16.

Claims and Reimbursement

Chapter Chairs:	Susan Lepping Siemens Medical Solutions Health Services
	Kathleen Connor Fox Systems Inc
	Francine Kitchen IDX Systems Corporation
Editors:	Beat Heggli HL7 Switzerland
	Michael van Campen, FM TC Co-Chair Gordon Point Informatics Ltd., HL7 Canada

16.1 CONTENTS

16.2   PURPOSE

This document contains the HL7 messaging specifications to support Claims and Reimbursement (CR) for the electronic exchange of health invoice (claim) data. The document is intended for use by benefit group vendors, Third Party Administrators (TPA) and Payers who wish to develop software that is compliant with an international standard for the electronic exchange of claim data.

The content of this document is not intended to be an alternative to or replacement for those ASC X12 standards mandated for use in this domain in the United States

16.2.1   Scope

The scope of the Claims and Reimbursement informative document defines the HL7 messaging and technical standards for:

- Electronic transmission of healthcare invoices, with supporting documents and reports, to authorized individuals and/or organizations;

- Inclusion of diagnostic and preventative intervention codes with each healthcare invoice;

- A query mechanism to allow authorized users to electronically inquire about information they have previously provided to a Payer;

- Minimum data sets;

- Minimum display and print standards; and

- Minimum data storage.

As used in this document the domain of Claims and Reimbursement excludes:

- Payer and benefit group specific processing and implementation rules;

- Jurisdictional specific processing and implementation rules;

- Processes for the submission of supporting documentation by third parties to Payers.

- Processes for the capture and processing of healthcare invoice data by a Provider;

- Processes for the adjudication, payment and reconciliation of healthcare invoices by a Payer;

- Referrals between Providers;

- Electronic funds transfer (EFT) messages; and,

- Implementation of the standard.

16.3   TRIGGER EVENTS AND MESSAGE DEFINITIONS

16.3.1 EHC^E01 – Submit HealthCare Services Invoice (event E01)

This message is used to submit a HealthCare Services Invoice to a TPA/Payer for processing and payment. A HealthCare Services Invoice may have 1 or more Product/Service Line Items (detail lines), grouped as a Product/Service Group. Each Product/Service Line Item represents a specific fee item. Refer to the beginning of this section for more information on the structure of a HealthCare Services Invoice.

This message can be used to submit a HealthCare Services Invoice or to resubmit a previously submitted HealthCare Services Invoice (in case it was not properly acknowledged the first time that it was submitted). This message cannot be used to update an Invoice (e.g., add or cancel Product/Service Line Items) or cancel a HealthCare Services Invoice. To cancel a HealthCare Services Invoice, use the EHC^E02 – Cancel HealthCare Services Invoice message. To update a HealthCare Services Invoice it must first be cancelled (see EHC^E02 – Cancel HealthCare Services Invoice) and then re–submitted using this message with new Invoice numbers.

This message can also be used as a Pre-Determination message. This allows a Provider Application to submit a HealthCare Services Invoice to a Payer Application and run it through the Payer's edit and adjudication engine. The only difference between a Pre-Determination Invoice and a regular Invoice is the Payer will not pay the Pre-Determination Invoice. Setting the Invoice Control on IVC to "PD" identifies a Pre-Determination Invoice.

Note that an EHC^E12 – Request Additional Information (pending) is a valid response for an EHC^E01 – Submit HealthCare Services Invoice. In this case, the interactions would be EHC^E01 -> EHC^E12 (pending).

Processing Rules:

1) Where multiple Payers can pay Invoices, they must be sent to Payers in the order identified as primary, secondary, tertiary, etc. Rules for determining primary, secondary, tertiary, etc. are not set in this document; these are set out by agencies in various jurisdictions.
   In addition, an Invoice must only be sent to a subsequent Payer (e.g., secondary) once Edit/Adjudication results have been received from a prior Payer (e.g., primary).

2) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
   These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.
   The Provider Invoice Number and Payer Invoice Number must be echoed on any subsequent interactions for the Invoice between the Provider Application and Payer Application.

3) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
   If the Payer Application accepts the Invoice, the Provider Application must store 2 tracking numbers for each Product/Service Line Item, if present in the message pair. The Payer Application must also store 2 tracking numbers for each Product/Service Line Item, if present in the message pair.
   The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

4) Each Product/Service Line Item must reference Location Identification information, which is defined by the LOC segment. Location Identification information may be specified with the Invoice, Product/Service Group and/or Product/Service Line Item.
   If specified with the Invoice Information, then the Location Identification information acts as a default for all Product/Service Line Items in the Invoice.
   If specified with the Product/Service Group Information, then the Location Identification

information acts as a default for all Product/Service Line Items in the Product/Service Group. If specified with the Product/Service Line Item, then the Location Identification information supersedes (replaces) any defaults set by specifying Location Identification information with the Invoice or Product/Service Group.

Location Identification information must be specified with the Product/Service Line Item if it has not been defaulted for the Invoice or Product/Service Group.

5) Some Payers require Provider Information to be included with an Invoice, which is defined by the ROL segment. In these situations, the ROL segment may be specified with the Invoice, Product/Service Group and/or Product/Service Line Item (note that the ROL segment also appears with Procedure Information, which is not covered by this processing rule).

If specified with the Invoice Information, then the Provider Information acts as a default for all Product/Service Line Items in the Invoice.

If specified with the Product/Service Group Information, then the Provider Information acts as a default for all Product/Service Line Items in the Product/Service Group.

If specified with the Product/Service Line Item, then the Provider information supersedes (replaces) any defaults set by specifying Provider information with the Invoice or Product/Service Group.

Provider Information, if required by the Payer, must be specified with the Product/Service Line Item if it has not been defaulted for the Invoice or Product/Service Group.

6) If Authorization Information is entered (AUT segment), then either the Authorization Identifier on AUT or Name of Authorizer on AUT must be specified.

7) The Billed Amount on PSG must be equal to the sum of all Product/Service Billed Amounts on PSL for all Product/Service Line Items for the particular Product/Service Group.

8) Procedures: If a PR1 segment (procedure/service) is specified for a particular patient, then the Provider performing the Procedure must be specified (using the corresponding ROL segment) if different from the Primary Care Provider specified for the same Product/Service Line Item.

9) The Product/Service Billed Amount on PSL must be equal to the Product/Service Gross Amount on PSL + sum of all Adjustment Amount on ADJ for all Provider Adjustments for the particular Product/Service Line Item. That is, the gross amount + any adjustments such as taxes, mark ups, dispensing fees, etc. must equal the billed amount.

The Product/Service Billed Amount on PSL should be the amount the Provider is billing and should include all adjustments and all unit cost multipliers.

10) Product/Service Clarification Codes: Each Product/Service Line Item allows a number of clarification codes to be specified. These are specified as 2 fields: Product/Service Clarification Code Type and Product/Service Clarification Code Value. Both of these fields repeat within the PSL segment and must repeat the same number of times. For example, if 2 clarification codes are specified, then 2 repetitions of each field is required, the first repetition corresponding to the 1st clarification code, the second repetition corresponding to the 2nd clarification code.

11) Re-submitting an Invoice: If an Invoice or component is resubmitted with corrections (this rule does not apply to Invoices re-submitted in whole, without modification, due to network problems, etc.), new Invoice, Product/Service Group and Product/Service Line Items must be specified (for the subsequent Invoice).

12) A single group cannot have both multiple Patients and multiple Product/Service Line Items for the same Product/Service Group. In this situation, the multiple Patient and Product/Service Line Item must be split into multiple Product/Service Groups.

EHC^E01^EHC_E01	Submit HealthCare Services Invoice	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Software		2
[{ UAC }]	User Authentication Credential		2
	--- INVOICE_INFORMATION begin		
IVC	Invoice		16
[PYE]	Payee Information		16

```
EHC^E01^EHC_E01                 Submit HealthCare Services Invoice        Status    Chapter
[ { CTD } ]                     Contact Data
[ AUT ]                         Authorization Information
[ { LOC } ]                     Location Identification                               8
[ { ROL } ]                     Role                                                 15
{                               --- PRODUCT_SERVICE_SECTION begin
  PSS                           Product/Service Section                              16
  {                             --- PRODUCT_SERVICE_GROUP begin
    PSG                         Product/Service Group                                16
    [ { LOC } ]                 Location Identification
    [ { ROL } ]                 Role                                                 15
    [ {                         --- PATIENT_INFO begin
      PID                       Person Identification                                 3
      [ PV1 ]                   Patient Visit                                         3
      [ PV2 ]                   Patient Visit - Additional Info                       3
      [ { ACC } ]               Accident
      {                         --- INSURANCE begin
         IN1                    Insurance
         [ IN2 ]                Insurance Additional Info
      }                         --- INSURANCE end
      [ {                       --- DIAGNOSIS begin
        DG1                     Diagnosis
        [ { NTE } ]             Notes and Comments
      } ]                       --- DIAGNOSIS end
      [ { OBX } ]               Observation
    } ]                         --- PATIENT_INFO end
    {                           --- PRODUCT_SERVICE_LINE_ITEM begin
      PSL                       Product/Service Line Item                            16
      [{ NTE }]                 Notes and Comments
      [{ ADJ }]                 Adjustment                                           16
      [ AUT ]                   Authorization Information
      [{ LOC }]                 Location Identification
      [{ ROL }]                 Role                                                 15
    }                           --- PRODUCT_SERVICE_LINE_ITEM end
    [ {                         --- PROCEDURE begin
      PR1                       Procedures
      [{NTE}]                   Notes and Comments
      [{ROL}]                   Role
    } ]                         --- PROCEDURE end
    [ {                         --- INVOICE_PROCESSING begin
      IPR                       Invoice Processing Results
    }]                          --- INVOICE_PROCESSING end
  }                             --- PRODUCT_SERVICE_GROUP end
}                               --- PRODUCT_SERVICE_SECTION end
                                --- INVOICE INFORMATION end
```

16.3.2 EHC^E02 – Cancel HealthCare Services Invoice (event E02)

This message is used to cancel one HealthCare Services Invoices or one Product/Service Group in an Invoice or one Product/Service Line Item in an Invoice that have previously been submitted to a TPA/Payer for processing and payment. Invoice Control codes are used to indicate the specific action being requested of the Payer (CN for Cancel Invoice, CG for Cancel Product/Service Group and CI for Cancel Product/Service Line Item). An Invoice that is cancelled must be marked as cancel only and not purged from the Payer Application's database.

The Payer may/may not be able to cancel the Invoice/Product/Service Line Item, and will indicate processing results in the response message. In some situations, the Payer has already paid the Product/Service Line Item, and therefore will hold a debit amount for the Payee until subsequent billing from the Payee utilizes the debit amount.

This message cannot be used to cancel or remove ancillary information for an Invoice and/or Product/Service Line Item such as Authorization or Contact information or any referenced health documents.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) At least one NTE segment must be included with this message to describe the cancellation reason for each Product/Service Line Item. The NTE segment may be specified with the Invoice (following the IVC segment) and applies to all Product/Service Line Items for that Invoice. If not specified with the Invoice, then it must be specified for each Product/Service Line Item (following the PSL segment).

4) Sending Organization and Sending Application on input message must be the same as the Sending Organization and Sending Application from the original Invoice (submitted via the EHC^E01 – Submit HealthCare Services Invoice message) for the specified Invoice being queried.

5) Provider reference numbers and Payer reference numbers must exist on Payer Application's database and must point to the same Invoice, Product/Service Group or Product/Service Line Item, otherwise an error must be generated (mismatched Invoice and/or Product/Service Line Item).

6) Product/Service Clarification Codes: Each Product/Service Line Item allows a number of clarification codes to be specified. These are specified as 2 fields: Product/Service Clarification Code Type and Product/Service Clarification Code Value. Both of these fields repeat within the PSL segment and must repeat the same number of times. For example, if 2 clarification codes are specified, then 2 repetitions of each field is required, the first repetition corresponding to the 1st clarification code, the second repetition corresponding to the 2nd clarification code.

