



**Availity Revenue Cycle Management  
PM Integration  
Development Guide**

**Version 20150618**

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## Overview

Availity Revenue Cycle Management (RCM) provides multiple integration opportunities to support varying levels and needs of a Practice Management System or specific client. Depending on the nature of the integration, one or more integration choices can be implemented to enable the needed business functionality and automation. Since every practice and PM system has its own business model and workflow, it would be unreasonable to expect that a single solution would be able to meet the needs of every implementation. Understanding this requirement, Availity RCM has developed a suite of programming interfaces to allow for the appropriate level of integration to match the needs of a practice.

Even with the varying levels of integration, Availity RCM will continue to deliver several advanced capabilities through our portal web site. These advanced capabilities are items that can bring great value to the practice but have little opportunity for integration through a Practice Management System in a consistent manner. These services include items such as Provider Dashboard to provide a complete overview of the practice, detailed claims tracking similar to FedEx, and an array of management reports to provide detailed analytics about the revenue cycle of a practice.

Consequently, Availity RCM recommends an approach where transactions that can be accommodated by the PM system are integrated to Availity RCM using the provided services and interfaces such as claims submission, remit posting, and eligibility checking. Additionally, providers will access features that the PM system is unable to support or no interface has been established using the Availity RCM Application Portal.



# Data Transfer Methods

## Overview

Availity RCM has made available four types of file transmission options for new and existing clients. The available options are Availity RCM Secure File Exchange, FTP with SSL, FTP with PGP (FTP-PGP), FTP through a VPN connection (FTP-VPN), or FTP with SSH. However, not all options may be applicable due to the setup and configuration options of the customer site. Clients will need to determine which option suits the technology requirements of their site.

These automated file transmission options enable clients to upload data to and download data from Availity RCM's processing systems in an automated and secure fashion. This allows clients to more seamlessly integrate Availity RCM's services into their existing processes by bypassing the Availity RCM front-end application for file upload and download functions. The transmission and receipt of files from the customer's location may be automated with the use of client created scripts. Clients will need to contact their Client Account Manager to start the setup process for these connectivity options.

## Automated File Transmission Matrix

Transfer Method	Source File Requirements	Client Requirements	Encryption	Notes
Secure File Exchange	Plain-Text	Windows only. Availity RCM installed software.	128-bit SSL (HTTPS)	Data transmitted is encrypted with SSL during transmission from Client to the Availity RCM secure web interface.
FTP w/SSL	Plain-Text	WS_FTP Professional client software (Windows only) or compatible	128-bit SSL	Data transmitted is encrypted with SSL during transmission from Client to Availity RCM Secure FTP server.
FTP w/PGP	Client source file must be pre-encrypted with Availity RCM PGP public key prior to transmission. Availity RCM source file must be pre-encrypted with client public key prior to placing on FTP site.	FTP Client Software , PGP Encryption Software	PGP	Data transmitted to Availity RCM is sent in clear-text, including logon username and password. However, contents of claim file are pre-encrypted with PGP for security.
FTP w/VPN	Plain-Text	VPN capable network device at Client Site; establishment of peer-to-peer VPN connection to Client network	164-bit 3DES VPN Tunnel	All data transferred across VPN tunnel between Availity RCM and Client is encrypted
FTP w/SSH (Preferred FTP Method)	Plain-Text	WS_FTP Professional client software (Windows only) or other compatible FTP client	Encrypted tunnel	Secure Shell uses strong cryptography to protect the data in transit and also to authenticate both the user and the server.

## Secure File Exchange

Secure File Exchange provides an alternative method of data transfer for clients not interested in using FTP transmission. Secure File Exchange consist of a locally installed client applications used to configure and run each upload or download directory set and an Availity RCM hosted web service used to verify client credentials and provide control information to the client application.

Secure File Exchange is built on Microsoft Windows technology which enables secure, authenticated transmission of files to and from the Availity RCM Application with Microsoft BITS (Background Intelligent Transfer Service) used as the data transfer technology. A customized application will be installed on the client machine which provides scheduling functionality and the automated transmission interface. Since the transmission is secured by using HTTPS, the source file does not have to be encrypted.

An Availity RCM representative will install a customizable internally developed transmission application on the client machine. This application will enable the secure and automated file transmission features of this option.

Previous version of Secure File Exchange may be referred to as RealMed Unity, Unity Basic, or RealLink.

## Secure File Exchange Hardware/Software Requirements

Server	<ul style="list-style-type: none"><li>• Windows 2000 and higher (Not verified for Windows 7)</li><li>• Always on.</li><li>• Password changes not required.</li><li>• Access to Internet via HTTPS</li><li>• No proxy authentication</li><li>• Install-time access as admin. Default install loc = C:\Program Files\Realmed\Unity</li><li>• Local System account has access to Unity subdirectory structure</li><li>• Windows Task Scheduler (WTS)</li><li>• User account on the Secure File Exchange box with full permissions to Unity subdirectory structure for WTS</li> <li>• Microsoft .NET Framework 1.1</li><li>• How to tell what you have: <a href="http://support.microsoft.com/kb/318785">http://support.microsoft.com/kb/318785</a></li><li>• How to get the download if you need it: <a href="http://www.microsoft.com/downloads/details.aspx?familyid=262d25e3-f589-4842-8157-034d1e7cf3a3&amp;displaylang=en">http://www.microsoft.com/downloads/details.aspx?familyid=262d25e3-f589-4842-8157-034d1e7cf3a3&amp;displaylang=en</a></li> <li>• Microsoft BITS 2.0 or higher</li><li>• How to tell what you have: <a href="http://msdn2.microsoft.com/en-us/library/aa362837.aspx">http://msdn2.microsoft.com/en-us/library/aa362837.aspx</a></li><li>• How to get the download if you need it: <a href="http://www.microsoft.com/downloads/details.aspx?FamilyID=3fd31f05-d091-49b3-8a80-bf9b83261372&amp;DisplayLang=en">http://www.microsoft.com/downloads/details.aspx?FamilyID=3fd31f05-d091-49b3-8a80-bf9b83261372&amp;DisplayLang=en</a></li> <li>• Run virtual? Yes</li><li>• Run 64-bit? Yes (in 32-bit emulation)</li></ul>
Storage space	<ul style="list-style-type: none"><li>• 1.2 MB at install-time in C:\Program Files\RealMed\Unity (Increases in use with configuration file, last manifest, log files)</li><li>• Data: Varies by user</li> <li>• Files delete? No</li> <li>• Growth of log file:<ul style="list-style-type: none"><li>◦ 10 lines per run plus 15 per file transferred/archived.</li><li>◦ 2500 characters to transfer/archive one file</li><li>◦ 500 characters per Eligibility attempt</li><li>◦ 1500 characters per additional file transfer/archive</li><li>◦ Archives off with date/time stamp. Not compressed or deleted.</li></ul></li></ul>

## FTP

### FTP with SSL

FTP with SSL enables a secure encrypted transmission from the client host to the Availity RCM Secure FTP server. Since the transmission is secure, the source file does not have to be encrypted.

Availity RCM's Production Secure FTP server utilizes industry standard 128-bit SSL encryption to ensure that data transmissions across the Internet are kept confidential. Availity recommends the use of a fully licensed version of Ipswitch's WS\_FTP Pro client software to establish connectivity to the Availity RCM Production Secure FTP system.

Trial licenses are designated with the letter "T" in their version number (Help → About WS\_FTP). The minimum required client version is 8.03; however the recommended version is 9.0 or higher.

Licenses for WS\_FTP may be purchased directly from Ipswitch's website at [www.ipswitch.com](http://www.ipswitch.com) for approximately \$55, or a license and one year of support and maintenance for approximately \$90. Availity RCM highly recommends the purchase of the support agreement with the WS\_FTP client software as it entitles the licensee to direct technical support from Ipswitch, software patches, and version upgrades.

If a client wishes to use a Secure FTP client, other than Ipswitch, then Availity RCM will be unable to support connection issues that may occur with that client software package.

Files downloaded from Availity RCM to the client site will remain available on the FTP site for a period of two weeks unless specifically deleted by the client via FTP scripting.

### ***Availity RCM's Production Environment Secure FTP Site for SSL***

Host Address:	prodftp.realmed.com
User Id:	[user id's are all uppercase and assigned by Availity RCM]
Password:	[as assigned by Availity RCM]
Encryption:	128-bit SSL Required

### ***WS\_FTP Client Configuration Settings***

The following settings should be used when configuring the WS\_FTP Pro client software:

Connection Name:	user defined description
Host Address:	see above
User Id:	as assigned by Availity RCM
Password:	as assigned by Availity RCM
Save Password:	enabled
Account:	leave this entry blank
Save Account:	disabled
Server Type:	FTP/SSL (AUTH SSL)
Port:	21 – Control; 1024 – 5000 – Data
Host Type:	WS_FTP Server
Passive Mode:	enabled
Firewall:	no firewall

## ***Client Firewall Settings***

The Secure FTP client uses TCP port 21 to communicate with the Availity RCM secure FTP server. The Availity RCM secure FTP server will communicate with the secure FTP client via a TCP port range of 1024 – 5000. Depending on your firewall manufacturer, your firewall administrator MAY need to allow communication between the computer that has the client installed and Availity RCM's server (prodftp.realmed.com – IP Address: 208.79.134.63) via ports 21 and 1024 through 5000. Notably "Checkpoint Firewall-1" has been shown to require this change.

## ***FTP with PGP Encrypted File or VPN***

Availity RCM's Production FTP server is available for clients who do not wish to utilize the Secure FTP transmission option. All transmission between the client host and Availity RCM must utilize either PGP encryption or a VPN encrypted tunnel to provide security for the contents of the file transmission. If a client wishes to utilize the VPN tunnel option, Availity RCM will need to work with the client's IT staff to configure this connectivity. Due to the complexity of the VPN option, the implementation time may take a longer period of time than the other FTP transmission options.

The FTP with PGP option requires the source file to be encrypted for security by the client using Availity RCM's public encryption key. If Availity RCM provides files back to the client then the client's public encryption key will need to be provided to Availity RCM. These keys are required because the FTP transmission is not encrypted.

FTP with VPN, utilizes a virtual private network connection between the client site and Availity RCM for the secure encrypted transmission. Again, since the transmission is secure, the source file does not have to be encrypted.

## ***Availity RCM's Production Environment FTP Site (PGP and VPN options)***

Host Address:	prodftp2.realmed.com
User Id:	[user id's are all uppercase and assigned by Availity RCM]
Password:	[as assigned by Availity RCM]
Encryption:	None

## ***Availity RCM's Production Environment VPN Configuration***

Peer Address:	208.79.134.7
Pre-Shared Key:	mutually defined during setup and configuration
Equipment:	Cisco VPN Concentrator 3500 with Fail-Over Support

If a client wishes to utilize the FTP with PGP functionality then the client must provide Availity RCM with their public encryption key also. This will enable Availity RCM to encrypt files that are provided for client download.

