STATE of HAWAII DEPARTMENT of HUMAN SERVICES MED-QUEST DIVISION

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

Version 1.4
March 2016

Revision History

Version	Date	Description	Author
1.0	July 2012	Draft document for Unsolicited (277U) Encounter Status Transactions	MQD Information Services Division
1.1	Sep 2012	GS08 – Expect ‘003070X070	MQD Information Services Division
1.2	March 2013	Add New Status Code P5 = Pending/Payer Administrative/System hold 41 = Special handling required at payer site	MQD Information Services Division
1.2	April 2014	Include updated Interchange Flow Diagram	MQD Information Services Division
1.3	July 2014	Corrections and Clarifications to the following sections: 1.2, 2.1, 2.2, 3.1, 3.2, 5.2	MQD Information Services Division
1.4	March 2016	Updated reference to 14-digit Claim Reference number. Removed the reference to the 14-digit.	MQD Systems Office

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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 MQD.

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 MQD 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 MQD and MQD trading partners. MQD uses the unsolicited version of the 277 Transaction to inform submitting health plans of the statuses of encounters that have been adjudicated by MQD. For this transaction, the document describes the data sent electronically to MQD 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 MQD 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 MQD 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 MQD.

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 MQD uses to support implementation of 837 and NCPDP Transactions for encounters by returning information to health plans on encounters accepted and adjudicated by MQD.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between MQD 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, MQD 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 MQD 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)
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with MQD 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 MQD and other HIPAA covered entities. ▪ Detailed specifications that show how MQD expects to populate data elements in the 277 Unsolicited Encounter Status Transactions when MQD 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

MQD 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 MQD. Encounters that have been accepted by MQD and adjudicated by the Hawaii Pre-Paid Medical Management Information System (HPMMIS) are reported on the Unsolicited 277 Transaction. Encounters that have been pended or denied by HPMMIS as well as approved encounters are included.

Following periodic HPMMIS batch encounter adjudication, MQD 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 MQD and when they are pended for correction and require modification. For each health plan, encounters are in 277 sequence by Servicing Provider ID, MQD Recipient ID, and Encounter Reference Number.

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 MQD and used in preparation of this document is:

- ASC X12N 277 (003070X070) dated May 2003

An Addenda to this Guide has not been published. MQD MCOs may either purchase the 277U Implementation Guide or rely on MQD 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 MQD to return both the MQD 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 MQD uses on the 277U reflect encounter processing categories determined by HPMMIS. Complete translation of HPMMIS encounter error codes is not attempted.

Further information on the Status Category and Status Codes used by MQD 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 MQD, 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 MQD SFTP server following encounter processing.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

MQD Data Center Communications Requirements

The SFTS (Secure File Transfer Server) is the source of all file transfers between the MQD and the health plans. The SFTS accepts a standard web browser via Hypertext Transfer Protocol over Secure Socket Layer (HTTPS) and File Transfer Protocol (FTP) over Secure Shell (SSH) SFTP. The SFTS is available 24 hours a day, seven days a week. An Electronic Data Request form along with instructions will be made available to Health Plans in order to receive access to the SFTS. A health plan can request a service account which is used for automated processes as well as individual logon access. There will no longer be a generic logon account for each health plan.

Technical Assistance and Help

Med-QUEST Systems Office

System	Primary
All Systems	MQD Help Desk 692-7953
Encounter	Wileen Ortega 692-7990
Provider	Wileen Ortega 692-7990
Health Plan & Rosters Questions	Haidee Shaw 692-7963
VPN, Connectivity to MQD SFTP, Logins	Network Support 692-7953

To report problems, please send an email to mqdhelpdesk@medicaid.dhs.state.hi.us.

If your problem is critical to your operation, please call the above personnel.

For calls reaching Systems Office Staff voicemail, a customer can leave a message or press “03” and the call will be transferred to the MQD Help Desk for assignment. If you get the Help Desk voicemail, please leave a message and a SO staff member will return your call within 2 hours **(during normal business hours)**.