7) To cancel an Invoice, use Invoice Control Code on IVC of "CN". In addition, the following fields must be supplied and must match the original Invoice submitted:
HDR.Sending Organization
IVC.Provider Organization
IVC.Invoice Amount
IVC.Provider Invoice Number
IVC.Payer Invoice Number
PYE.Payee Identification List

8) To cancel a Product/Service Group within an Invoice, use Invoice Control Code on IVC of "CG". In addition, the following fields must be supplied and must match the original Invoice submitted:
HDR.Sending Organization
IVC.Provider Organization
IVC.Invoice Amount
IVC.Provider Invoice Number
IVC.Payer Invoice Number
PYE.Payee Identification List
PSG.Provider Product/Service Group Number
PSG.Payer Product/Service Group Number

9) To cancel a Product/Service Line Item within an Invoice, use Invoice Control Code on IVC of "CI". In addition, the following fields must be supplied and must match the original Invoice submitted:

HDR.Sending Organization
IVC.Provider Organization
IVC.Invoice Amount
IVC.Provider Invoice Number
IVC.Payer Invoice Number
PYE.Payee Identification List
PSG.Provider Product/Service Group Number
PSG.Payer Product/Service Group Number
PSL.Provider Product/Service Line Item Number
PSL.Payer Product/Service Line Item Number
PSL.Product/Service Code
PSL.Product/Service Effective Date
PSL.Billed Amount

10) This message must not be used to cancel a Product/Service Line Item in a Product/Service Group which was submitted with Adjudicated as Group = "Y".

```
EHC^E02^EHC_E02                     Cancel HealthCare Services Invoice        Status    Chapter
MSH                                 Message Header                                      2
[ { SFT } ]                         Secondary Header                                    2
[ { UAC } ]                         User Authentication Credential                      2
                                    --- INVOICE_INFORMATION begin
IVC                                 Invoice                                             16
PYE                                 Payee Information                                   16
[ { CTD } ]                         Contact Data
[ { NTE } ]                         Notes and Comments
[ {                                 --- PRODUCT_SERVICE_SECTION begin
    PSS
  [ {                               --- PSG begin
    PSG                             Product/Service Group
    [ { PSL } ]                     Product/Service Line Item
  } ]                               --- PSG end
} ]                                 --- PRODUCT_SERVICE_SECTION end
                                    --- INVOICE_INFORMATION end
```

16.3.3 QBP^E03 – Query HealthCare Services Invoice Status (event E03)

This message is used to query the status of a HealthCare Services Invoice. There are 3 types of queries handled by this message: 1) a specific Invoice, 2) a specific Product/Service Group or 3) a specific Product/Service Line Item. If a Provider wants to obtain information on a group of invoices (e.g., submitted in a date range), each individual Invoice must be queried.

This message may also be used to query an Invoice submitted at another Network Application ID and Network Facility ID, as long as sufficient identification information is provided to qualify the request and requestor. These are noted as Processing Rules for this message.

Note that the response to this query has the same content as an EHC^E10 – Edit/Adjudication Results message.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
   These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
   The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent

interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) A unique query identifier (Query Tag on QPD) must be generated for each query. Provider Invoice Number + Payer Invoice Number + Product/Service Line Item Number on input message must exist on Payer Application's database and must point to the same Product/Service Line Item, otherwise an error must be generated (mismatched Invoice and/or Product/Service Line Item).

4) To query an Invoice, the following fields must be supplied and must match the original Invoice submitted:
QPD.Sending Organization
QPD.Provider Organization
QPD.Invoice Amount
QPD.Provider Invoice Number
QPD.Payer Invoice Number
QPD.Payee Identification List

5) To query a Product/Service Group within an Invoice, the following fields must be supplied and must match the original Invoice submitted:
QPD.Sending Organization
QPD.Provider Organization
QPD.Invoice Amount
QPD.Provider Invoice Number
QPD.Payer Invoice Number
QPD.Payee Identification List
QPD.Provider Product/Service Group Number
QPD.Payer Product/Service Group Number

6) To query a Product/Service Line Item within an Invoice, the following fields must be supplied and must match the original Invoice submitted:
QPD.Sending Organization
QPD.Provider Organization
QPD.Invoice Amount
QPD.Provider Invoice Number
QPD.Payer Invoice Number
QPD.Payee Identification List
QPD.Provider Product/Service Group Number
QPD.Payer Product/Service Group Number
QPD.Provider Product/Service Line Item Number
QPD.Payer Product/Service Line Item Number

QBP^E03^QBP_E03	Query HealthCare Services Invoice	Status	Chapter
MSH	Message Header		2
[{ SFT }]	Secondary Header		2
[{ UAC }]	User Authentication Credential		2
	--- QUERY_INFORMATION begin		
QPD	Query Parameter Definition		5
RCP	Response Control Parameter		5
	--- QUERY_INFORMATION end		

16.3.4 RSP^E03 – HealthCare Services Invoice Status Query Response (event E03)

This message is used to respond to a QPB^E03 – Query HealthCare Services Invoice. It provides Invoice and invoice processing information to a Provider.

A QBP^E03 – Query HealthCare Services Invoice can be used to query against an Invoice or a specific Product/Service Line Item in an Invoice. The same response message, RSP^E03 – HealthCare Services Invoice Query Response, is used for both types of query.

Processing Rules:

1) Provider Invoice Number + Payer Invoice Number + Product/Service Line Item Number on input message must exist on Payer Application's database and must point to the same Product/Service Line Item, otherwise an error must be generated (mismatched Invoice and/or Product/Service Line Item).

2) Sending Organization and Sending Application on input message must be the same as the Sending Organization and Sending Application from the original Invoice (submitted via the EHC^E01 – Submit HealthCare Services Invoice message) for the specified Invoice being queried.

3) A unique query identifier (Query Tag on QPD) must be generated for each query.

```
RSP^E03^RSP_E03                    HealthCare Services Invoice Query Response   Status   Chapter
MSH                                Message Header                                        2
[ { SFT } ]                        Software                                              2
[ { UAC } ]                        User Authentication Credential                        2
MSA                                Message Acknowledgement                               2
[ { ERR } ]                        Error                                                 2
                                   --- QUERY_ACK begin
QAK                                Query Acknowledgement
QPD                                Query Parameter Definition
[ {                                --- INVOICE_PROCESSING_RESULTS_INFO begin
   IPR                             Invoice Processing Results                            16
} ]                                --- INVOICE_PROCESSING_RESULTS_INFO end
                                   --- QUERY_ACK end
```

16.3.5 EHC^E04 – Re-Assess HealthCare Services Invoice Request (event E04)

This message is used to submit a single Re-Assess HealthCare Services Invoice Request to a TPA/Payer for processing. The Re-Assess HealthCare Services Invoice Request is used by a Provider, to request review of a previously adjudicated HealthCare Services Invoice, with optional specification of a Product/Service Line Item within that Invoice. Note that the HealthCare Services Invoice need not necessarily be sent to a TPA/Payer using the EHC^E01 – Submit HealthCare Services Invoice: it may be manually submitted.

Adjudication for a HealthCare Services Invoice may be re-assessed either because background information, such as a Provider's billing rate may have changed or if some of the adjudication rules have changed since original adjudication of the Invoice.

This message cannot be used to change or delete information from the HealthCare Services Invoice. The only information allowed in this message are Provider Invoice Number and Payer Invoice Number, and optional notes to assist in the re-assessment by the TPA/Payer.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent

interactions for the Product/Service Line Item between the Provider Application and Payer Application.

```
EHC^E04^EHC_E04             Re-Assess HealthCare Services Invoice    Status    Chapter
                            Request
MSH                         Message Header                                     2
[ { SFT } ]                 Software                                           2
[ { UAC } ]                 User Authentication Credential                     2
                            --- REASSESSMENT_REQUEST_INFO begin
IVC                         Invoice                                            16
[ { NTE } ]                 Notes and Comments
[ {                         --- PRODUCT_SERVICE_SECTION begin
   PSS                      Product/Service Section                            16
  [ {                       --- PRODUCT_SERVICE_GROUP begin
    PSG                     Product/Service Group
    [ { PSL } ]             Product/Service Line Item                          16
  } ]                       --- PRODUCT_SERVICE_GROUP end                      16
} ]                         --- PRODUCT_SERVICE_SECTION end
                            --- REASSESSMENT_REQUEST_INFO end
```

16.3.6 EHC^E10 – Edit/Adjudication Results (event E10)

This message is used to send edit and/or adjudication results for a HealthCare Services Invoice. Edit/Adjudication results are sent to the same Network Application ID that originated the Invoice, which was specified as the Sending Application on MSH on the original HealthCare Services Invoice.

This message is returned to a Provider Application each time an EHC^E01 – Submit HealthCare Services Invoice message is successfully processed by a Payer Application. As a minimum, the EHC^E10 – Edit/Adjudication Results message will contain the Payer Applications' Invoice number (Payer Invoice Number on IVC), status codes for each Product/Service Line Item in the Invoice and optionally, a tracking number for the Payer Application (Payer Tracking Number on PSL).

Note that an EHC^E12 – Request Additional Information (pending) is a valid response for an EHC^E01 – Submit HealthCare Services Invoice. In this case, the interactions would be EHC^E01 -> EHC^E12 (pending). If the Payer Application is able to process the Invoice on-line, the EHC^E10 – Edit/Adjudication Results message will contain the Invoice Processing Results portion completely filled out, indicating the results of the adjudication (e.g., paid as submitted, paid partial, etc.).

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
   These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
   The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) The EHC^E10 – Edit/Adjudication Results message must only report against one HealthCare Services Invoice within a message. In other words, each IPR in this message must have the same Provider Invoice Number on IVC and the same Payer Invoice Number for all repetitions of the IVC segment in this message.

4) The Provider Invoice Number on IVC must be the same as the Provider Invoice Number on IVC as specified on the EHC^E01 input message. In other words, this message must be used to respond to the incoming EHC^E01 and not a previous EHC^E01 HealthCare Services Invoice.

Only IPRs for the Invoice specified on the EHC^E01 may be included in the EHC^E10 response.

```
EHC^E10^EHC_E10              Edit/Adjudication Results                Status    Chapter
MSH                          Message Header                                     2
[ { SFT } ]                  Software                                           2
[ { UAC } ]                  User Authentication Credential                     2
MSA                          Message Acknowledgement                            2
[ { ERR } ]                  Error                                              2
{                            --- INVOICE_PROCESSING_RESULTS_INFO begin
   IPR                       Invoice Processing Results                         16
   [ { NTE } ]               Notes and Comments
   PYE                       Payee                                              16
   IN1                       Insurance                                          3
      [ IN2 ]                Insurance Additional Info
   IVC                       Invoice
   {                         PRODUCT_SERVICE_SECTION begin
    PSS                      Product/Service Section                            16
     {                       PRODUCT_SERVICE_GROUP begin
      PSG                    Product/Service Group                              16
       {                     --- PRODUCT/SERVICE LINE_INFO  begin
        PSL                  Product/Service Line Item                          16
       [{ ADJ }]             Adjustment
       }                     --- PRODUCT_SERVICE_LINE_INFO end
     }                       PRODUCT_SERVICE_GROUP end
   }                         PRODUCT_SERVICE_SECTION end
}                            --- INVOICE_PROCESSING_RESULTS_INFO end
```

16.3.7 EHC^E12 – Request Additional Information (event E12)

A Payer or TPA uses this message to request additional information in support of an Invoice or a (Pre) Authorization Request. Normally, this request would be sent following receipt of an E01 or E20 message. However, it can also be sent following receipt of an E04 Re-Assess HealthCare Services Invoice Request. In this latter case the request for additional information still has as its object the original invoice (which is now under review) rather than the Re-assessment request per se.

The E12 can only be used to initiate a request for information and cannot be used to modify, place on hold or cancel an earlier request. This message cannot be used to convey information on the status of a claim and/or adjudication results (i.e., cannot be used in place of an E10 Edit/Adjudication Results message).

The scope of the request for additional information is defined through the inclusion of contextual data from the original Invoice or (Pre) Authorization Request. By specifying a particular Product/Service Group, patient and/or Product/Service Line item the requested information (e.g., a discharge narrative) is deemed to apply to those particular service events and not to any others which may have been part of the original Invoice or (Pre) Authorization Request.

In terms of absolute limits the E12 request is restricted to a single Product/Service Group from the original Invoice or (Pre) Authorization Request.   Thereafter, the context can be more narrowly defined by inclusion of patient and/or Product/Service Line item information from within the same Product/Service Group. Thus, if a particular P/S Line Item is included, the message recipient must interpret this to mean that the request is related to that one line item. If the P/S Line Item is excluded the request is related to any and all line items in the original Product/Service Group. Similarly for patients: identification of a particular patient restricts the request to that patient alone, whereas omission of patient information means that the request applies to any and all patients identified in the original Product/Service Group.

The E12 message is restricted to zero or one patients and to zero or one Product/Service Line items. One consequence of these limits is that a Payer requiring information about a variety of patients or products/services from an original invoice may have to generate multiple (E12) requests.

