROVIDER NAME*****XX*9999999999~
HL*3*2*19*1~
NM1*1P*2*PROVIDERLAST*PROVIDERFIRST****FI*9999999999~
HL*4*3*22*0~
NM1*IL*1*Subscriber LAST*Subscriber FIRST****MI*9999999999~
TRN*2*TRACE NUMBER~
STC*XX:XX:IL:RX*20131113**0*0*20130619~
SVC*XX:XXXX*268*0****1~
STC*XX:XX:IL:RX*20131113~
DTP*472*D8*20130614~
SE*16*0001~
GE*1*1420~
IEA*1*000001420~
```

Appendix F – Revision History

Revision Number	Date	Section	Notes
0.1	10/24/2013	Full Document	Initial Draft
0.2	11/1/2013	Full Document	Updates from Walkthrough
0.3	11/5/2013	Full Document	Final revisions. Include input from Carol Pitts and Liza Moran via email.
0.4	12/31/2013	Sections 6 and 10	Updated based on feedback from EDI team during UAT testing.
0.5	6/19/2017	Maintenance	Updated Fallon Health EDI system Maintenance. Removed FTC information from CG.
0.6	4/10/2018	Section 3	Removed MIME.
0.6	4/10/2018	Section 3	Updated the clearing house information.
0.7	5/12/2018	Section 3	Updated Fallon Health Maintenance Information.
0.8	8/17/2018	Section 1	Updated the link to Fallon Health provider portal.
0.9	11/5/2019	Section 3 and Section 5	Updated CAQH SOAP & SOAP Body Requirements under Section 3 and Section 5. Special characters are updated.
1	1/14/2022	Section 3	Updated Fallon Health Maintenance Information.
1.1	3/29/2024	Section 3	Updated the clearing house information.