## FTP with SSH

SSH (Secure Shell) lets a user connect from one computer to another over a network and execute commands, transfer files, or get a command prompt. It uses strong cryptography to protect the data in transit and also to authenticate both the user and the server. SSH serves as a drop-in replacement for TELNET, FTP, rlogin, rsh, and rcp, none of which use strong cryptography by default.

### **Availity RCM's Production Environment Secure FTP Site for SSH**

Host Address: prodftp.realmed.com  
User Id: [user id's are all uppercase and assigned by Availity RCM]  
Password: [as assigned by Availity RCM]  
Encryption: 128-bit SSL Required

### **SSH Client Configuration Settings**

The following settings should be used when configuring the SSH client software:

Connection Name: user defined description  
Host Address: see above  
User Id: as assigned by Availity RCM  
Password: as assigned by Availity RCM  
Save Password: enabled  
Account: leave this entry blank  
Save Account: disabled  
Server Type: FTP/SSL (AUTH SSL)  
Port: 22  
Host Type: WS\_FTP Server  
Passive Mode: enabled  
Firewall: no firewall

# Web Services

## Overview

Availity RCM provides real-time services through various web services. For information about the specific services available using real-time web services see the [Advanced Integration](#) section.

## Environments

### ***Prod-Support (QA)***

This environment provides a platform for doing development and testing against the eligibility web service. This environment should never be used for eligibility checking of actual production patients or data. Depending on the payer, the Prod-Support environment is connected to either their development or production environments. Many payers have very limited data available for testing in their development environments which may present difficulties when testing.

### ***Production***

When setting the web reference in Visual Studio for .Net applications to the Availity RCM production environment, do not reacquire the WSDL as this production employs load balancing and SSL offloading technology that results in an invalid URL. Instead, use the WSDL provided by the Prod-Support environment and modify the URL to the production address.

# File Processing

## File Naming Conventions

Availity RCM's Automated File Transmission Gateway Sweeper process is configured to validate consistent file extensions. Availity RCM will need to be provided with up to three distinct file extensions of your choice per type of input file service (Claim, Eligibility, Patient Statements...). Those file extensions will be configured for the proper input directory and will be validated on every file submission. If the file loaded does not match the configured extensions the file will fail and be moved to the \FAILURE directory. After Availity RCM accepts the file from the Availity RCM Automated File Transmission Gateway, the file will be checked for duplication, translated and processed.

Availity RCM can also accept zipped files. These files will be unzipped and the contents processed. The file extension for zipped files is also the choice of the client, but they cannot be the same file extension as the actual files that will be processed.

The Automated File Transmission Gateway Sweeper checks all configured input directories approximately every minute, 24 hours a day, seven days a week, unless application maintenance is being performed.

Unique file names should be used to prevent the possibility of a file being overwritten.

## Availity RCM File Directory Structure

The information contained within braces, [], differs according to the specific client setup; however the underlying directory structure is identical for all clients.

```
\[OFFICE-NAME]
  \[SUB-OFFICE NAME (OPTIONAL)]
    \CLAIMS
      \INPUT      (claim file: hcfa/nsf/5010/ect.)
      \OUTPUT     (997 or file level acknowledgement)
      \SUCCESS    (15 day archive of successful input files)
      \FAILURE    (15 day archive of unsuccessful input files)
    \ELIG
      \INPUT      (270, legacy eligibility request)
      \OUTPUT     (271, 997, TA1, legacy response, file level acknowledgement)
      \SUCCESS    (15 day archive of successful input files)
      \FAILURE    (15 day archive of unsuccessful input files)
    \ERA
      \INPUT
      \OUTPUT     (835, custom ERA response)
      \SUCCESS
      \FAILURE
    \REPORTS
    \POSTBACK
      \INPUT      (Custom PM System Post request file)
      \OUTPUT     (Custom PM System return file)
      \SUCCESS    (15 day archive of successful input files)
      \FAILURE    (15 day archive of unsuccessful input files)
    \STATUS
      \INPUT      (276, custom claim status request)
      \OUTPUT     (277, 277U, 997, TA1, custom claim status response)
      \SUCCESS    (15 day archive of successful input files)
      \FAILURE    (15 day archive of unsuccessful input files)
    \PTST
      \INPUT      (custom patient statement file)
      \OUTPUT     (file level acknowledgement)
      \SUCCESS    (15 day archive of successful input files)
      \FAILURE    (15 day archive of unsuccessful input files)
    \TEST
      \CLAIMS
      \ELIG
      \ERA
      \POSTBACK
      \STATUS
      \PTST
```

## File Level Acknowledgement Responses

Availity RCM has the ability to return various responses for files that are uploaded via any available automated file transmission option. These responses will be placed in the OUTPUT directory. Clients will need to contact their Client Account Manager to start the setup process for these response options.

### Automated File Transmission Gateway Response

This response is created out of our file sweeper program and would be available for pickup within 5 minutes of submission. File naming convention is the original file name with a new extension of .ack.

File Name Example:

If you upload a file named CLM0503.txt the response file would be named CLM0503.ack

Text output:

TYPE: FILE ACKNOWLEDGEMENT  
DATE: 5/3/2005  
TIME: 09:54:01 AM  
INFO: CLM0503.txt  
STATUS: RECEIVED

### 997 Response (Claims file only – 4010 submission format only)

This response is created out of the translation program and would be available after the file was translated by Availity RCM. Availity RCM performs a compliance check on the inbound file when we return a 997. This type of response would require additional testing to ensure the 4010 files that are being submitted would pass a compliance checker.

File Name Example:

If you upload a file named CLM0503.TXT the response file would be named CLM0503.997

### Batch Claim Summary Response (Claims file only – any format)

This response is created out of our translation program and would be available after the file was translated by Availity RCM. The file contains only the number of claims translated by Availity RCM. If a file fails translation then a zero is returned. If the file was reprocessed then you would receive another response file for the correct number of translated claims. File naming convention replaces the first three characters of the original file name and also replaces the original extension with .ASC

File Name Example:

If you upload a file named CLM0503.TXT the response file would be named RESP\_CLM0503.TXT.ASC

Text Output:

1234

### Translation Response (Claims file only – any format)

This response is created out of our translation program and would be available after the file was translated by Availity RCM. The response contains the file name, Availity RCM assigned batch name,

submission date / time stamp, total claims and total charges. File naming convention adds a .rpt to the full uploaded file name.

File Name Example:

If you upload a file named CLM0503.TXT the response file would be named CLM0503.TXT.RPT

Text Output:

```
FILE_NAME: CLM0503.TXT
RM_BATCH_NAME: 20060812-022603
SUBMIT_DATE: 8/12/2006 2:26:03 AM
TOTAL CLAIMS: 496
TOTAL CHARGES: 155350.28
```

## **Availity RCM Data Availability Guidelines**

Availity RCM retains all data received from clients and payers. There are two different ways in which data is stored: 1) online and immediately accessible or 2) archived electronically and available through reports or by a request to the Client Service Center (CSC).

### **Screen Data within the Availity RCM Application**

All transaction data is available for least 5 years within the application. All transaction data is available in the Report Analysis module within 24 hours; this includes data up to 5 years. This guideline affects Claims Submission, Status Management, Patient Statement, Payment Management, and Remittance Management modules.

### **Recommended Screen Data Reports**

- Claim Progress Report
- Claim Status Report
- Claim Detail Report
- Deleted Claims Report
- Drop to Paper Claims Report
- Payer Total Claims/Total Charges
- Provider Total Claims/Total Charges
- Remit Delivery Report
- Patient Statement Progress Report
- Patient Statement Summary Report
- Patient Statement Address Correction Report
- Patient Statement Force Mail Report

All eligibility data within the Eligibility module is available from 1 to 5 days as defined in the Administration module under Office Preferences. Some offices may have eligibility information available for longer if a custom time frame is established. Eligibility information is not archived and is not available in any form after it has been removed from the Eligibility module.

### **Recommended Eligibility Data Reports**

- Eligibility Summary Report

### **Ability to Edit Data within the Availity RCM Application**

All editable data is available for least 2 years within the application. This guideline affects Edit/Error Management, Patient Statement Edit/Error Management, and Remit Generation. After the 2 year time period, the data can be accessed for viewing only through various screens as outlined above, or through Report Analysis. Claim errors and Patient Statement addresses cannot be corrected after 2 years. Remits in a received status cannot be generated after 2 years.

## **Report Analysis**

All transaction information is available in the Report Analysis module 24 hours after it has been posted within the application.

All reports created in the Report Analysis module are available for the time period defined in the Administration module. The following settings are available under Office Preferences:

- Reports expire from the inbox every 30, 60 or 90 days (60 days is the default setting)
- Remove inactive custom report from the report library every 30, 60, 90 or 365 days (90 days is the default setting)
- Remove scheduled non-viewed reports after 5,10 or 15 generations (10 generations is the default)

## **Inbound Claim, Eligibility, and Patient Statement Files**

All successful inbound claim, eligibility and patient statement files are available in their native state (i.e. same format as received) for a period of 12 months.

All failed eligibility and patient statement files submitted using FTP or Secure File Exchange is stored for 14 days. After 14 days, the files are deleted and are not available.

All claims files that are not successfully processed when submitted through FTP due to any failure (example: incorrect file extension) will be stored on the FTP site for 14 days.

All claim files that fail within the application are available for a period of 12 months in its native state.

## **Remittance Download Files**

All remittance download files are available within the application for 90 days. After 60 days, and up to 18 months, remittance files can be regenerated for an office upon request through a ticket to CSC. These are regenerated with the current version of the file format set-up for the payer in the specific office. All remit data is available in the Report Analysis module within 24 hours; this includes data over 18 months and up to 5 years. Remits cannot be regenerated after 18 months.

## **Custom Reports**

Custom reports delivered directly by Application Support may be able to be reproduced depending on the content of the report. Reports that are not listed directly within an email (FTP delivered reports and reports attached to email) are not archived.

## **Secure File Exchange / FTP Site Files**

All files received in FTP sites are available for 14 days. After 14 days the files are deleted and are not available. Clients may delete files from the FTP site at any time.

Secure File Exchange file availability is the same as FTP. However, clients do not have access to the files.

## **Claim Confirmation Reports (FTP only)**

All confirmation files generated by Availity RCM for clients are available for 14 days with the FTP site. This includes the HIPAA compliant 997 confirmation files and Availity RCM proprietary confirmation files.

# Standard Integration

## 837 – Batch Claims Submission

### Overview

Availity RCM supports the submission of batch ANSI 837 claims submission to enable a provider to submit one or more claims in a single transaction file and is capable of handling a very large volume of claims using this method. Claim batches will be posted to the Availity RCM Application Portal for review, correction, and/or resubmission.

### Implementation

#### File Transfer

The ANSI 837 claims submission transaction files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

#### Version

Availity RCM currently supports both ANSI 4010 and 5010 versions for claims submission.