The E12 message requires the use of LOINC classification standard to describe the information being requested (as do the E13/14 response messages). The codified request can also be supplemented by free-form text if greater specificity is required.

This message supports the use of pre-defined responses. That is, the sender specifies both the request as well as a range of possible answers for the recipient to choose from. This is an optional usage that is designed for real-time environments in which the Payer employs an adjudication engine to both solicit the additional information and manage the responses.

Processing Rules:

1) The Payer application must have already received an Invoice, (Pre) Authorization Request or Re-assessment request before a Request for Additional Information can be issued.

2) The Payer Application must uniquely identify each request. The Payer Application specifies its unique Request number as the Placer Order Number in the OBR segment. The number is comprised of the Payer Application's NAID + a unique sequence number.

3) Interpretative Rule: Patient Consent. If Patient Consent in the RFI segment is marked "Y" (Yes) the Payer is signifying possession of proof of patient consent for release of confidential information.

4) This request message is restricted to zero or one patients. If information is required for multiple patients in an original invoice or (pre) authorization request, a separate message is required for each individual.

5) Interpretative Rule: If the optional PID segment is omitted, the receiving system will interpret this to mean that the information request applies to any and all patients associated with the Product/Service Group in the original Invoice or (Pre) Authorization request. (See E01 message for rules governing the construction of Product/Service Groups.)

6) The Provider Organization, as identified in the IVC segment is normally responsible for responding to the request for additional information. However, the sender may identify an alternate individual or department as responsible for responding to the Request for Additional Information using the CTD segment of the Information Request. In such a case the Role field must be set to "FL" = Filler.

7) All data supplied in the IVC, PSG, and PID segments must be identical to that in the original invoice or (pre) authorization request.

8) With the exception of "Payer Tracking Number" and "Product/Service Line Item Status" all data supplied in the PSL segment must be identical to that in the original invoice or (pre) authorization request.

9) Interpretive Rule: Inclusion of Product/Service Line item information implies that the request is directly related to the Product/Service described in PSL. Omitting this optional segment implies that the request is related to all product/service line items in the original Product/Service Group. (See E01 message for rules governing the construction of Product/Service Groups.)

```
EHC^E12^EHC_E12              Request Additional Information          Status    Chapter
MSH                         Message Header                                    2
[ { SFT } ]                 Software                                          2
[ { UAC } ]                 User Authentication Credential                    2
RFI                         Request for Information
{ [ CTD } ]                 Contact Data
IVC                         Invoice                                 Identi
                                                                    fier.
PSS                         Product/Service Section
PSG                         Product/Service Group
[ PID ]                     Person Identification
[ { PSL } ]                 Product/Service Line Item
{                           --- REQUEST begin
  [ CTD ]                   Contact Data
  OBR                       Observation Request
  [ NTE ]                   Notes and Comments
  [ { OBX } ]               Observation Results
}                           --- REQUEST end
```

16.3.8 EHC^E13 – Additional Information Response (event E13)

This message is used by a Provider to immediately respond to an EHC^E12 Request for Additional Information, in other words an automated response. The EHC^E13 message cannot be sent unsolicited.

The EHC^E13 message supports three types of response modalities:

- Free-form ASCII text. This is generally brief, descriptive text that is formulated to be read by a human recipient.

- Attachments. The primary content is a multimedia attachment containing the information that has been requested. Depending upon agreements between the Provider and Payer this attachment may contain human-readable information, codified data that can be manipulated by an application, or some combination of the two.

- Pre-defined responses. The Payer has posed both a question and a range of possible answers that the responder chooses from when formulating the reply. The question and answers are codified so that they can be manipulated by an application.

The structure of the EHC^E13 message closely follows that of the EHC^E12 request, which in turn is patterned on the Invoice or (Pre) Authorization which preceded the request for additional information. The hierarchical structural of the message indicates the context of the request for additional information and the data being supplied in the response. More specifically, the EHC^E12 request is formulated against a particular Product/Service Group (from the earlier Invoice or (Pre) Authorization Request) and may be further circumscribed by reference to a particular patient and/or Product/Service Line Item from within that Product/Service Group. The parameters set by the EHC^E12 request are re-iterated in the EHC^E13 response message so that the receiving system can interpret the return data in the appropriate context without necessarily having to refer to the original Invoice or (Pre) Authorization request.

Parties to the Request for Additional Information and the Response:

- The individual or organization that initiates the request for additional information is described as the "Placer". (Normally, this would be the individual in the Payer organization that has placed the Invoice or (Pre) Authorization Request in suspense pending the return of the additional information that is being requested.)

- The individual or organization that is responsible for the information being sent in reply is described as the "Filler". (Normally, the Primary Care Provider would be responsible for supplying the requested information however, in some cases the Payer and/or Provider may stipulate some other party as the Filler.)

- The individual or organization that the response is to be directed to is described as the "Payer Contact".

The EHC^E13 message uses the LOINC classification standard to describe the information being sent. Local codes are also supported. The message allows the use of free-form text to supplement the coding schemes if greater specificity is required.

The EHC^E13 message supports the use of attachments. All attachments must follow the HL7 Claim Attachments implementation guide for additional information to support a healthcare claim or encounter standard that is described in Health Level Seven (HL7) Version 2.4 Standard; Implementation Guide: *"Additional information message implementation guide, HL7 version 2.4 Standard, Release 1.0, NPRM Draft, December 11, 2001"*.

The EHC^E13 message supports the inclusion of multiple attachments, i.e., multiple instances of the ESDA, through repetition of the OBX segment. However, this use is NOT recommended. The ESDA specification permits multiple objects (documents, images etc.) to be imbedded in the attachment, so, when responding to a single OBR, a single OBX (with attached multi-part ESDA) should be the preferred method of returning the additional information.

Processing Rules:

1) The Provider Application must uniquely identify each request. The Provider Application specifies its unique Request number as the Filler Order Number in the OBR segment. The number itself is comprised of the Provider Application's NAID + a unique sequence number.

2) The Person or organization supplying the additional information is described as the "Filler" and must be identified in the CTD segment of the Information Request. When another party is responsible for producing a particular piece of data (e.g., an external laboratory) that Person or organization is described in the OBX fields: "Producer's ID" and/or "Responsible Observer". Usage: The Producer's ID field can be used to identify an external agency or organization that is responsible for the observation, e.g., a laboratory. The Responsible Observer field is used to describe the individual who either performed or verified the observation.
If these fields are null the receiving system assumes that the Filler produced the results.

3) All data supplied in the IVC, PSG, PID and PSL segments must be identical to that in the EHC^E12 Request message.

4) Interpretive Rule: the presence of the PSL segment in the message indicates that the information supplied in the response message is directly related to the Product/Service described in the PSL segment.

5) Interpretive Rule: the presence of the PID segment in the message indicates that the information supplied in the response message is directly related to the Patient described in the PID segment.

6) If the Placer has supplied a set of pre-defined responses (i.e., the EHC^E12 message contains one or more OBX segments) then Observe Results Status must be completed. Valid value is "F" - Final value (an Affirmative response). Only OBX segments containing an Observe Results Status = "F" are included in the message.

7) When attaching multimedia documents: OBX.2 is set to "ED", the mime-encoded document (per ESDA specification) is inserted in OBX.5 and the TXA segment must be completed. The Unique Document Identifier in TXA must be identical to the Health Document Reference Identifier in the ESDA header.

8) Informative Rule: Document Confidentiality Status on TXA. When this optional field is completed it indicates that the Payer is to restrict access to the attached document according to the Payer's established policies and/or in accordance with prior business agreements between the Provider and Payer.

```
EHC^E13^EHC_E13                  Additional Information Response          Status    Chapter
MSH                              Message Header
[ { SFT } ]                      Software
[ { UAC } ]                      User Authentication Credential                        2
MSA                              Message Acknowledgement
[ {ERR} ]                        Error
RFI                              Request for Information
{ [ CTD ] }                      Contact Data
IVC                              Invoice
PSS                              Product/Service Section
PSG                              Product/Service Group
[ PID ]                          Person Identification
[ PSL ]                          Product/Service Line Item
{                                --- REQUEST begin
  [ CTD ]                        Contact Data
  OBR                            Observation Request
  [ NTE ]                        Notes and Comments
  {                              --- RESPONSE begin
    OBX                          Observation Result
    [ NTE ]                      Notes and Comments
    [ TXA ]                      Transcription Document Header
  }                              --- RESPONSE end
}                                --- REQUEST end
```

16.3.9   EHC^E15 – Payment/Remittance Advice (event E15)

This message is used to send a payment/ remittance advice to a Payee for the payment of HealthCare Services Invoices and/or other adjustments.   The Payment/Remittance Advice can be sent to the originating Provider Application (Network Application ID) or alternately to the Payee's Network Application ID, depending on how the Payee has been configured by the Payer. If a Payment/Remittance Advice is paid by check, it typically has a 1 to 1 correspondence with a check number. However, there are occasions when one check number covers multiple Payment/Remittance Advices. This message does not enforce a 1 to 1 relationship between check number and Payment/Remittance Advice. That is, the same check number (Check Number on PMT) can be used on multiple Payment/Remittance Advices.

A Payment/Remittance Advice may not be generated if a Payee is a Person and not an organization (Payee Type on PYE = "PERS" or "PPER").

Once an EHC^E15 message is prepared (which may be on a regular basis such as monthly or bi-weekly), it is either sent to the Provider Application (if the Provider Application is able to receive unsolicited results) or stored on a queue for the Provider Application. If left on a queue for the Provider Application, then the QBP^E99 message must be used by the Provider Application to poll the Payer Application for the EHC^E15.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Invoice, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Invoice, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) The Payer Application must uniquely identify each Payment/Remittance Advice. The unique Payment/Remittance Advice identifier must be specified as Payment/Remittance Advice Number on PMT.

4) At least one of Payment/Remittance Detail Information or Adjustment(s) to Payee block must be specified with this message (see EHC^E15 – Message Summary for details) to describe the details of the Payment/Remittance Advice.

5) The Payment/Remittance Amount on PMT must equal to the sum of all Adjudicated/Paid Amount for all IPR segments PLUS the sum of all Adjudication/Paid Amounts for all ADJ segments in the Payment/Remittance Advice, excluding information adjustment types (Adjustment Category on ADJ = "IN").

```
EHC^E15^EHC_E15                 Payment/Remittance Advice                Status    Chapter
MSH                             Message Header                                     2
[ { SFT } ]                     Software                                           2
[ { UAC } ]                     User Authentication Credential                     2
                                --- PAYMENT_REMITTANCE_HEADER_INFO begin
PMT                             Payment Information                                16
PYE                             Payee Information                                  16
                                --- PAYMENT_REMITTANCE_HEADER_INFO End
[ {                             --- PAYMENT_REMITTANCE_DETAIL_INFO begin
  IPR                           Invoice Processing Results
  IVC                           Invoice
    {                           --- PRODUCT_SERVICE_SECTION begin
      PSS                       Product/Service Section
      {                         --- PRODUCT_SERVICE_GROUP begin
```

```
EHC^E15^EHC_E15                    Payment/Remittance Advice                     Status    Chapter
      PSG                         Product/Service Group
       {                          --- PSL_ITEM_INFO begin
        PSL                       Product/Service Line Item
       [{ ADJ }]                  Adjustment
        }                         --- PSL_ITEM_INFO end
      }                           --- PRODUCT_SERVICE_GROUP end
    }                             --- PRODUCT_SERVICE_SECTION end
} ]                               --- PAYMENT_REMITTANCE_DETAIL_INFO End
[ {                               --- ADJUSTMENT_PAYEE begin
  ADJ                             Adjustment
  [ ROL ]                         Role
} ]                               --- ADJUSTMENT_PAYEE end
```

16.3.10   EHC^E20 – Submit Authorization Request (event E20)

This message is used to submit a single Authorization Request to a TPA/Payer for authorization (for payment). An Authorization Request is made for one or more patients and may include 1 or more Product/Service Line Items (detail lines), each of which represents a specific, billable item or Payer allowed Treatment Plan.

If the Authorization is approved, then the Payer Application will return either an Authorization Number (Authorization Identifier on AUT) or individual who has authorized the Authorization Request (Name of Authorizer on AUT). The Authorization Number is not the same number as the Authorization Request Number; the latter indicates the number used to identify the request for authorization. The presence of the AUT segment in the EHC^E24 – Authorization Request Response message implies authorization. However, the Authorization may be restricted, which is described as Payer Adjustments.