3.2 Directory and File Naming Conventions

SFTP Directory Naming Convention

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

SFTP\HPNAME\(PROD\TEST)\(EDI-IN\EDI-OUT)

- HPNAME – The Health Plan acronym assigned by MQD.
- Prod – The default directory name indicating it is the production environment.
- Test – The default directory name indicating it is the test environment.
- EDI-IN – The default directory name indicating inbound data.
- EDI-OUT – The default directory name that indicating outbound data.

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.

HIU277-nnnnnn-YYMMDD.TXT

- HI 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, MQD 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 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, MQD 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 MQD 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 MQD SFTP 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 MQD.

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 MQD.

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

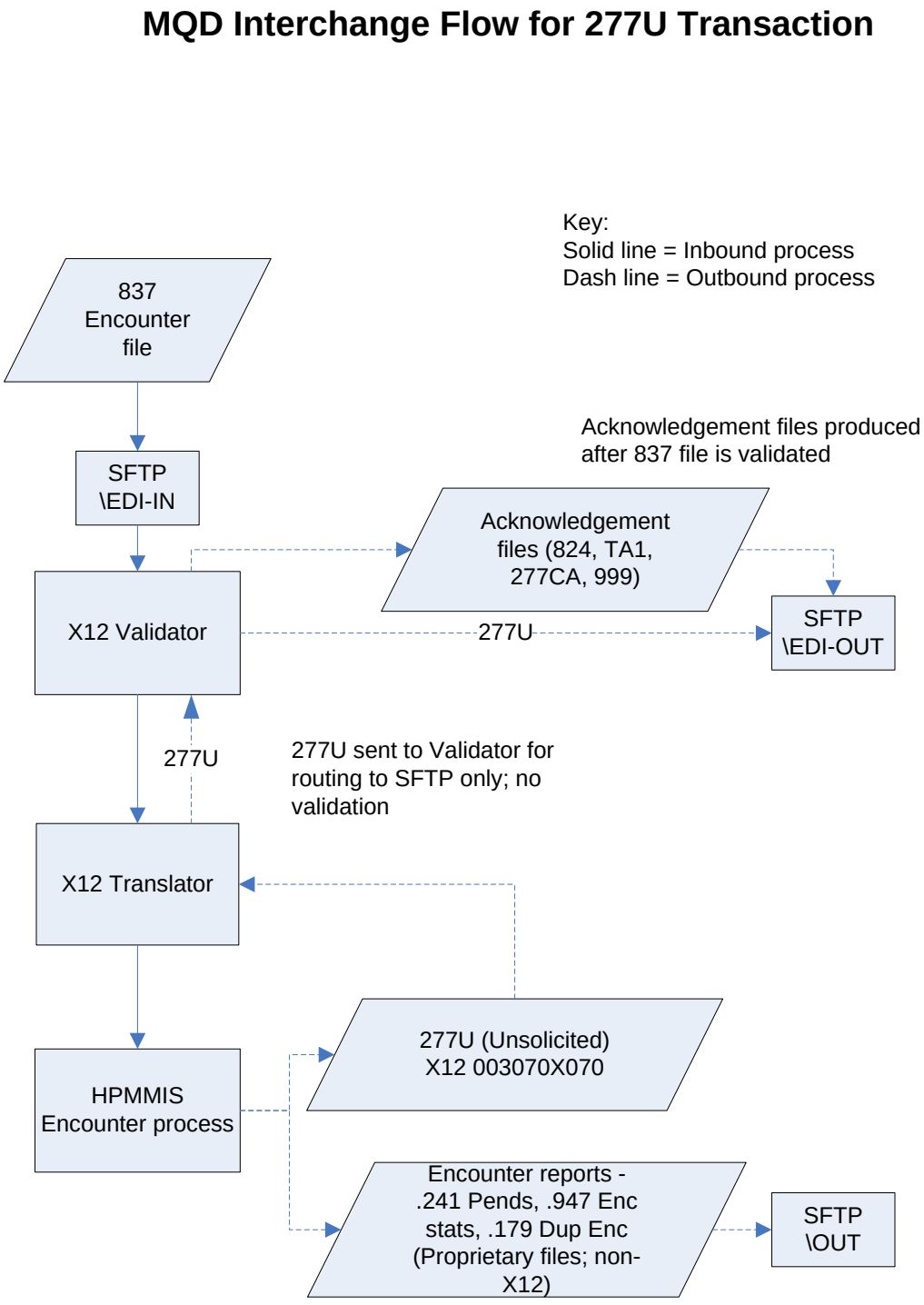
ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the 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 MQD
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 MQD
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		"MQD" followed by the nine-digit MQD Federal Tax ID number (996001089)
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 six-character Health Plan acronym plus the Health Plan Tax ID (HHHHHH990000000).
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 MQD does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the MQD translator will receive them and notify MQD 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 MQD 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 MQD on outgoing transactions:

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Segment Delimiter - “~’ (tilde – hexadecimal 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		"MQD" followed by the nine-digit MQD 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 six-digit Health Plan ID assigned by MQD.	Transmission sender
NA	GS	GS04	DATE	Date expressed as YYMMDD		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 MQD 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 MQD 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 MQD 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 HAWI ID. The length and format of the field are based on the characteristics of the MQD 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. MQD 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 MQD 277U Encounter Status Transaction. These elements tell encounter submitters the results of the periodic MQD encounter adjudication process. Approved, pended and denied encounters are included.

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 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 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.

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

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

STATUS CODES USED BY MED-QUEST ON THE 277U ENCOUNTER STATUS TRANSACTION				
HC Claim Status Category Code (STC01-1)	**Description**	**HC Claim Status Code (STC01-2)**	**Description**	**MQD Comments**
P1	Pending/In Process – The Claim or Encounter is in the Adjudication System	02	More detailed information in letter.	Refer to the .241 file for further info on the pended encounter.
F0	Finalized – The Claim or Encounter has completed the adjudication cycle and no more action will be taken	0	Cannot provide further status electronically.	Encounter has adjudicated successfully.
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	Encounter has been successfully Voided.
F3	Finalized/Revised – Adjudication information has been changed	0	Cannot provide further status electronically.	Encounter has been successfully Replaced.
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	Encounter will appear in MQD's system as Denied by Health Plan.
P5	Pending/Payer Administrative/System hold	41	Special handling required at payer site	Internal system issue with encounter to be resolved internally. Health Plan can disregard unless otherwise instructed by MQD.

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 MQD.

Definition/Format
Definitions of valid values used by MQD and additional information about MQD 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 MQD 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	0010	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 MQD 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 YYMMDD 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	MED-QUEST	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	996001089	The MQD 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 MQD, 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 MQD 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 MQD, 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 begins 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 MQD, 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 Or "No Name Available"
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 MQD 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 MQD, 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 MQD, 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 MQD.
2100D	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QC	Patient
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	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 MED-QUEST 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 MQD 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. 'No Data Available' for NCPDP transaction
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 HPMMIS. 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 HPMMIS. 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 MQD 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 Claim Reference number (CRN) assigned by MQD.
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

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 and pharmacy encounters. Expressed in format CCYYMMDD-CCYYMMDD
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	HC ND	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes National Drug Code The “HC” value is 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 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 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	0	Expect "0"
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 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 HPMMIS. 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 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 HPMMIS. 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 MQD Encounter Processing Date in YYMMDD format

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/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.
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 MQD Claim Reference Number (CRN) Suffix assigned to the service line.
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. 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 – in CCYYMMDD-CCYYMMDD format

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 MQD 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. 'No Data Available' for NCPDP transaction
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 HPMMIS. 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 HPMMIS. Specific code values and descriptions can be found in the Status Code Table earlier in this section.
2200D 2nd occurrence	STC	STC02	Status Information Effective Date	The date that the status information provided is effective		The MQD 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.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 Or "Health Plan CRN Not Available"
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
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

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
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 and pharmacy encounters. Expressed in format CCYYMMDD-CCYYMMDD
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	HC ND	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes National Drug Code The “HC” value is 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 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.
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.

277U ENCOUNTER STATUS TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2220D 2nd occurrence	SVC	SVC02	Line Item Charge Amount	Charges related to this service		For professional 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 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 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 HPMMIS. 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 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 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 HPMMIS. 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 MQD 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 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. 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 in CCYYMMDD-CCYYMMDD format
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.