#### ANSI ISA and GS Specific Recommendations

Availity RCM has the ability to process almost any ISA and GS segments and will correct or default the needed values for processing. Elements not listed here should be completed following your normal business practice.

Field	Field Description	Value	Comment
ISA05	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA06	Interchange Sender ID	Public Office ID	The Public Office ID used on the credentials.
ISA07	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA08	Interchange Receiver ID	'REALMED'	Constant
ISA16	Component Element Separator	:	Constant
GS02	Application Sender's Code	Public Office ID	The Public Office ID used on the credentials.
GS03	Application Receiver's Code	Availity RCM Tax ID	The Federal Tax Identification Number for Availity RCM which can be provided by your Customer Account Manager.

#### Routing

Availity RCM has the ability to route claims to sub offices within a client's office hierarchy. Typically this is accomplished at the corporate office level down based on a unique identifier such as the tax id or and NPI for the rendering or billing provider. The ability to route claims to a sub office eliminates the need for a separate claims prior to sending to Availity RCM. Each routing rule must have a unique ID such as a tax id to ensure that claims are properly routed to the correct sub office.

#### Custom Edits

Availity RCM has the ability to develop custom edits for clients that will be applied at claim submission. These edits are applied as part of the standard claims editing process and will prevent a claim from being submitted to a payer until the data is corrected and passes the edit. Claims that fail a custom edit will be placed in the Edit Error Management screen of the Availity RCM Application Portal, so that they can be corrected and sent to the payer.

## **Advanced Claims Editing**

Availity RCM's Advanced Claims Editing package is a comprehensive rules authoring solution that enables physicians and healthcare providers to quickly respond to changing healthcare industry rules. Advanced Claims Editing gives practices the ability to customize and maintain their own business rules without the need for highly technical and specialized resources.

With Advanced Claims Editing, the practice's unique editing situations are addressed through a set of wizard-like screens. Advanced Claims Editing handles the most complex editing needs in an efficient, user-friendly fashion.

### **Advanced Claims Editing Benefits**

- Create and control unique custom edits at your fingertips!
- Utilize step-by-step screens that eliminate the need for programming resources.
- Experience fewer denials through customized, up-front, provider-specific identification of errors.
- Eliminate the need for additional hardware or software.
- Gain adaptability for all unique provider and payer specific rules in any practice-management system environment.
- Integrated within a single, standardized workflow that significantly reduces the burden and cost of using multiple vendors.
- Enjoy a higher level of customization, beyond anything that Availity RCM has offered to date.

### **Advanced Claims Editing Features**

- Build custom provider and payer-based edits.
- Enjoy advanced editing functionality (LCD / NCD / CCI).
- Integrated security and role-based permissions.
- Speed results with the easy-to-use wizard.
- View dropdown lists for comparison and field selection.
- Customize error messages.
- Easily manage content lists.
- Gain real-time testing of new rules and removal when edits are no longer required.
- Facilitate immediate or scheduled implementation of new edit rules.

## **Rules**

Availity RCM has the ability to develop rules that will provide default information, alter existing information, or remove erroneous information before edits can be applied. If a PM system is not able to create claims in the way that the payer can process correctly, a custom rule can be applied prior to the claim being processed. Rules are applied before any editing takes place. Rules can be applied at a client or office level.

## Edit Matrix

Editing Capability	Professional		Hospital	
	RCM	Advanced Claims Editing	RCM <span style="color:red">1</span>	Future
<b>ANSI/HIPAA Compliance Levels 1-7 (situational by payer)</b>				
Level 1: Integrity (Valid segments, segment order, X12 syntax, etc.)	✓		✓	
Level 2: Requirements (HIPAA Implementation Guide Specific)	✓		✓	
Level 3: Balancing (Field totals, record and segment counts, etc.)	✓		✓	
Level 4: Situation (Inter Segment Situations; if A occurs then B is required)	✓		✓	
Level 5: Code Set (Valid code set values)	✓		✓	
Level 6: Product / Types of Service (Line-of-Business / Specialty)	✓		✓	
Level 7: Trading Partner Specific (Clearinghouse, Payer Specific Edits)	✓		✓	
<b>Code Validation</b>				
ICD-9 (Diagnosis and Procedure)	✓		✓	
ICD-10 (Diagnosis and Procedure)	2		2	
CPT/HCPCS Procedure	✓		✓	
Modifier	✓		✓	
Revenue Code Validation			✓	
DRG (Diagnostic Related Groups) validation			✓	
Taxonomy Code Validation	✓		✓	
Occurrence Codes Validation			✓	
Occurrence Span Validation			✓	
Value Code Validation			✓	
Condition Code Validation			✓	
MUE (Medically Unlikely Edits)		✓	✓	
PQRI (Physician Quality Reporting Initiative)		Future		Future
CPT to Allowable Modifier		Future		Future
Home Health Treatment		Future		Future

Editing Capability	Professional	Hospital		
	RCM	Advanced Claims Editing	RCM <sup>1</sup>	Future
<b>Correct Coding and Usage Edits</b>				
Age (Procedure, CPT, HCPCS)	✓		✓	
Gender (Procedure, CPT, HCPCS)	✓		✓	
Place of Service / Type of Bill	✓		✓	
CCI/NCCI (mutually exclusive, components and modifier overrides)	✓		✓	
Add-on Codes		✓	✓	
Modifier Crosswalk (Modifier to Unallowed Modifiers)		✓	✓	
OCE/OPPS/IOCE (Outpatient Code Editor)			✓	
MCE (Medicare Code Editor)			✓	
DRG (Diagnostic Related Groups) Grouper - Validation				Future
APC (Ambulatory Payment Classification) Grouper - Validation				Future
<b>Medical Necessity (LCD/NCD/LMRP)</b>				
Medicare	□	✓	✓	
Medicare - DME	□	✓	✓	
Medicaid <sup>3</sup>	□	✓	✓	
Aetna <sup>4</sup>		Future		Future
United <sup>4</sup>		Future		Future
BCBS <sup>4</sup>		Future		Future
<b>Client Defined Custom Edits</b>				
RealClean Practice Managed Edits - Customer built (any field)		✓	\$\$\$	
RealClean Practice Managed Historical Edits - Customer built (any field) <sup>5</sup>		✓	\$\$\$	
RealMed Managed Implementation Edits (0-90 days post-implementation)			✓	
RealMed Managed Post-Implementation Edits (90+ days post-implementation)			\$\$\$	

<sup>1</sup> - While editing content is included in the standard Hospital RCM package, Hospital RCM and Advanced Claims Editing for Hospitals will be invoiced as separate line items.

<sup>2</sup> - Will be implemented in preparation for ICD-10 mandates.

<sup>3</sup> - Not all State Medicaid medical necessity policies available.

<sup>4</sup> - Not all BCBS or commercial medical necessity policies available.

<sup>5</sup> - Historical comparison are based on claims submitted to RealMed. The Core RCM product is required to utilize this functionality.

\$\$\$ - Available Option (Additional fees apply)

## Payer Mapping

Availity RCM uses a payer mapping functionality to route claims to the specific payers. The mapping of payers is based on the name and/or the payer ID from the PM system to a specific payer ID available within the Availity RCM Application Portal. The mapping process allows a PM system to maintain a list of payers in the desired format and naming conventions without needing to populate the Availity RCM payer list. The first time a claim is sent to a payer that has not been mapped, the claim will be stopped in the Availity RCM Application Portal Payer Mapping screen until the mapping process can be completed for the payer and the claim released. Claims held in payer mapping do not need to be resubmitted.

## Claims Payer List

Availity RCM provides a list of supported payers on the Availity RCM corporate website at [http://www.realmed.com/payer\\_connections\\_list.aspx](http://www.realmed.com/payer_connections_list.aspx). This list website can be used to select and filter a list of payers, print a report, or download to an excel csv file. To download the file, click on the "Export" link and save the file.

The list is driven by the current payer definition within the Availity RCM Application Portal and is updated on a daily basis with new payers or payer capabilities.

## Claims Payer List – Excel Definition

Column	Column Header	Comment
A	Payer Name	Name of the payer.
B	Payer Number	Availity RCM payer number. This payer number still requires payer mapping within the Availity RCM Application Portal.
C	Payer Type	Blue Commercial Medicaid Medicare Tricare Workers Comp.
D	State	Two character state restrictions.
E	Professional Claims	X – Available
F	Eligibility	X – Available through Availity RCM Application Portal \$ – Available through Availity RCM Application Portal and fees apply
G	Claims Status	X – Available through Availity RCM Application Portal
H	Remit	X – Available
I	Secondary-Tertiary	S – Secondary electronic claim submission supported. T – Secondary and Tertiary electronic claim submission supported.
J	Enrollment Paperwork	Payer required notification and/or paperwork C – Paperwork required for Professional claim submission E – Paperwork required for eligibility verification S – Paperwork required for claim status R – Paperwork required to receive ERA (remittance)

## 835 – Claims Remit Posting

### Overview

Availity RCM supports the return of claim remittance advice information from the payers in the ANSI 835 format. Once the 835 has been delivered back to the originating system, it can be used for auto-posting of the accounting information including adjustments.

### Implementation

#### File Transfer

The ANSI 835 remittance advice transaction files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

#### Version

Availity RCM currently supports both ANSI 4010 and 5010 versions for remittance advice.

#### Reference

Full ANSI guide for the 835 claims remit is available from Availity RCM.

#### Options

The following options can be used to control the structure and content of the 835 file. These options must be set on a client-by-client basis with some options available for each payer. These options are set within the Availity RCM Applications Portal for each office and/or payer.

Option	Settings	Default	Comments
Splitting		Payer	See detailed description below.
Time	<ul style="list-style-type: none"><li>• 7:00 A.M.</li><li>• 11:00 A.M.</li><li>• 1:00 P.M.</li><li>• 3:00 P.M.</li><li>• 5:00 P.M.</li></ul>		All times in EST. Multiple runs per day may be scheduled.
Auto Accept	Yes/No	No	Yes – Forces 835 remits to be auto accepted from the payer into the Availity RCM application. No – The 835 remit must be manually accepted into the Availity RCM application.
Auto Generate	Yes/No	No	Yes – Force the 835 remit file to be automatically generated for delivery to the provider. No – The 835 remit file must be manually generated for delivery to the provider.
File Name			See detailed description below.
Sort			See detailed description below.
ISA06 & GS02 Override			See detailed description below.

## **Splitting**

Availity RCM allows for splitting of 835 remits into multiple physical files based on several criteria designed to support specific office or vendor needs.