This message can be used to submit an Authorization Request or to resubmit an Authorization Request (in case it was not properly acknowledged the first time that it was submitted). This message cannot be used to update an Authorization Request (e.g., add or cancel Product/Service Line Items) or cancel an Authorization Request. To cancel an Authorization Request, use the EHC^E21 – Cancel Authorization Request message. To update an Authorization it must first be cancelled (see EHC^E21 – Cancel Authorization Request) and then re–submitted using this message with new Provider control numbers.

Processing Rules:

1)   The Provider Application and the Payer Application must uniquely identify each Authorization Request, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Authorization Request, group or line item between the Provider Application and Payer Application.

2)   The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
If the Authorization Request is successfully accepted by the Payer Application, the Provider Application must store up to 2 tracking numbers for each Product/Service Line Item, if present in the message pair. The Payer Application must also store up to 2 tracking numbers for each Product/Service Line Item, if present in the message pair.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3)   This message can contain only one Authorization Request, directed to a single Payer Organization, with multiple patients and multiple insurance policies for each patient. If there are multiple insurance policies and/or Payers identified for authorization, the EHC^E20 – Submit Authorization Request message must be sent to each TPA/Payer.

4)   Location Identification information, defined by the LOC segment, may be specified with the Authorization Request (header) or Product/Service Line Item.

If specified with the Authorization Request (header), then the Location Identification information acts as a default for all Product/Service Line Items in the Authorization Request. If specified with the Product/Service Line Item, then the Location Identification information supersedes (replaces) any defaults set by specifying Location Identification information with the Authorization Request (header).

5) Some Payers require Provider information to be included with an Authorization Request, which is defined by the ROL segment. In these situations, the ROL segment may be specified with the Authorization Request (header) and/or Product/Service Line Item.
If specified with the Authorization Request (header), then the Provider Information acts as a default for all Product/Service Line Items in the Authorization Request.
If specified with the Product/Service Line Item, then the Provider Information supersedes (replaces) any defaults set by specifying Provider information with the Authorization Request (header).
Provider Information, if required by the Payer, must be specified with the Product/Service Line Item if it has not been defaulted for the Authorization Request (header).

6) Product/Service Clarification Codes: Each Product/Service Line Item allows a number of clarification codes to be specified. These are specified as 2 fields: Product/Service Clarification Code Type and Product/Service Clarification Code Value. Both of these fields repeat within the PSL segment and must repeat the same number of times. For example, if 2 clarification codes are specified, then 2 repetitions of each field is required, the first repetition corresponding to the 1st clarification code, the second repetition corresponding to the 2nd clarification code.

```
EHC^E20^EHC_E20                 Submit Authorization Request            Status   Chapter
MSH                             Message Header                                   2
[ { SFT } ]                     Software                                         2
[ { UAC } ]                     User Authentication Credential                   2
                                --- AUTHORIZATION_REQUEST begin
IVC                             Invoice Header                                   16
{ CTD }                         Contact Data
[ { LOC } ]                     Location Identification
[ {   ROL } ]                   Provider Identification
{                               --- PAT_INFO begin
  PID                           Person Identification
  [ { ACC } ]                   Accident
  {                             --- INSURANCE begin
    IN1                         Insurance
    [ IN2 ]                     Insurance Additional Info
  }                             --- INSURANCE end
  [                             --- DIAGNOSIS begin
   {
    DG1                         Diagnosis
    [{ NTE }]                   Notes and Comments
   }
  ]                             --- DIAGNOSIS end
  [ { OBX } ]                   Observation
}                               --- PAT_INFO end
{                               --- PSL_ITEM_INFO begin
  PSL                           Product/Service Line Item
  [ { NTE } ]                   Notes and Comments
  [ { ADJ } ]                   Adjustment
  [ { LOC } ]                   Location Identification
  [ { ROL } ]                   Role
}                               --- PSL_ITEM_INFO End
                                --- AUTHORIZATION_REQUEST end
```

16.3.11 EHC^E21 – Cancel Authorization Request (event E21)

This message is used to cancel an Authorization Request, as a result of a previously submitted EHC^E20 – Submit Authorization Request message.

This message can be used to cancel the entire Authorization Request, or an individual Product/Service Line Item within an Authorization Request.

This message cannot be used to update ancillary information in an Authorization that has been submitted to a Payer. The original request must be cancelled, and a new Authorization Request submitted to the Payer.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Authorization Request, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Authorization Request, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) An Authorization Request can be cancelled regardless of its status with the Payer (i.e., whether approved, denied, pending or status unknown).

4) At least one NTE segment must be included with this message to describe the cancellation reason for each Product/Service Line Item. The NTE segment may be specified with the (Pr) Authorization Request (following the IVC segment) and applies to all Product/Service Line Items for that Authorization Request. If not specified with the Invoice, then it must be specified for each Product/Service Line Item (following the PSL segment).

5) Sending Organization and Sending Application on input message must be the same as the Sending Organization and Sending Application from the original request (submitted via the EHC^E20 – Submit Authorization Request message).

6) Provider reference numbers must exist on Payer Application's database and must point to the same Invoice, Product/Service Group or Product/Service Line Item; otherwise, an error must be generated (mismatched Invoice and/or Product/Service Line Item).

```
EHC^E21^EHC_E21              Cancel Authorization Request              Status    Chapter
MSH                         Message Header                                       2
[ { SFT } ]                 Software                                             2
[ { UAC } ]                 User Authentication Credential                       2
                            --- AUTHORIZATION_REQUEST begin
IVC                         Invoice Header                                       16
{                           --- PSL_ITEM_INFO begin
  PSL                       Product/Service Line Item                            16
  [ { NTE } ]               Notes and Comments
  [ AUT ]                   Authorization                                        16
}                           --- PSL_ITEM_INFO end
                            --- AUTHORIZATION_REQUEST end
```

16.3.12 QBP^E22 – Query Authorization Request Status (event E22)

This message is used to query the status of an Authorization Request. There are 2 types of queries handled by this message: 1) a specific Authorization Request or 2) a specific Product/Service Line Item. If a Provider wants to obtain information on a group of Authorization Requests (e.g., submitted in a date range), each individual Authorization Request must be queried.

Note: The response to this query has the same content as an EHC^E24 – Authorization Response message.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Authorization Request, Product/Service Group, Product/Service Line Item and Adjustment.

These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Authorization Request, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer Application.

3) A unique query identifier (Query Tag on QPD) must be generated for each query.

4) Selection criteria for one of the 2 supported methods must be entered as below:

Query for a specific Authorization Request:

- Sending Application on MSH.

- Sending Organization from original Authorization Request (Sending Organization on QPD).

- Provider Organization from original Authorization Request (Provider Organization on QPD).

- Payer Organization from original Authorization Request (Payer Organization on QPD).

- Provider Invoice Number on QPD.

- Payer Invoice Number on QPD.

Query for a specific Product/Service Line Item - same as Query for a specific Authorization Request PLUS:

- Product/Service Line Item (Product/Service Line Item Number on QPD).

5) Sending Organization and Sending Application on input message must be the same as the Sending Organization and Sending Application from the original Authorization Request (submitted via the EHC^E20 – Submit Authorization Request message).

6) Provider Invoice Number + Payer Invoice Number + Product/Service Line Item Number on input message must exist on Payer Application's database and must point to the same Product/Service Line Item, otherwise an error must be generated (mismatched Authorization Request and/or Product/Service Line Item).

```
QBP^E22^QBP_E22              Query Authorization Request              Status    Chapter
MSH                          Message Header                                        2
[ { SFT } ]                  Software                                              2
[ { UAC } ]                  User Authentication Credential                        2
                             --- QUERY begin
QPD                          Query Parameter Definition                            5
RCP                          Response Control Parameter                            5
                             --- QUERY end
```

16.3.13 RSP^E22 – Authorization Request Status Query Response (event E22)

This message is used to respond to a QPB^E22 – Query Authorization Request Status. It provides Authorization status information to a Provider.

A QBP^E22 – Query Authorization Request Status can be used to query against a Authorization Request or a specific Product/Service Line Item in a Authorization Request. The same response message, RSP^E22 – Authorization Request Query Response, is used for both types of query.

Processing Rules:

1) Provider Invoice Number + Payer Invoice Number + Product/Service Line Item Number on

input message must exist on Payer Application's database and must point to the same Product/Service Line Item; otherwise, an error must be generated (mismatched Authorization Request and/or Product/Service Line Item).

2) Sending Organization and Sending Application on input message must be the same as the Sending Organization and Sending Application from the original Authorization Request (submitted via the EHC^E20 – Submit Authorization Request message) for the specified Authorization Request being queried.

3) A unique query identifier (Query Tag on QPD) must be generated for each query.

```
RSP^E22^RSP_E22                      Authorization Request Query Response    Status   Chapter
MSH                                  Message Header                                   2
[ { SFT } ]                          Software                                         2
[ { UAC } ]                          User Authentication Credential                   2
MSA                                  Message Acknowledgement                          2
[ { ERR } ]                          Error                                            2
                                     --- QUERY_ACK begin
QAK                                  Query Acknowledgement
QPD                                  Query Parameter Definition
[                                    --- AUTHORIZATION_INFO begin
   IVC                               Invoice
   PSG                               Product/Service Group
   {                                 --- PSL_ITEM_INFO begin
      PSL                            Product/Service Line Item
   }                                 --- PSL_ITEM_INFO end
]                                    --- AUTHORIZATION_INFO end
                                     --- QUERY_ACK end
```

16.3.14 EHC^E24 – Authorization Response (event E24)

This message is used to send results of an Authorization Request to a Provider Application. Authorization results are sent to the same Network Application ID that originated the Authorization Request, which was specified as the Sending Application on MSH on the original Authorization Request.

If the Payer Application is able to process the Authorization Request on-line, the EHC^E24 – Authorization Response message will contain the results of the authorization (e.g., approved, not approved).

If the Payer Application is **not** able to process the Authorization Request on-line, it creates an EHC^E24 – Authorization Response message once it has processed the Authorization Request (which may be the next day following receipt of the EHC^E20). Once prepared, the EHC^E24 is either sent to the Provider Application (if the Provider Application is able to receive unsolicited results) or stored on a queue for the Provider Application. If left on a queue for the Provider Application, then the QBP^E99 message must be used by the Provider Application to poll the Payer Application for the EHC^E24. If the Authorization is approved, then the Payer Application will return either an Authorization Number (Authorization Identifier on AUT) or individual who has authorized the Authorization Request (Name of Authorizer on AUT). The presence of the AUT segment in the EHC^E24 – Authorization Request Response message implies authorization has been granted. However, the Authorization may be restricted. Restrictions are specified under Payer Adjustments.

Processing Rules:

1) The Provider Application and the Payer Application must uniquely identify each Authorization Request, Product/Service Group, Product/Service Line Item and Adjustment.
These numbers appear as a pair on the IVC, PSG, PSL and ADJ segments and must be echoed on any subsequent interactions for the Authorization Request, group or line item between the Provider Application and Payer Application.

2) The Provider Application and/or Payer Application may also supply a tracking number for each Product/Service Line Item it processes, specified as the Provider Tracking Number or Payer Tracking Number.
The Provider Tracking Number and Payer Tracking Number must be echoed on any subsequent interactions for the Product/Service Line Item between the Provider Application and Payer

Application.

3) The presence of the AUT segment in the EHC^E24 – Authorization Response message indicates the Payer's approval of the Authorization Request (with or without Payer Adjustments).

4) If the AUT segment is specified, then either the Authorization Identifier on AUT or Name of Authorizor on AUT must be specified.

5) The Provider Invoice Number on IVC must be the same as the Provider Invoice Number on IVC as specified on the EHC^E20 input message. In other words, this message must be used to respond to the incoming EHC^E20 and not a previous EHC^E20 Authorization Request.

```
EHC^E24^EHC_E24                Authorization Response                     Status     Chapter
MSH                            Message Header
[ { SFT } ]                    Software
[ { UAC } ]                    User Authentication Credential                          2
MSA                            Message Acknowledgement
[ { ERR } ]                    Error
                               --- AUTHORIZATION_RESPONSE_INFO begin
IVC                            Invoice
{                              --- PSL_ITEM_INFO begin
  PSL                          Product/Service Line Item
  [ AUT ]                      Authorization
  [                            --- PAYER_ADJUSTMENT Begin
   {
     ADJ                       Adjustment
   }
  ]                            --- PAYER_ADJUSTMENT end
}                              --- PSL_ITEM_INFO end
                               --- AUTHORIZATION_RESPONSE_INFO end
```

16.3.15 EHC^E30 – Submit Health Document related to Authorization Request (event E30)

Not yet defined.

16.3.16 EHC^E31 – Cancel Health Document related to Authorization Request (event E31)

Not yet defined.