Option	Default	Comments
Payer	Yes	By default, Availity RCM will split remits by payer. This functionality matches the concept of downloading a remit file from each payer and working them individually. Remits may be split by payer and one additional criterion.
Check Number	No	Split remits based on check number. The resulting files will have remits for a single check number.
Zero Paid Checks	No	Split zero pay claims into a separate file. Using this split will result in a file of zero pay remits as well as a file of remits that contain payment information.
Patient Account Number	No	Split remits based on the patient account number. The resulting files will have remits for a single patient account number.
Payment Type	No	Split remits based on the payment type. The resulting files will have remits for a single payment type. Payment types: ACH – Automated Clearinghouse BOP – Financial Institution Option CHK – Check FWT – Federal Reserve Funds/Wire Transfer NON – Non-Payment Data
Check Number with Check Date	No	Split remits based on the check number and check date. The resulting files will have remits for a single check number and check date.

## **File Name**

The file name can be constructed of various text, keyword, and extension codes to help facilitate workflow and processing of the 835 remit file to the PM system. The file name can be tailored for each payer for which remits are generated. The maximum length of the file name is 30 characters including the period and extension.

Parameter	Comments
Text	Any valid text A – Z and 0 – 9.
BATCH_ID	This keyword will be substituted with the actual Batch ID for the remit file.
MMDDYY	This keyword will be substituted with the generation date.
HHMMSS	This keyword will be substituted with the generation time.
SPLIT	This keyword will be substituted with the split type.
Extension	Any valid file extension for the 835 remit file. Example: .835 .4010 .5010 .txt

Sample:

Parameters → AETNA\_(MMDDYY)\_(BATCH\_ID).4010

Result → AETNA\_051901\_39947.4010

## **Sort**

The file name can be sorted on various criteria to help facilitate workflow and processing of the 835 remit file to the PM system. The sort criteria can be tailored for each payer for which remits are generated. Only one sort option can be assigned per file.

<b>Option</b>	<b>Default</b>	<b>Comments</b>
Check Number / Patient name	Yes	By default, Availity RCM will sort remits by the check number and patient name ascending.
Check Number / Patient Account Number	No	Sort remits by the check number and patient account number ascending.
Check Number / Billed Amount	No	Sort remits by the check number ascending and the billed amount descending.
Payment Issue Date / Billed Amount	No	Sort remits by the payment issue date ascending and the billed amount descending.
Payment Issue Date / Patient Account Number	No	Sort remits by the payment issue date and the patient account number ascending.
Payment Issue Date / Patient Name	No	Sort remits by the payment issue date and the patient name ascending.
Total Charge / Patient Name	No	Sort remits by the total charges descending and the patient name ascending.
Total Charge / Patient Account Number	No	Sort remits by the total charges descending and the patient account number ascending.
Total Charge / Billed Amount	No	Sort remits by the total charges and billed amount descending.

## **ISA06 & GS02 Override**

By default, Availity RCM will fill the ISA06 and GS02 values with the constant 'REALMED'. This value may be overridden on a per client per payer basis. Either of these fields or both can be overridden but if an override is entered for both, the same value will apply to each element.

## 270/271 – Batch Eligibility Verification

### Overview

Availity RCM supports the submission of batch ANSI 270 eligibility request to enable a provider to verify one or more patients in a single transaction file and is capable of handling a very large volume of request using this method. Once responses have been received for the batch or after a specified time period has passed, Availity RCM will generate an ANSI 271 eligibility response to communicate the results received from the payers. Eligibility request and responses will be posted to the Availity RCM Application Portal for review, correction, and/or resubmission.

### Eligibility Payer List

Availity RCM will provide a list of payers which support either batch or real-time eligibility verification. This is delivered as an excel spreadsheet and should be used to provide valid Payer IDs for each desired payer. No payer mapping process is used for eligibility verification meaning that the Payer IDs provided in this list must be used.

Availity RCM will periodically provide updates to this list which may include new payers, new services for an existing payer, removal of a service from an existing payer, or removal of an existing payer.

### Eligibility Payer List – Excel Definition

Column	Column Header	Comment
A	Payer Name	Name of the payer.
B	Public Payer ID	Payer ID to be used on the NM109 element for the payer loop.
C	Batch	Indicates support for batch eligibility Yes – Supported Blank – Not Supported
D	Real-Time	Indicates support for real-time eligibility Yes – Supported Blank – Not Supported
E	EDI Payer Name	Optional field indicating name of EDI payer servicing the request.

### Implementation

#### File Transfer

The ANSI 270 and 271 batch eligibility request and response transaction files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

#### Version

Availity RCM currently supports both ANSI 4010 and 5010 versions for eligibility verification.

#### Reference

Full definition of the ANSI 270 and 271 transactions are available in [Appendix A – 270/271 Quick Start Guide \(5010\)](#)

## **ANSI ISA and GS Specific Requirements**

The following segments of the 270 request should be completed as defined below to support Availity RCM's processing of the request. Elements not listed here should be completed following your normal business practice.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
ISA05	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA06	Interchange Sender ID	Public Office ID	The Public Office ID used on the credentials.
ISA07	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA08	Interchange Receiver ID	'REALMED'	Constant
ISA16	Component Element Separator	:	Constant
GS02	Application Sender's Code	Public Office ID	The Public Office ID used on the credentials.
GS03	Application Receiver's Code	Availity RCM Tax ID	The Federal Tax Identification Number for Availity RCM which can be provided by your Customer Account Manager.

# Availity RCM Proprietary – Batch Eligibility Verification

## Overview

The Availity RCM provides a proprietary pipe | delimited file format for requesting eligibility verification from systems that are unable to generate an ANSI 270 request. Availity RCM will translate this request in to a standard format and submit the transaction for processing. Eligibility request and responses will be posted to the Availity RCM Application Portal for review, correction, and/or resubmission.

Availity RCM may add additional optional fields to this definition to accommodate specific needs of various payers. Any additional fields will always be added at the end of the record so that existing sources will continue to process correctly without modification.

Optionally, Availity RCM can generate a proprietary pipe | delimited response file which can be used to update the originating system. Each row in this file contains the original request as well as the actual status information.

## Cross-Reference Data

Specific elements of the batch eligibility file are used to cross reference within Availity RCM Application Portal:

- Field 1 – Office Number - Practice Management Office ID (001 – Office1)  
This value is used to determine which office the eligibility request will route. The Office Number should be set up by Availity RCM Application Support prior to batch eligibility file upload.
- Field 2 – Payer Number - Practice Management Payer ID (022 – BCBS, 047 – AETNA)  
This value is used to determine the payer for which the eligibility is being requested. The Payer Number needs to be mapped to the specific eligibility payer in the Set-up Payers screen within the Availity RCM Application Portal.
- Field 7 – Provider ID - Practice Management Provider ID (010 – John Smith)  
This value is used to determine the provider for which the eligibility is being requested. This value can be mapped to the specific provider information to be displayed on the Eligibility Management screen. The Provider ID needs to be mapped in Set-Up Providers. This is an optional field.

## Implementation

### *File Transfer*

The Proprietary Batch Eligibility transaction files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

## Request File Definition

The Proprietary Batch Eligibility Request file must be generated using pipe | delimited format. Fields not populated should be blank and the file should still contain a place on each row for that specific data element.

#	Field Name	Data type	Size	Required	Comments
1	Office Number	Character	35	Y	Practice Management (PM) Office ID to create cross reference (See details below)
2	Payer Number	Character	36	Y	PM Payer ID or payer EDI code to create cross reference. (see details below)
3	Patient Account Number	Character	25	Y	PM Patient Account Number
4	Request Date	DATE		Y	Should be able to default (Current Date)  MM/DD/CCYY HH:MM:SS  *Note: If policy request date is in the future, current date will be used for eligibility verification
5	Policy Number	Character	30	Y	Subscribers insured number or subscribers SSN
6	Group Number	Character	30	N	Subscribers group number
7	Provider ID	Character	35	Y	PM Physician ID to create cross reference. This number is used in Provider Mapping within the Availity RCM application. (see details below)
8	Provider Tax ID	Character	30	N	Federal tax number, Payer assigned provider number, or NPI. This field should be populated for any payer that requires a provider ID for an eligibility request.  *Note: This field can also be used for automatic provider mapping
9	Provider Group	Character	10	N	Payer specific group number or NPI.  *Note: This can be used for BCBS North Carolina automatic provider mapping
10	Service Code	Character	5	N	The specific benefit code for which eligibility information will be retrieved. This list is available in the Reference section below.  *Note: Use benefit code "30" for Health Benefit Plan Coverage for AETNA.

	<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Required</b>	<b>Comments</b>
11	Patient Date of Birth	DATE		Y	Will be used to match patient to information in the payers system. MM/DD/CCYY
12	Patient First Name	Character	25	Y	Will be used to match patient to information in the payers system.
13	Patient Last Name	Character	25	Y	Will be used to match patient to information in the payers system.
14	Patient SSN	Numeric	9	N	Will be used to match patient to information in the payers system.
15	Relationship	Character	1	Y	Will be used to match patient to information in the payers system.  P - Primary S - Spouse C - Child O - Other
16	Card Number	Character	5	N	Additional information for insured/dependents  *Note: This should be used for Pennsylvania and South Dakota Medicaid
17	Policy Suffix	Character	5	N	Additional information for insured/dependents  *Note: This should be used for Mercy Care Plan and Nationwide Health Plans of Ohio
18	Plan Code	Character	5	N	Additional information for insured/dependents  *Note: This should be used for TriCare and UnitedHealthcare HMO
19	Card Issue Date	DATE		N	Date the policyholder's card was issued MM/DD/CCYY
20	Patient Sex Code	Character	1	Y	Patient's Gender F – Female M – Male U – Unknown
21	Provider Type	Character	5	N	Provider Type Code  *Note: Specifically used for Michigan Medicaid. Two digit Provider code assigned by the payer.
22	Subscriber Last Name	Character	25	N	Last name of the subscriber, for matching the subscriber for the policy in the payers system.

	<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Required</b>	<b>Comments</b>
23	Subscriber First Name	Character	25	N	First name of the insured, for matching the subscriber for the policy in the payers system.
24	Service State	Character	2	Y	State in which the visit/service was performed
25	Patient State	Character	2	N	State in which the patient is a resident
26	Patient Name Suffix	Character	3	N	The patient's name suffix.
27	Insured Name Suffix	Character	3	N	The subscriber's name suffix.
28	Primary ID Number	Character	100	N	The primary identifier of the provider should be populated in this field. If NPI is placed in this field the format will be validated before being sent on to payers.
29	Primary ID Number Type	Character	100	N	The type of identifier being sent in the PRIMARY_ID_NUM field. XX - NPI SY - Social Security Number EI - Tax Identifier
30	Place of Service Code	Character	4	N	The place where the service is being performed on the patient. This is for BCBS Illinois only.
31	Billing Provider Taxonomy Code	Character	30	N	Taxonomy Code for the Billing Provider.
32	Service Facility Zip Code	Character	15	N	Zip code of where the service was Rendered.
33	Service Facility City	Character	19	N	City in which the service was rendered.
34	Service Facility State	Character	2	N	State in which the service was rendered.
35	Procedure Service Type	Character	2	N	Optional Procedure Service Type qualifier CJ – CPT HC – HCPCS
36	Procedure Code	Character	100	N	Optional Procedure Code

## Sample

10|001|PAT1234|05/16/2002|YPP123456789||22|000000000|00000||01/01/1970| ↵  
 JOHN|DOE|000000000|P|01||||M|103|DOE|JOHN|IN|MI||JR||| ↵

12|001|PAT1234|05/16/2002|YPP123456789||22|000000000|00000|30|01/01/1971| ↵  
 JANE|DOE|111111111|S|01||||F|103|DOE|JANE|IN|MI|||1234567893|XX| ↵

12|001|PAT1234|05/16/2002|YPP123456789||22|000000000|00000||01/01/1971| ↵  
 JANE|DOE|111111111|S|01||||F|103|DOE|JANE|IN|MI|||1234567893|XX|CJ|99214| ↵

## Response File Definition

The Proprietary Batch Eligibility Response file will be generated using pipe | delimited format. The initial response will be appended to the beginning of each response with the actual request appended to the end.

Field Name	Data type	Size	Required	Comments
INITIAL REQUEST FIELDS				All fields included in the original request.
EligibilityStatus	Character	10		
PatientInsured Number	NUMBER	10,0		
PatientAddress Line1	Character	55		
PatientAddress Line2	Character	55		
PatientCity	Character	30		
PatientState	Character	2		
PatientZipCode	Character	15		
PatientDateOfBirth	Character	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PatientGender	Character	1		"M" or "F"
RelationshipTo Primary	Character	80		
PatientAccount MRN	Character	50		
PatientEligibility Status	Character	20		"Unknown", "Active", "Inactive", "Passthrough", or "Excluded"
PatientEligibility Date	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PatientExpire Date	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PatientContact Name	Character	60		
PatientContact Phone	Character	80		
OriginalPatientID	Character	50		
PatientFirstName	Character	35		
PatientLastName	Character	60		
PrimaryCare PhysicianContact	Character	60		
PrimaryCare PhysicianContact Phone	Character	256		
Benefits Message1	Character	264		

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Required</b>	<b>Comments</b>
Benefits Messsage2	Character	264		
Benefits Messsage3	Character	264		
Benefits Messsage4	Character	264		
Benefits Messsage5	Character	264		
Benefits Messsage6	Character	264		
Benefits Messsage7	Character	264		
Benefits Messsage8	Character	264		
Benefits Messsage9	Character	264		
Benefits Messsage10	Character	264		
PrimaryInsured Number	NUMBER	10,0		
PrimaryName	Character	150		
PrimaryAddress	Character	55		
PrimaryCity	Character	30		
PrimaryState	Character	2		
PrimaryZipCode	Character	15		
PrimaryDateOf Birth	Character	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PrimaryGender	Character	1		"M" or "F"
Primary RelationshipTo Primary	Character	4		"SELF"
PrimaryAccount MRN	Character	50		
PrimaryInsured EligibilityStatus	Character	20		"Unknown", "Active", "Inactive", "Passthrough", or "Excluded"
PrimaryInsured EligibilityEffective Date	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PrimaryInsured ExpireDate	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PrimaryInsured GroupName	Character	80		

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Required</b>	<b>Comments</b>
PrimaryInsured GroupNumber	Character	50		
PrimaryInsured ContactName	Character	100		
Primary ResponsibleParty	Character	100		
PrimaryCase Number1	Character	50		
PrimaryCase Number2	Character	50		
PrimaryCase Number3	Character	50		
PayerName	Character	100		
PayerAddress	Character	165		
PayerCity	Character	30		
PayerState	Character	2		
PayerZipCode	Character	15		
PayerPhone	Character	16		
PayerID	Character	80		
Additional PayerName	Character	100		
Additional PayerAddress	Character	165		
Additional PayerCity	Character	30		
Additional PayerState	Character	2		
Additional PayerZipCode	Character	15		
Additional PayerPhone	Character	16		
Additional PayerInsurance Type	Character	100		
Additional PayerID	Character	80		
Additional PayerMemberID	Character	100		
Additional PayerGroup Number	Character	50		

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Required</b>	<b>Comments</b>
Additional PayerEligibility Date	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
Additional PayerCoverage Type	Character	100		
Additional PayerInformation Contact	Character	60		
Additional PayerInformation ContactPhone	Character	256		
Additional PayerIdentifier	Character	100		
BenefitsPlan Description	Character	250		
BenefitsIdentifier	Character	80		
BenefitsName	Character	50		
BenefitsAddress	Character	165		
BenefitsCity	Character	30		
BenefitsState	Character	2		
BenefitsZipCode	Character	15		
BenefitsActive CoverageDate	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
OtherSources Name	Character	100		
OtherSources Address	Character	165		
OtherSourcesCity	Character	30		
OtherSourcesState	Character	2		
PolicyDates Enrollment	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
PolicyDates Eligibility	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
Application SelectPatient InsuredNumber	Character	100		
Application SelectPatient Name	Character	100		
Application SelectPatient Gender	Character	100		

Application SelectPatient DateOfBirth	Character	100		
Application SelectPatient EligibilityStatus	Character	100		
InformationLine Passthrough FromDate	Character	100		
InformationLine Passthrough ExpireDate	Character	100		
Submitted PatientName	Character	100		
Submitted PatientMRN	Character	25		
Submitted PatientDOB	DATE	35		Any form of ANSI formatted date range, including "yyyymmdd-yyyymmdd".
Submitted GroupNumber	Character	30		
Submitted PolicyNumber	Character	30		
Submitted PayerName	Character	100		
Submitted ProviderName	Character	100		
InsuredAAA1	Character	NO MAX		
InsuredAAA2	Character	NO MAX		
InsuredAAA3	Character	NO MAX		
InsuredAAA4	Character	NO MAX		
InsuredAAA5	Character	NO MAX		
InsuredAAA6	Character	NO MAX		
InsuredAAA7	Character	NO MAX		
InsuredAAA8	Character	NO MAX		
InsuredAAA9	Character	NO MAX		



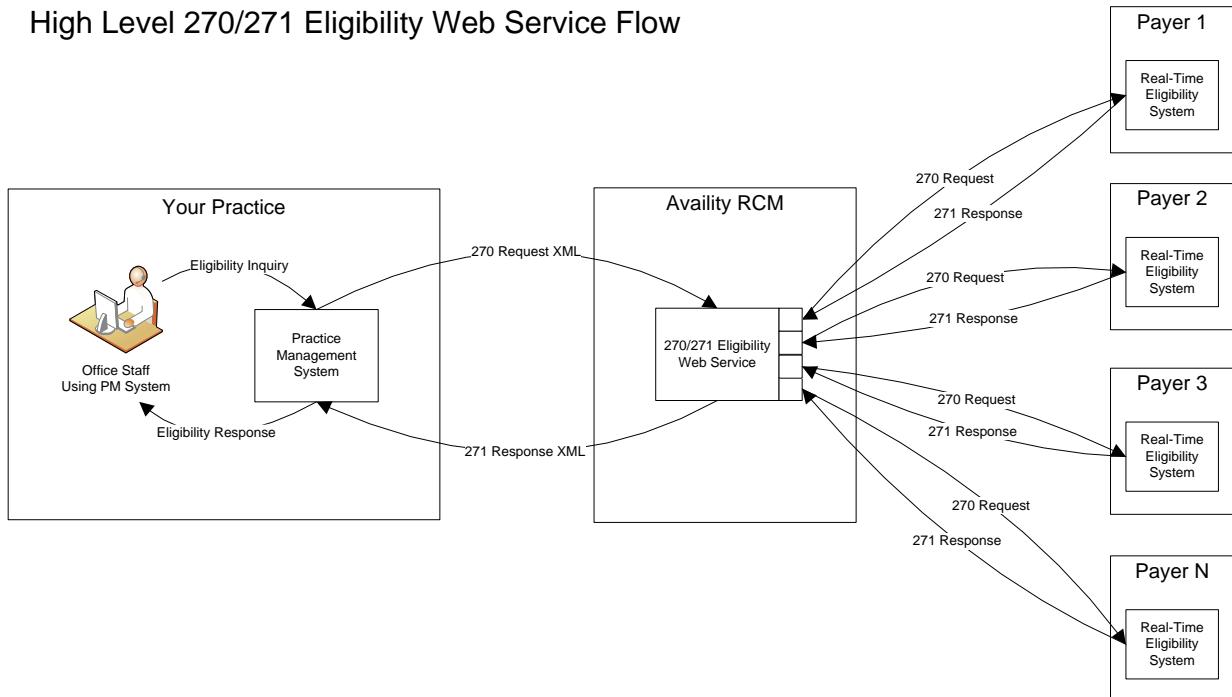
# Advanced Integration

## 270/271 – Real-Time Eligibility Web Service

### Overview

The Availity RCM 270/271 Eligibility web service provides an online real-time utility that can be used by Practice Management systems to electronically perform patient eligibility check. The eligibility web service receives an ANSI standard 270 request, forwards the request to the appropriate payer in their format, receives the response from the payer, and returns the ANSI standard 271 response to the requestor.

High Level 270/271 Eligibility Web Service Flow



### Payer Real-time Availability

Payers must support real-time eligibility response checking for the web service to successfully process an eligibility check. When calling the eligibility service for payers who do not support real-time eligibility checking, a 997 response will be returned to the calling application.

## **Eligibility Payer List**

Availity RCM will provide a list of payers which support either batch or real-time eligibility verification. This is delivered as an excel spreadsheet and should be used to provide valid Payer IDs for each desired payer. No payer mapping process is used for eligibility verification meaning that the Payer IDs provided in this list must be used.

Availity RCM will periodically provide updates to this list which may include new payers, new services for an existing payer, or removal of an existing payer.

### ***Eligibility Payer List – Excel Definition***

Column	Column Header	Comment
A	Payer Name	Name of the payer.
B	Public Payer ID	Payer ID to be used on the NM109 element for the payer loop.
C	Batch	Indicates support for batch eligibility Yes – Supported Blank – Not Supported
D	Real-Time	Indicates support for real-time eligibility Yes – Supported Blank – Not Supported
E	EDI Payer Name	Optional field indicating name of EDI payer servicing the request.

## **Implementation**

### ***Credentials***

In order to use the web service, the user must have valid credentials for the environment being called. These credentials are available through your customer service representative and must be populated on each web service call.

- Submitter ID – The Public Office ID for the office calling the web service. Each office calling the web service should have a unique Submitter ID.
- User Name – Availity RCM user name associated to the office.
- Password – The user's password.

Request with invalid credentials will result in 997 or TA1 response being returned to the calling application.

Practice Management system vendors or integration partners must develop their systems in such a manner to ensure that the proper credentials are used for each client. It will not be sufficient to develop the system in a manner that the web service will be called with a single set of credentials no matter which client is using the system.