16.4 MESSAGE SEGMENTS

16.4.1 RFI – Request for Information

HL7 Attribute Table – RFI – Request for Information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	Element Name
1	24	DTM	R			01910	Request Date
2	24	DTM	R			01911	Response Due Date
3	1	ID	O		0136	01912	Patient Consent
4	24	DTM	O			01913	Date Additional Information was submitted

16.4.1.0   RFI field definitions

16.4.1.1   RFI-1   Request Date   (DTM)   01910

Definition:

16.4.1.2   RFI-2   Response Due Date   (DTM)   01911

Definition: The latest date by which the additional information is to be returned to requestor.

16.4.1.3   RFI-3   Patient Consent   (ID)   01912

Definition: Code indicating if the Payer has obtained patient consent for release of information (1) – Optional. Refer to *HL7-Table 0136 – Yes/No-Indicator* for suggested values.

16.4.1.4   RFI-4   Date Additional Information was submitted   (DTM)   01913

Definition: The date on which the information was assembled for transmission to the Payer. Not necessarily the same as the message date.

16.4.2   IVC – Invoice Segment

The Invoice segment is used for HealthCare Services Invoices and contains header style information for an invoice including invoice numbers, Provider Organization and Payer Organization identification.

<div align="center">HL7 Attribute Table – IVC – Invoice Segment</div>

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	74	EI	R			01914	Provider Invoice Number
2	74	EI	O			01915	Payer Invoice Number
3	74	EI	O			01916	Contract/Agreement Number
4	2	IS	R		0553	01917	Invoice Control
5	4	IS	R		0554	01918	Invoice Reason
6	2	IS	R		0555	01919	Invoice Type
7	24	DTM	R			01920	Invoice Date/Time
8	254	CP	R			01921	Invoice Amount
9	80	ST	O			01922	Payment Terms
10	183	XON	R			01923	Provider Organization
11	183	XON	R			01924	Payer Organization
12	637	XCN	O			01925	Attention
13	1	ID	O		0136	01926	Last Invoice Indicator
14	24	DTM	O			01927	Invoice Booking Period
15	250	ST	O			01928	Origin
16	254	CP	O			01929	Invoice Fixed Amount
17	254	CP	O			01930	Special Costs
18	254	CP	O			01931	Amount for Doctors Treatment
19	250	XCN	O			01932	Responsible Physician
20	250	CX	O			01933	Cost Center
21	254	CP	O			01934	Invoice Prepaid Amount
22	254	CP	O			01935	Total Invoice Amount without Prepaid Amount
23	254	CP	C			01936	Total-Amount of VAT
24	1024	NM	O	Y		01937	VAT-Rates applied
25	4	IS	R		0556	01938	Benefit Group
26	20	ST	O			02038	Provider Tax ID
27	20	ST	O			02039	Payer Tax ID

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
28	4	IS	O		0572	02040	Provider Tax status
29	4	IS	O		0572	02041	Payer Tax status
30	20	ST	O			02042	Sales Tax ID

16.4.2.0 IVC field definitions

16.4.2.1 IVC-1 Provider Invoice Number (EI) 01914

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Invoice Number assigned by the Provider Application.

16.4.2.2 IVC-2 Payer Invoice Number (EI) 01915

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Invoice Number assigned by the Payer Application.

16.4.2.3 IVC-3 Contract/Agreement Number (EI) 01916

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Contract/agreement number issued by Payer which must be specified in some circumstances by the Provider.

16.4.2.4 IVC-4 Invoice Control (IS) 01917

Definition: Code indicating what action is being performed by this message. Refer to *User-defined Table 0553 – Invoice Control Code* for suggested values.

User-defined Table 0553 – Invoice Control Code

Code	Description	Comment
OR	Original Invoice	
CN	Cancel Invoice	Can be used to reverse or cancel an invoice in progress or reverse a paid invoice. Receiver may only mark Invoice as cancelled, not purge records
CG	Cancel Invoice Product/Service Group	Cancel a specific Product/Service Group in an Invoice
CL	Cancel Invoice Product/Service Line Item	Cancel a specific Product/Service Line Item in an Invoice
PD	Pre-Determination Invoice	Can be used to submit an invoice through a Payer's edit and adjudication engine to determine if the invoice will be paid – does not result in payment by Payer
RA	Re–Assessment	Used on EHC^E04 only
OA	Original Authorization	
SA	Special Authorization	
AI	Combined Authorization and Adjudication request	
PA	Pre-Authorization	
AA	Authorization request for inpatient admission	
EA	Authorization request for inpatient stay extension	
RC	Referral Pre-Authorization	
CA	Cancel Authorization request	
CP	Copy of Invoice	
CQ	Coverage Register Query	
RU	Referral authorization	

16.4.2.5   IVC-5   Invoice Reason   (IS)   01918

Definition: Code describing reason for this Invoice. Refer to *User-defined Table 0554 – Invoice Reason Codes* for suggested values.

User-defined Table 0554 – Invoice Reason Codes

Code	Description	Comment
LATE	Late Invoice	Over the Payer's published time limit for this invoice
NORM	Normal submission	
SUB	Subscriber coverage problem	

16.4.2.6   IVC-6   Invoice Type   (IS)   01919

Definition: Code indicating the type of Invoice. Refer to *User-defined Table 0555 – Invoice Type* for suggested values.

User-defined Table 0555 – Invoice Type

Code	Description	Comment
FS	Fee for Service	
SS	By Session	
GP	Group	
BK	Block	
SL	Salary	
IN	Information Only	Payee information not required for this Invoice Type
NP	Non Patient	Invoice without a patient. E.g. bulk invoicing for Pharmacy for a care facility.
FN	Final	Final Invoice
PA	Partial	Partial Invoice
SU	Supplemental	Supplemental Invoice

16.4.2.7   IVC-7   Invoice Date/Time   (DTM)   01920

Definition: Date Invoice was created.

16.4.2.8   IVC-8   Invoice Amount   (CP)   01921

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Sum total of Product/Service Billed Amount on PSL for all Product/Service Line Items for this Invoice.

16.4.2.9   IVC-9   Payment Terms   (ST)   01922

Definition: Terms for Payer payment of Invoice (e.g., 24% net 30 days).

16.4.2.10 IVC-10   Provider Organization   (XON)   01923

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
        <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
        Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
        <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
        <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
        & <Universal ID Type (ID)>
```

```
Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>
```

Definition: Business organization that is responsible for the invoice (e.g., Provider organization, clinic organization).

16.4.2.11 IVC-11 Payer Organization (XON) 01924

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
          <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
          Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
          <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
          <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>
```

Definition: The business organization that is designated as Payer for this Invoice. This Payer may be the primary, secondary, tertiary Payer, depending on Insurance Information specified in the Invoice

16.4.2.12 IVC-12 Attention (XCN) 01925

```
Components:  <ID Number (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and
          Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III)
          (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <DEPRECATED-Degree (e.g., MD) (IS)> ^
          <Source Table (IS)> ^ <Assigning Authority (HD)> ^ <Name Type Code (ID)> ^
          <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Identifier
          Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code
          (ID)> ^ <Name Context (CWE)> ^ <DEPRECATED-Name Validity Range (DR)> ^
          <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
          (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^
          <Assigning Agency or Department (CWE)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
          Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
          Partner/Spouse (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
          & <Universal ID Type (ID)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Name Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
          End Date/Time (DTM)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
          <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
          Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
          Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
          Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
          (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
          <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
          System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
          <Original Text (ST)>
```

Definition: Attention to individual in Payer Organization who needs to review this Invoice.

16.4.2.13 IVC-13 Last Invoice Indicator (ID) 01926

Definition: Can be set to indicate that this is the last Invoice for a particular Case, Claim and/or Encounter (1). Refer to *HL7-Table 0136 – Yes/No-Indicator* for suggested values.

16.4.2.14   IVC-14   Invoice Booking Period   (DTM)   01927

Definition: Period in which the invoice must be booked.

16.4.2.15   IVC-15   Origin   (ST)   01928

Definition: Responsible Person for this specific invoice. For more structured output use CTD-Segment instead.

16.4.2.16   IVC-16   Invoice Fixed Amount   (CP)   01929

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Fixed Amount for this invoice.

16.4.2.17   IVC-17   Special Costs   (CP)   01930

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Special costs for this invoice.

16.4.2.18   IVC-18   Amount for Doctors Treatment   (CP)   01931

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Special amount for doctor's treatment.

16.4.2.19   IVC-19   Responsible Physician   (XCN)   01932

```
Components:  <ID Number (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and
             Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III)
             (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <DEPRECATED-Degree (e.g., MD) (IS)> ^
             <Source Table (IS)> ^ <Assigning Authority (HD)> ^ <Name Type Code (ID)> ^
             <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Identifier
             Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code
             (ID)> ^ <Name Context (CWE)> ^ <DEPRECATED-Name Validity Range (DR)> ^
             <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
             (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^
             <Assigning Agency or Department (CWE)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
             Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
             Partner/Spouse (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>
```

```
Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Name Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
        End Date/Time (DTM)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
        <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
        Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
        Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
        Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
        (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
        <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
        System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
        <Original Text (ST)>
```

Definition: Doctor who is responsible for this invoice.

16.4.2.20   IVC-20   Cost Center   (CX)   01933

```
Components:  <ID Number (ST)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme
        (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
        <Assigning Facility (HD)> ^ <Effective Date (DT)> ^ <Expiration Date (DT)>
        ^ <Assigning Jurisdiction (CWE)> ^ <Assigning Agency or Department (CWE)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
        & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
        & <Universal ID Type (ID)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
        <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
        Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
        Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
        Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
        (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
        <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
        System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
        <Original Text (ST)>
```

Definition: Cost centers are organizational units or activities that provide goods and services. In this context, it would be the department which delivered the Service/Product Line Item, e.g., Radiology, Emergency Room.

16.4.2.21   IVC-22   Invoice Prepaid Amount   (CP)   01934

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Deposit paid to the service Provider prior to admission

16.4.2.22   IVC-22   Invoice Amount without Prepaid Amount   (CP)   01935

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Amount of Invoice without the prepaid deposit (IV-8 minus IVC-21)

16.4.2.23   IVC-23   Total-Amount of VAT   (CP)   01936

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Total Amount of VAT included in the Total Invoice Amount (IVC-8)

16.4.2.24   IVC-24   VAT-Rates applied   (NM)   01937

Definition: Applied VAT Rates on Invoice. Multiple VAT-rates may be applied according to the type of service

16.4.2.25   IVC-25   Benefit group (IS)   01938

Definition: Code indicating the Benefit group. Refer to *User-defined Table 0556 – Benefit Group* for suggested values.

User-defined Table 0556 – Benefit Group

Code	Description	Comment
AMB	AMBULATORY CARE	
DENT	DENTAL	

16.4.2.26   IVC-26   Provider Tax ID   (ST)   02038

Definition: The Tax ID of the Provider (general Tax identification number or VAT number).

16.4.2.27   IVC-27   Payer Tax ID   (CP)   02039

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: The Tax ID of the Payer (general Tax identification number or VAT number)

16.4.2.28   IVC-28   Provider Tax status   (IS)   02040

Definition: Code indicating the tax status of the provider. Refer to *User-defined Table 0572 – Tax status* for suggested values.

User-defined Table 0572 – Tax status

Code	Description	Comment
RVAT	Registered in VAT register	
UVAT	Unregistered in VAT register	

16.4.2.29   IVC-29   Payer Tax status   (IS)   02041

Definition: Code indicating the tax status of the payer. Refer to *User-defined Table 0572 – Tax status* for suggested values.

16.4.2.30   IVC-30   Sales Tax ID   (ST)   02042

Definition: The Tax ID specific to Sales Tax

16.4.3   PYE – Payee Information Segment

This segment is used to define payee information.

HL7 Attribute Table – PYE – Payee Information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	R			01939	Set ID – PYE
2	6	IS	R		0557	01940	Payee Type
3	2	IS	C		0558	01941	Payee Relationship to Invoice (Patient)
4	183	XON	C	0-5		01942	Payee Identification List
5	466	XPN	C	0-4		01943	Payee Person Name
6	235	XAD	C	0-4		01944	Payee Address
7	80	IS	O		0570	01945	Payment Method

16.4.3.0   PYE field definitions

16.4.3.1   PYE-1   Set ID – PYE   (SI)   01939

Definition: Sequence Number.

16.4.3.2   PYE-2   Payee Type   (IS)   01940

Definition: Type of Payee (e.g., Organization, Person). Refer to *User-defined Table 0557 – Payee Type* for suggested values.

User-defined Table 0557 – Payee Type

Code	Description	Comment
ORG	Payee Organization	
PERS	Person	
PPER	Pay Person	
EMPL	Employer	

16.4.3.3   PYE-3   Payee Relationship to Invoice (Patient)   (IS)   01941

Definition: Conditional or empty: if Payee Type in list ("PERS", "PPER"), then Required, else Not Permitted.

For Person Payee Types, the relationship to Invoice. Refer to *User-defined Table 0558 – Payee Relationship to Invoice* for suggested values.

User-defined Table 0558 – Payee Relationship to Invoice

Code	Description	Comment
PT	Patient	
FM	Family Member	
SB	Subscriber	
GT	Guarantor	

16.4.3.4   PYE-4   Payee Identification List   (XON)   01942

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
             <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
             Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
             <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
             <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>
```

Definition: Conditional or empty: if Payee Type in list ("PPER", "ORG"), then Required, else Not Permitted.

Payee or Business Arrangement identification information; up to 5; defined by Payer/Provider agreement.

16.4.3.5   PYE-5   Payee Person Name   (XPN)   01943

```
Components:  <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and Further Given Names
             or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III) (ST)> ^ <Prefix
             (e.g., DR) (ST)> ^ <DEPRECATED-Degree (e.g., MD) (IS)> ^ <Name Type Code
             (ID)> ^ <Name Representation Code (ID)> ^ <Name Context (CWE)> ^
             <DEPRECATED-Name Validity Range (DR)> ^ <Name Assembly Order (ID)> ^
             <Effective Date (DTM)> ^ <Expiration Date (DTM)> ^ <Professional Suffix
             (ST)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
             Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
             Partner/Spouse (ST)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Name Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
             End Date/Time (DTM)>
```

Definition: Conditional or empty: if Payee Type = ("PERS", "PPER), then Required, else Not Permitted.

Individual's name, may be a patient's name or other individual.

16.4.3.6   PYE-6   Payee Address   (XAD)   01944

```
Components:  <Street Address (SAD)> ^ <Other Designation (ST)> ^ <City (ST)> ^ <State
             or Province (ST)> ^ <Zip or Postal Code (ST)> ^ <Country (ID)> ^ <Address
             Type (ID)> ^ <Other Geographic Designation (ST)> ^ <County/Parish Code
             (IS)> ^ <Census Tract (IS)> ^ <Address Representation Code (ID)> ^
             <DEPRECATED-Address Validity Range (DR)> ^ <Effective Date (DTM)> ^
             <Expiration Date (DTM)> ^ <Expiration Reason (CWE)> ^ <Temporary Indicator
             (ID)> ^ <Bad Address Indicator (ID)> ^ <Address Usage (ID)> ^ <Addressee
             (ST)> ^ <Comment (ST)> ^ <Preference Order (NM)> ^ <Protection Code (CWE)>
             ^ <Address Identifier (EI)>

Subcomponents for Street Address (SAD):  <Street or Mailing Address (ST)> & <Street
             Name (ST)> & <Dwelling Number (ST)>

Subcomponents for Address Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
             End Date/Time (DTM)>

Subcomponents for Expiration Reason (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Protection Code (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Address Identifier (EI):  <Entity Identifier (ST)> & <Namespace ID
             (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>
```

Definition: Conditional or empty: if Payee Type = ("PERS", "PPER), then Required, else Not Permitted.

Address for payee. If not specified, then Payer will use address on file for this Payee, if applicable. If Payee is an individual, then this address can be used to send a check.

16.4.3.7   PYE-7   Payment Method   (IS)   01945

Definition: For Payee organizations that have more than one payment method.

If for individual, then we may also need to indicate EFT, bank info, etc.

Refer to *User-defined Table 0570 – Payment Method Code* for suggested values.

16.4.4   PSS – Product/Service Section Segment

The Product/Service Section segment is used to form a logical grouping of Product/Service Group segments, Patients and Response Summaries for a particular Invoice.

HL7 Attribute Table – PSS – Product/Service Section

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			01946	Provider Product/Service Section Number
2	73	EI	O			01947	Payer Product/Service Section Number
3	4	SI	R			01948	Product/Service Section Sequence Number
4	254	CP	R			01949	Billed Amount
5	254	ST	R			02043	Section Description or Heading

16.4.4.0   PSS field definitions

16.4.4.1   PSS-1   Provider Product/Service Section Number   (EI)   01946

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Unique Product/Service Section Number assigned by the Provider Application.

16.4.4.2   PSS-2   Payer Product/Service Section Number   (EI)   01947

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Unique Product/Service Section Number assigned by the Payer Application.

16.4.4.3   PSS-3   Product/Service Section Sequence Number   (SI)   01948

Definition: Unique sequence number for the Product/Service Section (3) – starts with 1, then 2, etc. for each unique Product/Service Section in this Invoice.

16.4.4.4   PSS-4   Billed Amount   (CP)   01949

```
Components:   <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
              <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):   <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):   <Identifier (ST)> & <Text (ST)> & <Name of
              Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
              & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
              & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Sum of all Product/Service Billed Amounts for all Product/Service Line Items for this Product/Service Section.

16.4.4.5   PSS-5   Section Description   (ST)   02043

Definition: Section description or heading.

16.4.5   PSG – Product/Service Group Segment

The Product/Service Group segment is used to form a logical grouping of Product/Service Line Items, Patients and Response Summaries for a particular Invoice. For example, a Product/Service Group can be used to group all Product/Service Line Items that must be adjudicated as a group in order to be paid.

HL7 Attribute Table – PSG – Product/Service Group

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			01950	Provider Product/Service Group Number
2	73	EI	O			01951	Payer Product/Service Group Number
3	4	SI	R			01952	Product/Service Group Sequence Number
4	1	ID	R		0136	01953	Adjudicate as Group
5	254	CP	R			01954	Product/Service Group Billed Amount
6	254	ST	R			02044	Product/Service Group Description

16.4.5.0   PSG field definitions

16.4.5.1   PSG-1   Provider Product/Service Group Number   (EI)   01950

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Product/Service Group Number assigned by the Provider Application.

16.4.5.2   PSG-2   Payer Product/Service Group Number   (EI)   01951

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Product/Service Group Number assigned by the Payer Application

16.4.5.3   PSG-3   Product/Service Group Sequence Number   (SI)   01952

Definition: Unique sequence number for the Product/Service Group (3) – starts with 1, then 2, etc. for each unique Product/Service Group in this Invoice.

16.4.5.4   PSG-4   Adjudicate as Group   (ID)   01953

Definition: Adjudicate all Product/Service Line Items together as a group (IPRs will be reported against the Product/Service Group). Refer to *HL7-Table0136 – Yes/No-Indicator* for suggested values.

16.4.5.5   PSG-5   Product/Service Group Billed Amount   (CP)   01954

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Sum of all Product/Service Billed Amounts for all Product/Service Line Items for this Product/Service Group.

16.4.5.6   PSG-6   Product/Service Group Description   (ST)   02044

Definition: Product/Service Group description or heading

16.4.6   PSL – Product/Service Line Item Segment

The Product/Service Line Item segment is used to identify individual product/service items that typically are aggregated into an Invoice. Each instance of a Product/Service Line Item corresponds to a unique product delivered or service rendered.

HL7 Attribute Table – PSL – Product/Service Line Item

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			01955	Provider Product/Service Line Item Number
2	73	EI	O			01956	Payer Product/Service Line Item Number
3	4	SI	R			01957	Product/Service Line Item Sequence Number
4	20	EI	O			01958	Provider Tracking ID
5	20	EI	O			01959	Payer Tracking ID
6	2	CWE	R		0559	01960	Product/Service Line Item Status
7	177	CWE	R		0879	01961	Product/Service Code
8	177	CWE	O	0-5	0880	01962	Product/Service Code Modifier
9	80	ST	O			01963	Product/Service Code Description
10	24	DTM	C			01964	Product/Service Effective Date
11	24	DTM	O			01965	Product/Service Expiration Date
12	222	CQ	C		0560	01966	Product/Service Quantity
13	254	CP	C			01967	Product/Service Unit Cost
14	10	NM	C			01968	Number of Items per Unit
15	254	CP	C			01969	Product/Service Gross Amount
16	254	CP	C			01970	Product/Service Billed Amount
17	10	IS	O	0-20	0561	01971	Product/Service Clarification Code Type
18	40	ST	O	0-20		01972	Product/Service Clarification Code Value
19	73	EI	O	0-5		01973	Health Document Reference Identifier
20	10	IS	O	0-20	0562	01974	Processing Consideration Code
21	2	ID	R		0532	01975	Restricted Disclosure Indicator
22	177	CWE	O		0879	01976	Related Product/Service Code Indicator
23	254	CP	O			01977	Product/Service Amount for Physician
24	5	NM	O			01978	Product/Service Cost Factor
25	250	CX	O			01933	Cost Center
26	49	DR	O			01980	Billing Period
27	5	NM	O			01981	Days without Billing
28	4	NM	O			01982	Session-No
29	20	XCN	O			01983	Executing Physician ID
30	20	XCN	O			01984	Responsible Physician ID
31	10	CWE	O		0881	01985	Role Executing Physician
32	10	CWE	O		0882	01986	Medical Role Executing Physician
33	3	CWE	O		0894	01987	Side of body
34	6	NM	O			01988	Number of TP's PP
35	6	CP	O			01989	TP-Value PP
36	4	NM	O			01990	Internal Scaling Factor PP

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
37	4	NM	O			01991	External Scaling Factor PP
38	7	CP	O			01992	Amount PP
39	6	NM	O			01993	Number of TP's Technical Part
40	6	CP	O			01994	TP-Value Technical Part
41	4	NM	O			01995	Internal Scaling Factor Technical Part
42	4	NM	O			01996	External Scaling Factor Technical Part
43	7	CP	O			01997	Amount Technical Part
44	8	CP	O			01998	Total Amount Professional Part + Technical Part
45	3	NM	O			01999	VAT-Rate
46	20	ID	O			02000	Main-Service
47	1	ID	O		0136	02001	Validation
48	255	ST	O			02002	Comment

16.4.6.0   PSL field definitions

16.4.6.1   PSL-1   Provider Product/Service Line Item Number   (EI)   01955

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Unique Product/Service Line Item Number assigned by the Provider Application.

16.4.6.2   PSL-2   Payer Product/Service Line Item Number   (EI)   01956

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Unique Product/Service Line Item Number assigned by the Payer Application.

16.4.6.3   PSL-3   Product/Service Line Item Sequence Number   (SI)   01957

Definition: Unique sequence number for the Product/Service Line Item – starts with 1, then 2, etc. for each unique Product/Service Line Item in this Invoice.

16.4.6.4   PSL-4   Provider Tracking ID   (EI)   01958

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Identifier for this Product/Service Line Item assigned by the Provider Application. This will be echoed on all interactions between participants for this Product/Service Line Item.

16.4.6.5   PSL-5   Payer Tracking ID   (EI)   01959

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Identifier for this Product/Service Line Item assigned by the Payer Application. This will be echoed on all interactions between participants for this Product/Service Line Item.