## **Version**

Availity RCM currently supports both ANSI 4010 and 5010 versions for eligibility verification.

## **Reference**

Full definition of the ANSI 270 and 271 transactions are available in [Appendix A – 270/271 Quick Start Guide \(5010\)](#)

## **ANSI ISA and GS Specific Requirements**

The following segments of the 270 request should be completed as defined below to support Availity RCM's processing of the request. Elements not listed here should be completed following your normal business practice.

Field	Field Description	Value	Comment
ISA05	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA06	Interchange Sender ID	Public Office ID	The Public Office ID used on the credentials.
ISA07	Interchange ID Qualifier	'ZZ'	Constant indicating mutually defined ID field.
ISA08	Interchange Receiver ID	'REALMED'	Constant.
ISA16	Component Element Separator	:	Do not use the less than symbol, <, when submitting request via the eligibility web service.
GS02	Application Sender's Code	Public Office ID	The Public Office ID used on the credentials.
GS03	Application Receiver's Code	Availity RCM Tax ID	The Federal Tax Identification Number for Availity RCM which can be provided by your Customer Account Manager.

## **Request Format**

<b>Field</b>	<b>Format</b>	<b>Description</b>
SubmitterID	String	The public office ID for the office calling the web service.
UserName	String	The Availity RCM user ID of the user calling the web service. This user ID must be a member of the office. This field is case sensitive.
Password	String	The password for the user calling the web service. This field is case sensitive.
AnsiRequest	String	The fully qualified ANSI 270 eligibility request.
ExternalPayerID	String	The Payer ID from Availity RCM Eligibility Payer List. This field is case sensitive.
UserDefined1	String	Optional user defined string field which will be sent back on the response. See Response Summary.
UserDefined2	String	Optional user defined string field which will be sent back on the response.
TimeStamp	String	Optional user defined time stamp field which will be sent back on the response.

## **Response Format**

<b>Field</b>	<b>Format</b>	<b>Description</b>
UserDefined1	String	The user supplied string field provided on the request or if Summary Response is request the response data. See Response Summary.
ResponseCode	String	Response Code.
Messages	String	Collection of response Messages
Message	String	Text of response message.
UserDefined2	String	The user supplied string field provided on the request.
TimeStamp	String	The user supplied time stamp field provided on the request.
AnsiResponse	String	The full 271, 997, or TA1 response provided by the payer for the 270 eligibility request.

## Response Summary

Availity RCM has the ability to provide additional information about the processing of each request. To request the Response Summary, enter “SUMMARY\_RESPONSE” in the UserDefined1 field of the request.

The response summary will be delivered in XML in the UserDefined1 field.

### Response Summary Codes

ResponseCode	Description	Messages
Success	Returned when a successful end-to-end call is made and a valid 271 is returned	No Message will be returned (Messages node will not be returned)
ValidationFailure	Returned when any or all of the following apply: <ul style="list-style-type: none"><li>• a TA1 or 997 is returned from the Payer</li><li>• credentials (submitter id, username, password) are invalid</li></ul>	The first message in the TA1 or 997 even if there are multiple messages.
PayerTimeout	Returned when a call to the Payer is made from Availity RCM and a response is not received in the defined timeframe.	Message returned will be ‘A timeout occurred while requesting eligibility from the Payer.’
PayerNotSupported	Returned when the public Payer ID submitted to Availity RCM is not valid.	Message returned will be ‘The ExternalPayerID could not be found in the Availity RCM Payer List.’
SystemError	Returned when an internal error occurs anywhere in the process.	Message returned will be ‘A system error occurred at Availity RCM. Please contact the Availity RCM Client Service Center at 877-927-8000 or support@realmed.com for further assistance.’
ProviderEnrollmentRequired	Returned when the AAA03 element of the 2100B loop of the 271 response contains a 43.	Message returned will be ‘.’

### UserDefined1 XML Structure

```
<UserDefined1>
  <ResponseCode></ResponseCode>
  <Messages>
    <Message></Message>
  </Messages>
</UserDefined1>
```

## **Development**

### **WSDL**

The eligibility web service supports SOAP 1.1 and 1.2. Web service calls using http post and http get are not supported.

The QA version of the Web Service Description Language is available at:

<https://rmhcpsupport.realmed.com/webservices/wsElig270.asmx>

The Production version of the Web Service Description Language is available at:

<https://claims.realmed.com/webservices/wsElig270.asmx>

### **Methods**

#### **ProcessEligibility**

The ProcessEligibility method receives the 270 request, validates the user's credentials, and passes the request to the appropriate payer for processing. When the 271 response is received from the payer, the formatted 271 transaction is returned to the calling application. Additionally any values provided in the user defined fields and time stamp are also returned to the calling application.

### **Test Application**

The format of the 270 request and other calling parameters can be tested using the following link.

<https://rmhcpsupport.realmed.com/eligibility/Elig270Tester.aspx>

A response should be returned to the 'ANSI Response' textbox as it would be from the web service call.

## Code Samples

### Visual Studio 2005 C#

wsElig270 is the web reference to the Availability RCM eligibility web service.

```
wsElig270.RequestHeader request = null;
wsElig270.ResponseHeader response = null;
wsElig270.wsElig270 elig = null;

try
{
    request = new wsElig270.RequestHeader();
    request.SubmitterID = "OFFICE ID HERE";
    request.UserName = "USER ID HERE";
    request.Password = "PASSWORD HERE";
    request.ExternalPayerID = "PAYER ID HERE";
    request.AnsiRequest = strAnsi270Request;
    request.UserDefined1 = "My User Defined Value 1";
    request.UserDefined2 = "My other User Defined Value";
    request.TimeStamp = "2010/11/01 4:55";

    elig = new wsElig270.wsElig270();

    response = elig.ProcessEligibility(request);

    txtAansiResponse.Text = response.AnsiResponse;
    txtUserDefined1Response.Text = response.UserDefined1;
    txtUserDefined2Response.Text = response.UserDefined2;
    txtTimestampResponse.Text = response.TimeStamp;
}
catch (System.Exception se)
{
    txtAansiResponse.Text = se.ToString();
}
finally
{
    request = null;
    response = null;
    elig = null;
}
```

## Visual Studio 2010 C#

wsElig270 is the web reference to the Availity RCM eligibility web service.

```
string strANSI271;

wsElig270.wsElig270SoapClient elig = new
wsElig270.wsElig270SoapClient("wsElig270Soap");
wsElig270.RequestHeader request = new wsElig270.RequestHeader();

try
{
    request.SubmitterID = "OFFICE ID HERE";
    request.UserName = "USER ID HERE";
    request.Password = "PASSWORD HERE";
    request.ExternalPayerID = "PAYER ID HERE";
    request.AnsiRequest = "ANSI 270 REQUEST HERE";
    request.UserDefined1 = "";
    request.UserDefined2 = "";
    request.TimeStamp = "";

    wsElig270.ResponseHeader response = elig.ProcessEligibility(request);

    strANSI271 = response.AnsiResponse;
}

catch (System.Exception se)
{
    strANSI271 = se.ToString();
}
finally
{
    request = null;
    elig = null;
}
```

## Payer System Outages

In the event that the payer's real-time eligibility service is unavailable or down, the Availity RCM's eligibility web service will return AAA-42 'Unable to Respond' in the 271 response message.

## Payer System Scheduled Maintenance

The following payer systems will be unavailable during the specified time periods for regularly scheduled maintenance.

Payer IDs	Payer Name	Timeframe Affected
54771	Highmark BCBS Pennsylvania	System Unavailable from 22:00-00:00
G00621	BCBS IL	System Unavailable from 03:00-08:00
G84980	BCBS TX	System Unavailable from 00:00-07:00 Daily Sunday Variable
SB890 SB8901	BCBS TN	System Unavailable from 02:00-03:00
CFNCA CFMD CFFEP	CareFirst BCBS MD	System Unavailable from 12:00-00:00 Sunday

## Payer Specific Situations

### **BCBS of NC**

- Blue Cross & Blue Shield of North Carolina requires providers be registered for the real-time eligibility service. If the provider is not registered, a 271 AAA-43 error will be returned.
- Blue Cross & Blue Shield of North Carolina requires unique values in the ISA13, Interchange Control Number. Transactions with Interchange Control Numbers that have already been used will result in a 271 AAA-42 – Unable to respond at current time.

### **Aetna**

- Aetna requires the use of UPPER CASE for the subscriber and dependent names. Use of lower case names in these search fields will result in an AAA-73 – Invalid or missing name error.
- Aetna requires the registration of each provider NPI to be used for real-time eligibility verification. Failure to use an NPI that has been registered with Aetna will result in a 271 AAA-43 – Invalid/Missing Provider. To register providers with Aetna see the following website, [http://www.aetna.com/healthcare-professionals/policies-guidelines/npi\\_overview\\_medical\\_professionals.html](http://www.aetna.com/healthcare-professionals/policies-guidelines/npi_overview_medical_professionals.html).

### **CareFirst**

- CareFirst requires the use of a Federal Tax ID Number on the provider NM1 segment of the 2100B loop. Without providing a valid TIN a TA1 will be returned.
- CareFirst does not allow for the use of REF – 1L segments to identify the group number on any loop. The policy number information should be sufficient to identify a policy holder on the NM1 segment. Inclusion of a REF – 1L will result in a 997 or TA1 result.

### **Medicaid Ohio**

- Medicaid Ohio requires the use of NPI instead of Federal Tax ID. Failing to use an NPI will result in a 271 AAA-43 – Invalid/Missing Provider.

### **Medicaid Georgia**

- Medicaid Georgia only accepts a service type code of 30. All request submitted with non-30 service type codes will result in a 271 AAA-42 response.

## **Medicaid Arkansas**

- Medicaid Arkansas requires the submission of the Provider Taxonomy code. This information must be submitted in the 2100B PRV segment. Failing to use the Provider Taxonomy code will result in a 271 AAA-43 – Invalid/Missing Provider.

## **Availity RCM Applied Rules**

Availity RCM applies a number of Edits or Rules to the inbound 270 request before transmitting to the payer.

RULE #	Description	Payers Affected
0001	Remove all REF segments from the 2100B loop that have a REF01 with the following values TJ, IC, EO, Q4 and have a 1P in NM101.	All Payers
0002	Verify provider name is entered in NM103 and NM104. If NM102 is a 1, person, NM103 and NM104 must be entered. If NM102 is a 2, non-person entity, NM103 must be entered. Error: AAA-43	Medicare, Aetna, BCBS NC, Cigna
0003	Verify provider NPI in correct format. If Loop 2100B NM108 is a SV, then NPI in NM109 must be 10 digits. Error: AAA-43	Medicare, Aetna, BCBS NC
0004	Remove DMG03 element, Gender Code, from DMG segments in loop 2100C and 2100D.	Medicare Texas
0005	Remove N3 and N4 segments from loop 2100C and 2100D.	All Availity payers, BCBS NC, Medicare, all WebMD payers
0006	Add TRN segment if none present.	BCBS TN

## **Payers requiring “P” Usage Indicator**

Various payers require the use of a “P” in the ISA15 – Usage Indicator, even in their test or QA environments. The submission of a “T” to these payers will result in an error being returned to the client. To avoid these errors, a “P” should be submitted in all cases including the test or QA environment.

PAYER ID	PAYER	ERROR
00401	BCBS SOUTH CAROLINA	271 - AAA*Y**42*R~
SB890	BCBS TENNESSEE	271 - AAA*Y**42*R~
00922	BLUE CHOICE HEALTH PLAN BCBS SOUTH CAROLINA	271 - AAA*Y**42*R~
54771	Highmark BCBS Pennsylvania	271 - AAA*Y**42*R~

# 277U – Batch Unsolicited Claims Status

## Overview

Availity RCM will generate an unsolicited claim status (277U) file for any claim which changed status code during the day. The change could be the result of activity initiated by the claim submission, the result of processing by Availity RCM, actions taken through the Availity RCM application portal, or updates from the payer. The 277U transaction will be generated using the 5010 implementation of the 277 transaction. The 277U transaction can then be used by the originating PM system to update the claims status. The 277U file will be transmitted to the provider using a secure FTP method or Secure File Exchange. The 277U transaction is not available in 4010 format.

The 277U transaction will return a payer or other entity's claim status in the 277U if that entity has the capacity to return a claim status (277) transaction to Availity RCM. If a claim status cannot be obtained from the payer or other entity, a claim's ANSI status will be calculated based on the current status in Availity RCM.

The 277U status can be configured to provide status at the claim level only or down to the service line level. For claims with an RCM status of "Claim Repair" the error description will be returned in STC segment of loop 2200D for claim level errors or loop 2220D for service line errors.

The 277U claims status files will be generated each night and will be available for transfer thereafter. If the claims status changes multiple times during a day, only the latest status code will be reported.

## Implementation

### File Transfer

The ANSI 277U Unsolicited Claims Status files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

### Options

The following options can be used to control the structure of the 277U file.

Option	Settings	Default	Comments
Batching	Grouped Ungrouped	Grouped	See detailed description below.
Files Per Day	Integer	-1	The number of files allowed per day. Use -1 for unlimited.
ISA Per File	Integer	1	The number of ISA loops allowed in a single physical file. Use -1 for unlimited.
GS Per ISA	Integer	1	The number of GS loops allowed per ISA loop. Use -1 for unlimited.
ST Per GS	Integer	1	The number of ST loops allowed per GS loop. Use -1 for unlimited.
Batch Size	Integer	3000	Limits the number of status transactions allowed per ST loop. Setting this value to 1 will result in a single transaction per file. Use -1 for unlimited.

Using the default values will result in a file with a maximum of 3000 status transactions and multiple files generated to accommodate additional volume.

### Version

Availity RCM currently supports the ANSI 5010 version for unsolicited claims status.

### Reference

Full definition of the 277U transactions is available in [Appendix B – 277U Quick Start Guide \(5010\)](#).

## **Batching**

Availity RCM supports two versions of transaction batching for the 277U file generation. This enables multiple claims status transactions to be included within a single physical file and simplifies transmission and processing.

### **Grouped (Default)**

Transaction files will be grouped together by Payer and Information Receiver with the specific information only present once. Each Payer/Information Receiver combination will then have multiple status transactions listed below the payer. This is the default behavior and results in a smaller transaction file.

Loop	Sample Data	
2000A	Payer 1	
2000B	Information Receiver 1	
2000C	Provider 1	
2000D	Patient 1	
2000C	Provider 1	
2000D	Patient 2	
2000A	Payer 2	
2000B	Information Receiver 1	
2000C	Provider 1	
2000D	Patient 4	
2000C	Provider 2	
2000D	Patient 5	

### **Ungrouped**

Transactions files are not grouped by Payer or Information Receiver and the specific information is repeated for each status request. Repeating the Payer and Information Receiver specific information for each transaction will result in a slightly larger file.

Loop	Sample Data	
2000A	Payer 1	
2000B	Information Receiver 1	
2000C	Provider 1	
2000D	Patient 1	
2000A	Payer 1	
2000B	Information Receiver 1	
2000C	Provider 1	
2000D	Patient 2	
2000A	Payer 2	
2000B	Information Receiver 1	
2000C	Provider 1	
2000D	Patient 4	
2000A	Payer 2	
2000B	Information Receiver 1	
2000C	Provider 2	
2000D	Patient 5	

## 277U Status Code Cross Reference

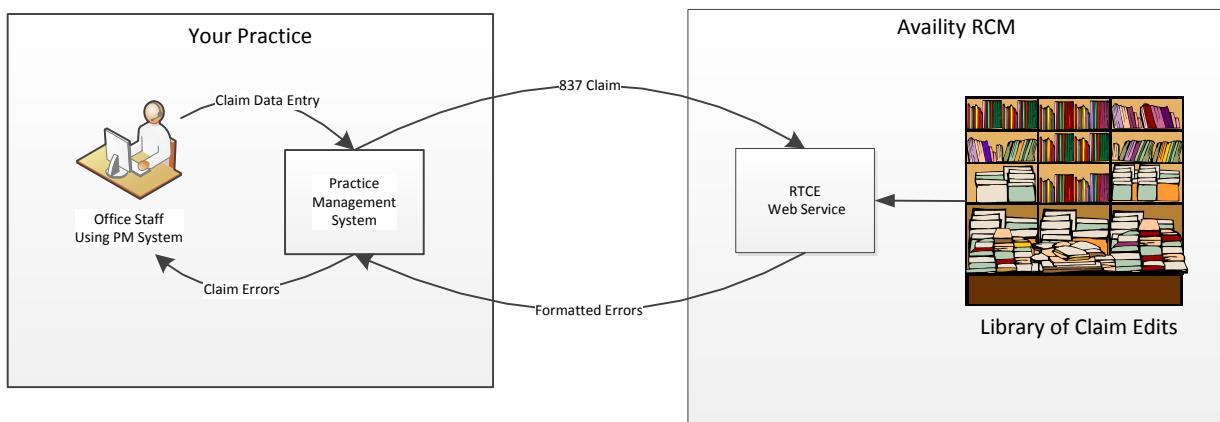
<b>Availity RCM Status Management Display Name</b>	<b>Category codes (507) &amp; Status codes(508) STC01-1:STC01-2</b>		<b>Action Code</b>
PClaim Ready	A1:277	Claim/encounter has been forwarded by third party entity to entity.	WQ
PClaim Sent	A1:16	Entity acknowledges receipt of claim/encounter.	WQ
PClaim Accepted	A0:20	Accepted for processing.	WQ
PClaim Mailed	A0:277	Paper claim.	WQ
Payer Accepted	A0:19	Claim/encounter has been forwarded to entity.	WQ
Edit Only	A1:0	Cannot provide further status electronically.	WQ
Provider Match	P3:50	Claim waiting for internal provider verification.	WQ
EClaim Adjudicated	F0:3	Claim has been adjudicated and is waiting payment cycle.	WQ
EClaim Ready	A1:19	Entity acknowledges receipt of claim/encounter.	WQ
Claim Repair	A8:21	Missing or invalid information.	U
EClaim Accepted	A0:17	Claim/encounter has been forwarded by third party entity to entity.	WQ
EClaim Paid	F1:1	For more detailed information, see remittance advice.	WQ
Payer Match	P3:677	Entity not affiliated	WQ
Translated	A0:45	Awaiting benefit determination.	WQ
EClaim Waiting	A1:20	Accepted for processing.	WQ
EClaim Sent	A0:16	Claim/encounter has been forwarded to entity.	WQ
Unknown	E1:18	Entity received claim/encounter, but returned invalid status.	WQ
Deleted	D0:23	Returned to Entity.	U
EClaim Pended	P2:46	Internal review/audit.	WQ
Payer Processing	P1:19	Entity acknowledges receipt of claim/encounter	WQ

# Real-Time Claim Editing (RTCE)

## Overview

The Availity Real-Time Claim Editing (RTCE) web service provides an online real-time utility that can be used by Practice Management systems to electronically validate claims information in real-time. The RTCE web service receives an ANSI standard 837 claim, validates it against a standard library of edits, and returns a formatted list of any errors identified to the requestor. The RTCE interface described in this document represents a real-time SOAP compliant web service which interacts in a synchronous request/response fashion.

## Real-Time Claim Editing (RTCE)



## Implementation

### Credentials

In order to use the web service, the user must have valid credentials for the environment being called. These credentials are available through your customer service representative and must be populated on each web service call.

- Sender ID – The Public Office ID for the office calling the web service. Each office calling the web service should have a unique Submitter ID.
- User Name – Availity RCM user name associated to the office.
- Password – The user's password.

Practice Management system vendors or integration partners must develop their systems in such a manner to ensure that the proper credentials are used for each client. It will not be sufficient to develop the system in a manner that the web service will be called with a single set of credentials no matter which client is using the system.

### Version

Availity RCM currently supports ANSI 5010 versions for RTCE.

### Security

All transmissions occurring between the Vendor and RealMed will be performed using Hypertext Transfer Protocol Secure (HTTPS) providing encrypted communication. Additionally, custom authentication utilizing Web Service Enhancements (WSE) will occur at the RealMed web service layer to further enhance security.

## Request Format

Field	Format	Description
parameters	String	XML structure containing all required request data elements. See Request XML Elements for definition.

## Request XML Elements

Field	Format	Description
Username	String	The Availity RCM user associated with the given Authorization ID in order to uniquely identify the user and authenticate the request.
Password	String	The password for the user calling the web service. This field is case sensitive.
AuthorizationID	Numeric	Unique value assigned by Availity RCM used to identify the external entity submitting the request. Typically the external entity or Trading Partner making the request.
SenderId	String	The public office ID for the office calling the web service.
TransactionID	String	This value is populated by the calling party and represents a unique identifier per Authorization ID and Sender ID. Used for troubleshooting purposes.
Payload		Complete 837 claims transaction.
OptionalField.Name	String	The name of the user-defined value that will be echoed back in the response. (Optional)
OptionalField.Value	String	The user-defined value that will be echoed back in the response. (Optional)

## XML Structure

```
<ValidationRequest>
  <Username></Username>
  <Password></Password>
  <AuthorizationId></AuthorizationId>
  <SenderId></SenderId>
  <TransactionId></ TransactionId >
  <Payload></ Payload >
  <OptionalFields>
    <OptionalField>
      <Name></Name>
      <Value></Value>
    </OptionalField>
  </OptionalFields>
</ValidationRequest>
```

## Sample XML Request

```
<ValidationRequest>
  <Username>MyUserName</Username>
  <Password>MyPassword99</Password>
  <AuthorizationId>TP18596</AuthorizationId>
  <SenderId>18596</SenderId>
  <TransactionId>U02000200704456495060H00</TransactionId >
  <Payloads>
    FULL 837 CLAIM TRANSACTION HERE
  </Payload>
  <OptionalFields>
    <OptionalField>
      <Name>Tracking Number</Name>
      <Value>2012053</Value>
    </OptionalField>
  </OptionalFields>
</ValidationRequest>
```

## Response Format

Field	Format	Description
parameters	String	XML structure containing all required response data elements. See Response XML Elements for definition.