16.4.6.6   PSL-6   Product/Service Line Item Status   (CWE)   01960

```
Components:   <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
              <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
              Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
              System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Processing status for the Product/Service Code.   Refer to *User-defined Table 0559 – Product/Service Status* for suggested values.

User-defined Table 0559 – Product/Service Status

Code	Description	Comment
P	Processed	
D	Denied	
R	Rejected	

16.4.6.7 PSL-7 Product/Service Code (CWE) 01961

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Code describing what service was delivered/received.

User-defined Table 0879 - Product/Service Code

Value	Description	Comment
	No suggested values defined	

16.4.6.8 PSL-8 Product/Service Code Modifier (CWE) 01962

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Additional optional modifier(s) for the Product/Service Code (e.g., after hours – evening, after hours – weekend); repeats up to 5 times.

User-defined Table 0880 - Product/Service Code Modifier

Value	Description	Comment
	No suggested values defined	

16.4.6.9 PSL-9 Product/Service Code Description (ST) 01963

Definition: Text describing Product/Service Code in PSL.

16.4.6.10 PSL-10 Product/Service Effective Date (DTM) 01964

Definition: [Start] Date/Time product/service was delivered/received.

16.4.6.11 PSL-11 Product/Service Expiration Date (DTM) 01965

Definition: [End] Date/Time product/service was delivered/received. If specified, must be greater than or equal to Product/Service Effective Date.

16.4.6.12 PSL-12 Product/Service Quantity (CQ) 01966

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
             System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
             of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
             <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Amount that has been negotiated for this Product/Service Code on PSL between a Provider and Payer for each unit. Refer to *User-defined table 0560 – Quantity Units* for valid values.

16.4.6.13 PSL-13 Product/Service Unit Cost (CP) 01967

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>
```

```
Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: This field contains the cost per unit either in monetary amount or in points.

Examples:

> 1. Qty * cost/unit = gross amount
>
> 2. Qty * cost/unit * factor = gross amount
>
> 3. Qty * cost/point * factor * points = gross amount

16.4.6.14   PSL-14   Number of Items per Unit   (NM)   01968

Definition: Number of items in each unit – for Services, this should be set to 1.

16.4.6.15   PSL-15   Product/Service Gross Amount   (CP)   01969

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
          <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: = Product/Service Quantity * Product/Service Unit Cost

16.4.6.16   PSL-16   Product/Service Billed Amount   (CP)   01970

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
          <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
          Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
          & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
          & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Amount that is being billed for this Product/Service Code on PSL, = Product/Service Gross Amount + sum of all Product/Service Adjustments on ADJ for this Product/Service Line Item.

= Product/Service Gross Amount + sum of all Product/Service Adjustments on ADJ

16.4.6.17   PSL-17   Product/Service Clarification Code Type   (IS)   01971

Definition: Additional codes describing the Product/Service Code on PSL – examples are Northern Allowance, Data Center Numbers, Sequence Numbers; repeats with Product/Service Clarification Code Value. Refer to *User-defined Table 0561 – Product/Services Clarification Codes* for suggested values.

User-defined Table 0561 – Product/Services Clarification Codes

Code	Description	Comment
DTCTR	Data Center Number	MSP: Data Center Number associated with the Provider's Network Application ID
SEQ	Sequence Number	MSP: Must be sequential by Data Center Number
DGAPP	Diagnostic Approval Number	MSP: assigned by MSP
CLCTR	Claim Center	
ENC	Encounter Number	
OOP	Out of Province Indicator	
GFTH	Good Faith Indicator	

16.4.6.18   PSL-18   Product/Service Clarification Code Value   (ST)   01972

Definition: Actual value for Product/Service Clarification Code Type (40) – examples are "Y", "N" for Northern Allowance, an actual number for a Data Center Number; repeats with Product/Service Clarification Code Type.

Repeats with Product/Service Clarification Code Type.

16.4.6.19   PSL-19   Health Document Reference Identifier   (EI)   01973

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Health Documents (electronic or paper) that support this Product/Service Line Item. This includes such health documents as forms used to register a claim with a Payer, reports, medical images, etc.

16.4.6.20   PSL-20   Processing Consideration Code   (IS)   01974

Definition: Codes indicating special processing requested of Payer for this Product/Service Line Item (e.g., hold until paper supporting documentation is received by Payer). Refer to *User-defined Table 0562 – Processing Considerations Codes* for suggested values.

User-defined Table 0562 – Processing Consideration Codes

Code	Description	Comment
PAPER	Paper documentation to follow	
EFORM	Electronic form to follow	E30 transaction to follow
FAX	Fax to follow	
RTADJ	Real Time Adjudication Processing	If permitted by Payer
DFADJ	Deferred Adjudication Processing	If permitted by Payer
PYRDELAY	Delayed by a Previous Payer	Allows Provider to explain lateness of Invoice to a subsequent Payer

16.4.6.21   PSL-21   Restricted Disclosure Indicator   (ID)   01975

Definition: Set to "Yes" if information on this invoice should be treated with increased confidentiality/security. Refer to *User-defined Table 0532 – Expanded Yes/No Indicator* for suggested values.

16.4.6.22   PSL-22   Related Product/Service Code Indicator   (CWE)   01976

```
Components:   <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
              <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
              Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
              System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Two Product /Service Line Items (PSL-7) may be in a relation to each other. One could be an addition to another. In this case this field contains the Code of PSL-7 of the "master" Product/Service Line Item.

User-defined Table 0879 - Product/Service Code

Value	Description	Comment
	No suggested values defined	

16.4.6.23   PSL-23   Product/Service Amount for Physician   (CP)   01977

```
Components:   <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
              <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
              Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
              & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
              & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Monetary Amount of product/service item which is for the physician.

16.4.6.24 PSL-24 Product/Service Cost Factor (NM) 01978

Definition: Factor to increase the billed amount.

16.4.6.25 PSL-25 Cost Center (CX) 01933

```
Components:  <ID Number (ST)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme
             (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
             <Assigning Facility (HD)> ^ <Effective Date (DT)> ^ <Expiration Date (DT)>
             ^ <Assigning Jurisdiction (CWE)> ^ <Assigning Agency or Department (CWE)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Jurisdiction (CWE): <Identifier (ST)> & <Text (ST)> &
             <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
             Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
             Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
             Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
             (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
             <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
             System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
             <Original Text (ST)>
```

Definition: Cost centers are organizational units or activities that provide goods and services. In this context, it would be the department which delivered the Service/Product Line Item, e.g., Radiology, Emergency Room.

16.4.6.26 PSL-26 Billing Period (DR) 01980

```
Components:  <Range Start Date/Time (DTM)> ^ <Range End Date/Time (DTM)>
```

Definition: Begin and end of billing period.

16.4.6.27 PSL-27 Days without Billing (NM) 01981

Definition: Number of Days for which no invoice is created.

16.4.6.28 PSL-28 Session-No (NM) 01982

Definition: Several line items may be grouped to a session.

16.4.6.29 PSL-29 Executing Physician ID (XCN) 01983

```
Components:  <ID Number (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and
             Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III)
             (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <DEPRECATED-Degree (e.g., MD) (IS)> ^
             <Source Table (IS)> ^ <Assigning Authority (HD)> ^ <Name Type Code (ID)> ^
             <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Identifier
             Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code
             (ID)> ^ <Name Context (CWE)> ^ <DEPRECATED-Name Validity Range (DR)> ^
             <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
             (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^
             <Assigning Agency or Department (CWE)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
             Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
             Partner/Spouse (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

```
Subcomponents for Name Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
        End Date/Time (DTM)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
        <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
        Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
        Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
        Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
        (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
        <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
        System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
        <Original Text (ST)>
```

Definition: ID of the physician who is providing the Service, e.g., executing the radiology-exam (EAN ID = European Article Numbering).

16.4.6.30   PSL-30   Responsible Physician ID   (XCN)   01984

```
Components:  <ID Number (ST)> ^ <Family Name (FN)> ^ <Given Name (ST)> ^ <Second and
        Further Given Names or Initials Thereof (ST)> ^ <Suffix (e.g., JR or III)
        (ST)> ^ <Prefix (e.g., DR) (ST)> ^ <DEPRECATED-Degree (e.g., MD) (IS)> ^
        <Source Table (IS)> ^ <Assigning Authority (HD)> ^ <Name Type Code (ID)> ^
        <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Identifier
        Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Name Representation Code
        (ID)> ^ <Name Context (CWE)> ^ <DEPRECATED-Name Validity Range (DR)> ^
        <Name Assembly Order (ID)> ^ <Effective Date (DTM)> ^ <Expiration Date
        (DTM)> ^ <Professional Suffix (ST)> ^ <Assigning Jurisdiction (CWE)> ^
        <Assigning Agency or Department (CWE)>

Subcomponents for Family Name (FN):  <Surname (ST)> & <Own Surname Prefix (ST)> & <Own
        Surname (ST)> & <Surname Prefix from Partner/Spouse (ST)> & <Surname from
        Partner/Spouse (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
        & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
        & <Universal ID Type (ID)>

Subcomponents for Name Context (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Name Validity Range (DR):  <Range Start Date/Time (DTM)> & <Range
        End Date/Time (DTM)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
        <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
        Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
        Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
        Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
        (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
        <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
        System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
        <Original Text (ST)>
```

Definition: ID of the physician who is responsible for the Service.

16.4.6.31   PSL-31   Role Executing Physician   (CWE)   01985

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
        <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
        Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
        System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Account role of the physician, for example only billing for the professional part, the technical part or both.

User-defined Table 0881 - Role Executing Physician

Code	Description	Comment
T	Technical Part	
P	Professional Part	
B	Both	

16.4.6.32   PSL-32   Medical Role Executing Physician   (CWE)   01986

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: The role of the Physician ("self-employed" or "employed").

User-defined Table 0882 - Medical Role Executing Physician

Code	Description	Comment
E	Employed	
SE	Self-employed	

16.4.6.33   PSL-33   Side of body   (CWE)   01987

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Left / right

User-defined Table 0894 - Side of body

Code	Description	Comment
L	Left	
R	Right	

16.4.6.34   PSL-34   Number of TP's PP   (NM)   01988

Definition: Cost of the service "professional part" expressed in "points".

16.4.6.35   PSL-35   TP-Value PP   (CP)   01989

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Monetary Value of one "point" for the professional part of the service.

16.4.6.36   PSL-36   Internal Scaling Factor PP   (NM)   01990

Definition: Internal Scaling Factor for the amount of the professional part of the service.

16.4.6.37   PSL-37   External Scaling Factor PP   (NM)   01991

Definition: External Scaling Factor for the amount of the professional part of the service.

16.4.6.38   PSL-38   Amount PP   (CP)   01992

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>
```

```
Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Total Amount for the professional part of this service.

16.4.6.39   PSL-39   Number of TP's Technical Part   (NM)   01993

Definition: Cost of the service (Technical Part) expressed in "points".

16.4.6.40   PSL-40   TP-Value Technical Part   (CP)   01994

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Monetary Value of one "point" for the technical part of the service.

16.4.6.41   PSL-41   Internal Scaling Factor Technical Part   (NM)   01995

Definition: Internal Scaling Factor for the amount of the technical part of the service.

16.4.6.42   PSL-42   External Scaling Factor Technical Part   (NM)   01996

Definition: External Scaling Factor for the amount of the technical part of the service.

16.4.6.43   PSL-43   Amount Technical Part   (CP)   01997

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Total Amount for the technical part of this service.

16.4.6.44   PSL-44   Total Amount Professional Part + Technical Part   (CP)   01998

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
        <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
        Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
        & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
        & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Total Amount of the cost of this service (Professional plus technical part)

16.4.6.45   PSL-45   VAT-Rate   (NM)   01999

Definition: VAT–Rate Applied on the total amount of this service.

16.4.6.46   PSL-46   Main-Service   (ID)   02000

Definition: Main service.

16.4.6.47   PSL-47   Validation   (ID)   02001

Definition: Service line item has passed an approved validator software (yes/no). For reason see PSL-48. Refer to *HL7-Table 0136 – Yes/No-Indicator* for suggested values.

16.4.6.48 PSL-48 Comment (ST) 02002

Definition: Reason why the service line item has not passed the validator software.

16.4.7 ADJ – Adjustment

This segment describes Provider and/or Payer adjustments to a Product/Service Line Item or Response Summary. These include surcharges such as tax, dispensing fees and mark ups.

X12 REF: Similar to CAS segment, with a few new fields.

HL7 Attribute Table – ADJ – Adjustment

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			02003	Provider Adjustment Number
2	73	EI	R			02004	Payer Adjustment Number
3	4	SI	R			02005	Adjustment Sequence Number
4	4	IS	R		0564	02006	Adjustment Category
5	254	CP	O	0-5		02007	Adjustment Amount
6	222	CQ	O		0560	02008	Adjustment Quantity
7	211	CWE	C	1	0565	02009	Adjustment Reason PA
8	250	ST	O			02010	Adjustment Description
9	250	NM	O			02011	Original Value
10	250	NM	O			02012	Substitute Value
11	4	IS	O		0569	02013	Adjustment Action
12	73	EI	O			02014	Provider Adjustment Number Cross Reference
13	73	EI	O			02015	Provider Product/Service Line Item Number Cross Reference
14	26	DTM	R			02016	Adjustment Date
15	183	XON	O			02017	Responsible Organization

16.4.7.0 ADJ field definitions

16.4.7.1 ADJ-1 Provider Adjustment Number (EI) 02003

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Adjustment Number assigned by the Provider Application.

16.4.7.2 ADJ-2 Payer Adjustment Number (EI) 02004

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Adjustment Number assigned by the Payer Application.

16.4.7.3 ADJ-3 Adjustment Sequence Number (SI) 02005

Definition: Unique sequence number for this adjustment – starts with 1, then 2, etc., for each unique adjustment for the Product/Service Line Item.

16.4.7.4 ADJ-4 Adjustment Category (IS) 02006

Definition: Indicates the category of adjustment and is used to assist in determining which table is used for Adjustment Reason. Refer to *User-defined Table 0564 – Adjustment Category Code* for suggested values.

User-defined Table 0564 – Adjustment Category Code

Code	Description	Comment
EA	Edit/Adjudication Response	Payer adjustment
IN	Information	Payer adjustment
PA	Provider Adjustment	Provider adjustment
PR	Processing Result	Payer adjustment

16.4.7.5   ADJ-5   Adjustment Amount   (CP)   02007

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Adjustment amount, such as taxes, deductibles, previously paid amount.

16.4.7.6   ADJ-6   Adjustment Quantity   (CQ)   02008

```
Components:  <Quantity (NM)> ^ <Units (CWE)>

Subcomponents for Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of Coding
             System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name
             of Alternate Coding System (ID)> & <Coding System Version ID (ST)> &
             <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Adjustment quantity.

X12 REF: table 673 Quantity Qualifier. New values from X12 673 can be added as required. Refer to *User-defined table 0560 – Quantity Units* for suggested values.

User-defined Table 0560 – Quantity Units

Code	Description	Comment
FL	Units	
HS	Hours	
DY	Days	
MN	Month	
YY	Years	

16.4.7.7   ADJ-7   Adjustment Reason PA   (CWE)   02009

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Reason for this adjustment. Codes used to explain a Provider adjustment to a Product/Service Group or Product/Service Line Item by a Provider. Refer to *User-defined table 0565 – Provider Adjustment Reason Code* for suggested values.

User-defined Table 0565 – Provider Adjustment Reason Code

Code	Description	Comment
PST	Provincial Sales Tax	
GST	Goods and Services Tax	
HST	Harmonized Sales Tax	
DISP	Dispensing Fee	
MKUP	Mark up Fee	

16.4.7.8   ADJ-8   Adjustment Description   (ST)   02010

Definition: Description of adjustment, such as client instructions.

16.4.7.9   ADJ-9   Original Value   (NM)   02011

Definition: Original value of data item noted in this adjustment.

16.4.7.10   ADJ-10   Substitute Value   (NM)   02012

Definition: Substituted value of data item noted in this adjustment.

16.4.7.11   ADJ-11   Adjustment Action   (IS)   02013

Definition: Action requested of party that receives this adjustment. Refer to *User-defined Table 0569 – Adjustment Action* for suggested values.

<div align="center">User-defined Table 0569 – Adjustment Action</div>

Code	Description	Comment
EOB	Print on EOB	Instructs party to print this adjustment on the EOB (Explanation of Benefits) handed to the patient
PAT	Inform Patient	
PRO	Inform Provider	

16.4.7.12   ADJ-12   Provider Adjustment Number Cross Reference   (EI)   02014

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Provider Adjustment Number assigned by the Provider Application that is referenced by this Payer Adjustment.

16.4.7.13   ADJ-13   Provider Product/Service Line Item Number Cross Reference   (EI)   02015

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Provider Product/Service Line Item Number assigned by the Provider Application that is referenced by this Payer Adjustment; used for groups with multiple line items that need to be singled out by a Payer Adjustment.

16.4.7.14   ADJ-14   Adjustment Date   (DTM)   02016

Definition: Date/Time adjustment was made. May also be synonymous with Adjudication Date.

16.4.7.15   ADJ-15   Responsible Organization   (XON)   02017

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
             <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
             Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
             <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
             <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
             & <Universal ID Type (ID)>
```

Definition: Business organization that is responsible for the adjustment (e.g., Payer organization); can be used for a Payment/Remittance Advice for 1 Payee from multiple Payers.

16.4.8   PMT – Payment Information Segment

This segment contains information that describes a payment made by a Payer organization.

HL7 Attribute Table – PMT – Payment Information

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			02018	Payment/Remittance Advice Number
2	26	DTM	R			02019	Payment/Remittance Effective Date/Time
3	26	DTM	R			02020	Payment/Remittance Expiration Date/Time
4	177	CWE	R		0570	02021	Payment Method
5	26	DTM	R			02022	Payment/Remittance Date/Time
6	254	CP	R			02023	Payment/Remittance Amount
7	15	EI	O			02024	Check Number
8	6	XON	O			02025	Payee Bank Identification
9	4	ST	O			02026	Payee Transit Number
10	20	CX	O			02027	Payee Bank Account ID
11	183	XON	R			02028	Payment Organization
12	100	ST	O			02029	ESR-Code-Line

16.4.8.0   PMT field definitions

16.4.8.1   PMT-1   Payment/Remittance Advice Number   (EI)   02018

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
             <Universal ID Type (ID)>
```

Definition: Unique Payment/Remittance Advice number for the sending Network Application ID.

16.4.8.2   PMT-2   Payment/Remittance Effective Date/Time   (DTM)   02019

Definition: [Start] Date/Time for this Payment/Remittance Advice.

16.4.8.3   PMT-3   Payment/Remittance Expiration Date/Time   (DTM)   02020

Definition: [End] Date/Time for this Payment/Remittance Advice.

16.4.8.4   PMT-4   Payment Method   (CWE)   02021

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Code identifying the method for the movement of payment. Refer to *User-defined Table 0570 – Payment Method Code* for suggested values.

User-defined Table 0570 – Payment Method Code

Code	Description	Comment
CASH	Cash	
CCCA	Credit Card	
CCHK	Cashier's Check	
CDAC	Credit/Debit Account	
CHCK	Check	
DDPO	Direct Deposit	EFT
DEBC	Debit Card	
SWFT	Society for Worldwide Interbank Financial Telecommunications (S.W.I.F.T.)	
TRAC	Traveler's Check	
VISN	VISA Special Electronic Funds Transfer Network	

16.4.8.5   PMT-5   Payment/Remittance Date/Time   (DTM)   02022

Definition: Date Payment/Remittance Advice was paid, which might not be the same as Date/Time of Message on MSH.

16.4.8.6   PMT-6   Payment/Remittance Amount   (CP)   02023

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
            <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
            Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
            & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
            & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Sum total of all Product/Service Paid Amount on PSL for this Payment/Remittance Advice, net of any Adjustments to Payee.

16.4.8.7   PMT-7   Check Number   (EI)   02024

```
Components:  <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
            <Universal ID Type (ID)>
```

Definition: Unique check number from the Payer's application system.

16.4.8.8   PMT-8   Payee Bank Identification   (XON)   02025

```
Components:  <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
            <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
            Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
            <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
            <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>
```

Definition: Identification of Payee's financial contact, e.g., name of the bank .

16.4.8.9   PMT-9   Payee Transit Number   (ST)   02026

Definition: Personal ID of the payee used in financial transaction.

16.4.8.10   PMT-10   Payee Bank Account ID   (CX)   02027

```
Components:  <ID Number (ST)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme
            (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
            <Assigning Facility (HD)> ^ <Effective Date (DT)> ^ <Expiration Date (DT)>
            ^ <Assigning Jurisdiction (CWE)> ^ <Assigning Agency or Department (CWE)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
            & <Universal ID Type (ID)>

Subcomponents for Assigning Jurisdiction (CWE):  <Identifier (ST)> & <Text (ST)> &
            <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate
            Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System
            Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original
            Text (ST)>

Subcomponents for Assigning Agency or Department (CWE):  <Identifier (ST)> & <Text
            (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> &
            <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding
            System Version ID (ST)> & <Alternate Coding System Version ID (ST)> &
            <Original Text (ST)>
```

Definition: Id of Payee's Bank account.

16.4.8.11   PMT-11   Payment Organization   (XON)   02028

```
Components:   <Organization Name (ST)> ^ <Organization Name Type Code (IS)> ^
              <DEPRECATED-ID Number (NM)> ^ <Identifier Check Digit (NM)> ^ <Check Digit
              Scheme  (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^
              <Assigning Facility (HD)> ^ <Name Representation Code (ID)> ^
              <Organization Identifier (ST)>

Subcomponents for Assigning Authority (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
              & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD):  <Namespace ID (IS)> & <Universal ID (ST)>
              & <Universal ID Type (ID)>
```

Definition: Organization identifier that made the Payment/Remittance Advice; could be a Payer, Insurance Company, TPA, Drug Company.

16.4.8.12   PMT-12   ESR-Code-Line (ST)   02029

Definition: Invoice Reference used with electronic banking methods.

16.4.9   IPR – Invoice Processing Results Segment

The Invoice Processing Results (IPR) segment provides summary information about an adjudicated Product/Service Group or Product/Service Line Item.

HL7 Attribute Table – IPR – Invoice Processing Results

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME
1	73	EI	R			02030	IPR Identifier
2	73	EI	R			02031	Provider Cross Reference Identifier
3	73	EI	R			02032	Payer Cross Reference Identifier
4	177	CWE	R		0571	02033	IPR Status
5	26	DTM	R			02034	IPR Date/Time
6	254	CP	O			02035	Adjudicated/Paid Amount
7	26	DTM	O			02036	Expected Payment Date/Time
8	10	ST	R			02037	IPR Checksum

16.4.9.0   IPR field definitions

16.4.9.1   IPR-1   IPR Identifier   (EI)   02030

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Unique IPR Number assigned by the Payer Application.

16.4.9.2   IPR-2   Provider Cross Reference Identifier   (EI)   02031

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Cross reference to Provider Product/Service Group Number or Provider Product/Service Line Item Number from original Invoice.

16.4.9.3   IPR-3   Payer Cross Reference Identifier   (EI)   02032

```
Components:   <Entity Identifier (ST)> ^ <Namespace ID (IS)> ^ <Universal ID (ST)> ^
              <Universal ID Type (ID)>
```

Definition: Cross reference to Payer Product/Service Group Number or Payer Product/Service Line Item Number from original Invoice.

16.4.9.4   IPR-4   IPR Status   (CWE)   02033

```
Components:  <Identifier (ST)> ^ <Text (ST)> ^ <Name of Coding System (ID)> ^
             <Alternate Identifier (ST)> ^ <Alternate Text (ST)> ^ <Name of Alternate
             Coding System (ID)> ^ <Coding System Version ID (ST)> ^ <Alternate Coding
             System Version ID (ST)> ^ <Original Text (ST)>
```

Definition: Processing status for the Product/Service Group (if Adjudicate as Group = "Y") or Product/Service Line Item. Refer to *User-defined Table 0571 – Invoice Processing Results Status* for suggested values.

These status codes represent status codes for an IPR (Invoice Processing Result).

User-defined Table 0571 – Invoice Processing Results Status

Code	Description	Comments
ACK	Acknowledge	
REJECT	Reject	
PEND	Pending	
ADJZER	Adjudicated to Zero	
ADJSUB	Adjudicated as Submitted	
ADJ	Adjudicated with Adjustments	
PAID	Paid	
PRED	Pre-Determination	Indicates that the IPR has been adjudicated but will not be paid. Equivalent to ADJUD (Adjudicate)

16.4.9.5   IPR-5   IPR Date/Time   (DTM)   02034

Definition: Date/Time IPR was created.

16.4.9.6   IPR-6   Adjudicated/Paid Amount   (CP)   02035

```
Components:  <Price (MO)> ^ <Price Type (ID)> ^ <From Value (NM)> ^ <To Value (NM)> ^
             <Range Units (CWE)> ^ <Range Type (ID)>

Subcomponents for Price (MO):  <Quantity (NM)> & <Denomination (ID)>

Subcomponents for Range Units (CWE):  <Identifier (ST)> & <Text (ST)> & <Name of
             Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)>
             & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)>
             & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>
```

Definition: Adjudicated Amount for the Product/Service Group or Product/Service Line Item, which could be 0 = sum of all Payer adjustments (Adjustment Amount on ADJ).

16.4.9.7   IPR-7   Expected Payment Date/Time   (DTM)   02036

Definition: Date payment is expected for this IPR.

16.4.9.8   IPR-8   IPR Checksum   (ST)   02037

Definition: Conditional, if Status = "Accepted", then Required, else Not Permitted.

The field contains a checksum generated by the first Payer (referenced by Payer Organization in the IVC Segment) to ensure that the contents of IPR have not been altered before sending to subsequent Payers.

16.5 OUTSTANDING ISSUES

The following items are being discussed in the Financial Management committee for addition to future versions of HL7:

Events E10 (Edit/Adjudication Response), E24 (Authorization Response) and E12 (Request Additional Information) assume that the Payer application is able to process the requests on-line. Future versions of the Standard would include provisions for deferred responses where the Payer responds to the request once it has processed the request offline. In this use case, the Payer would either send the response as unsolicited results, or store the responses on a

queue for the Provider application. If left on a queue for the Provider application, then the QVR^Q17^QVR_Q17 (Query for previous events) message might be used by the Provider application to poll the Payer application.