## Response XML Elements

Field	Format	Description
TransactionID	String	Echo of the value is populated by the calling party and represents a unique identifier per Authorization ID and Sender ID. Used for troubleshooting purposes.
Error.ErrorNumber	String	AV RCM unique error number.
Error.ErrorMessage	String	Text description of error message.
Error.ErrorLevel	String	Informational - Information only, this error will not prevent a claim for processing. Warning - This error must be corrected for the claim to process correctly. Fatal - Major error processing the claim. Either the claim was not in a valid format that could be recognized as a claim or encountered an internal processing problem. If this does occur and the claim is well formed, please notify Availability for support assistance.
Error.LineItemNum	String	Claim item line number
OptionalField.Name	String	The name of the user-defined value provided in the original request.
OptionalField.Value	String	The user-defined value provided in the original request.

## XML Structure

```

<ValidationResponse>
  <TransactionId></TransactionId>
  <Payload>
    <ScrubResponse>
      <Errors>
        <Error>
          <ErrorNumber></ErrorNumber>
          <ErrorMessage></ErrorMessage>
          <ErrorLevel></ErrorLevel>
          <LineItemNum></LineItemNum>
        </Error>
      </Errors>
    </ScrubResponse>
  </Payload>
  <OptionalFields>
    <OptionalField>
      <Name></Name>
      <Value></Value>
    </OptionalField>
  </OptionalFields>
</ValidationResponse>

```

## Sample XML Response

```
<ValidationResponse>
  <TransactionId>U02000200704456495060H00</TransactionId>
  <Payload>
    <ScrubResponse>
      <Errors>
        <Error>
          <ErrorNumber>EU182810</ErrorNumber>
          <ErrorMessage>Procedure Code ZZZZZ on detail line 1 is not a valid procedure code.</ErrorMessage>
          <ErrorLevel>Warning</ErrorLevel>
          <LineItemNum>1</LineItemNum>
        </Error>
        <Error>
          <ErrorNumber>EU221702</ErrorNumber>
          <ErrorMessage>The Principal Diagnosis Code ZZZ is not a valid code.</ErrorMessage>
          <ErrorLevel>Warning</ErrorLevel>
        </Error>
      </Errors>
    </ScrubResponse>
  </Payload>
  <OptionalFields>
    <OptionalField>
      <Name>Tracking Number</Name>
      <Value>2012053</Value>
    </OptionalField>
  </OptionalFields>
</ValidationResponse>
```

## **Development**

### **WSDL**

The eligibility web service supports SOAP 1.1 and 1.2. Web service calls using http post and http get are not supported.

The QA version of the Web Service Description Language is available at:

<https://qa-services.availity.com/claimediting/RealCleanService.svc>

The Production version of the Web Service Description Language is available at:

<https://services.realmed.com/claimediting/RealCleanService.svc/mex?wsdl>

## **Methods**

### **ProcessValidation**

The ProcessValidation method receives the 837 request, validates the user's credentials, and passes the request claims editing engine processing.

## Code Samples

### Visual Studio 2012 C#

wsRealClean is the web reference to the Availability RTCE web service.

```
wsRealClean.ValidationRequest request = new wsRealClean.ValidationRequest();
request.AuthorizationId = "AUTHORIZATION ID HERE";
request.SenderId = "SENDER ID HERE";
request.UserName = "USER ID HERE";
request.Password = "PASSWORD HERE";
request.Payload = "ANSI 837 REQUEST HERE";
request.TransactionId = "VENDOR TRANSACTION ID HERE";

// optional fields that will be echoed back
request.OptionalFields = new wsRealClean.OptionalField[]
    { new wsRealClean.OptionalField() { Name = "Transaction Date", Value =
DateTime.Now.ToShortDateString() } };

using (var service = new wsRealClean.RealCleanServiceClient())
{
    wsRealClean.ValidationResponse response =
service.ProcessValidation(request);

    string scrubResponsePayload = response.Payload;
    string transactionId = response.TransactionId;
    var optionalFields = response.OptionalFields;

    return scrubResponsePayload;
}
```

# Availity Patient Access – Capacity-to-Pay

## Overview

The Availity Capacity-to-Pay API provides an online real-time utility that can be used by external systems such as Practice Management systems to provider end users with the information needed to make informed decisions regarding a patient's likelihood to pay for healthcare services. This API will calculate the Capacity to Pay and is secured with OAuth2 to authenticate using a key/secret set of credentials.

## Implementation

### External API

The Demo version of the API, which can be used during development and integration testing, is available at:

<https://api.availity.com/demo/v1/capacity-to-pay>

The Production version of the API is available at:

<https://api.availity.com/v1/capacity-to-pay>

Additional information and samples may be available on the Availity Developers website at  
<https://developer.availity.com/documentation#capacity-to-pay-coming-soon->

## Headers

Header	API Client Managed	Value	Description
X-API-ID	No	GUID	A unique identifier returned back with each response and is used to track each transaction.
X-Availability-CorrelationId	Yes	GUID	Used to track an operation across multiple systems. If this header is not provided with a request the system will populate it with the x-api-iad Guid and return it in the response header.
X-Session-ID	Yes	GUID	Used to correlate all the transactions in a session. This can be sent as a request header and it will be echoed back in the response header. Use the same value for all requests that represent your session. If the header is not sent with a request the system will populate it with the X-API-ID Guid and returned in the response header.

## Request

The Capacity-to-Pay API accepts a POST request in x-www-form-urlencoded format and returns back a JSON response. Valid request will result in an endpoint status code of 201.

Parameter	Required	Type	Description
firstName	Yes	String	The first name of the Guarantor.
lastName	Yes	String	The last name of the Guarantor.
streetAddress	Yes	String	The street address of the Guarantor.
streetAddress2	No	String	The street address2 of the Guarantor.
city	Yes	String	The city of the Guarantor.
stateProvince	Yes	String	The state of the Guarantor.
postalCode	Yes	String	The postal code of the Guarantor.

## Response

The Capacity-to-Pay response contains the following fields. If the demographics could not be located, a default Capacity-to-Pay with Code="D" and Description="No Net Worth is returned."

Field	Type	Description
code	String	A single letter code providing a rating for the patient. Response Codes.  A – High B – Moderate C – Low D – No Net Worth
description	String	Provides a descriptive meaning for the code property.
demographics.firstName	String	The guarantor's first name.
demographics.lastName	String	The guarantor's last name.
demographics.gender	String	The guarantor's gender. Possible values are:  Male Female Unknown
demographics.address	String	The guarantor's address.
demographics.unitNumber	String	The guarantor's unit number.
demographics.city	String	The guarantor's city.
demographics.stateProvince	String	The guarantor's state or province.
demographics.postalCode	String	The guarantor's postal code.
demographics.housingStatus	String	The guarantor's housing status. Possible values are:  Owns Rents Unknown
demographics.isHomeOwner	Boolean	Does the guarantor own their own home?
demographics.numberOfWorkers	Integer	The number of adults living with the guarantor.
demographics.numberOfChildren	Integer	The number of children living with the guarantor.
demographics.numberOfCreditLines	Integer	The guarantor's number of open credit lines.
demographics.yearsInHome	Integer	The number of years the guarantor has lived in their home.

demographics.mortgageAmount	Integer	The guarantor's mortgage amount.
demographics.homeValueRange.high	Integer	The guarantor's high home value.
demographics.homeValueRange.low	Integer	The guarantor's low home value.
demographics.incomeRange.high	Integer	The guarantor's high income.
demographics.incomeRange.low	Integer	The guarantor's low income.
demographics.netWorthRange.high	Integer	The guarantor's high net worth value.
demographics.netWorthRange.low	Integer	The guarantor's low net worth value.

## Code Samples

### C#

```
var restClient = new
RestClient(ConfigurationManager.AppSettings[_ctpEndPoint]);

var request = new RestRequest(Method.POST);
request.RequestFormat = DataFormat.Json;
request.AddHeader(_apiKey, ConfigurationManager.AppSettings[_apiKey]);

request.AddObject(GetCapacityToPayRequest());

// execute the request
RestResponse response = (RestResponse)restClient.Execute(request);
var capacityToPay =
JsonConvert.DeserializeObject<CapacityToPay>(response.Content);
```

### VB.Net

```
Dim restClient = New
RestClient(ConfigurationManager.AppSettings(CtpEndPoint))

Dim request = New RestRequest(Method.POST)
request.RequestFormat = DataFormat.Json
request.AddHeader(ApiKey, ConfigurationManager.AppSettings(ApiKey))

request.AddObject(GetCapacityToPayRequest())

' execute the request
Dim response As RestResponse = DirectCast(restClient.Execute(request),
RestResponse)
Dim capacityToPay = JsonConvert.DeserializeObject(Of
CapacityToPay)(response.Content)
```

# Patient Statements

## Overview

In order to maximize patient payments, Availity RCM supports the flexible submission of patient statement data file for generation of statements. Availity RCM has the ability create custom file mapping in order to accept files in wide variety of formats and then parse these files in to a common internal format. Once a file has been stored internally, it can be used to produce any of the standard patient statement formats or a custom developed version needed to meet a client's needs.

Availity RCM includes automatic address verification for all requests with statements that fail verification being held for correction. Patient statement request that fail address verification will be posted to the Availity RCM Application Portal for correction or forced printing.

## Implementation

### File Transfer

The Patient Statement request files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

### File Formats

- **Print Image** – Usually a text file which contains an image of the statement as generated from the PM system.
- **Structured PM output file** – Usually a data file with defined record types and fields containing data to be mapped to a pre-agreed format.
- **Common Patient Statement File** – Availity RCM proprietary format which contains all the data necessary to create a patient statement.

### Logo

The preferred format for company logos is eps. Company logos can also be submitted in jpg, gif, and tiff formats.

### Details

- Patient statements are mailed every business day at 5:00 a.m.
  - Address verification is performed overnight and returns delivered at 10:00 p.m.
  - Statements returned in Edit/Error Management are only those considered “undeliverable” by the U.S. Postal Service.
  - Availity RCM utilizes NCOA Link<sup>48</sup> which provides 160 million records for address scrubbing, while other vendors typically provide a more limited NCOA product (60 million records). The use of advanced address scrubbing from NCOA Link<sup>48</sup> eliminates up to 85% of mail that would normally be returned. This service greatly minimizes errors in mailings and reduces delays through automatic, advanced address verification, allowing 96% of statements to be delivered.
  - Address errors can be corrected online through the Availity RCM application before mailing.
  - Clients who wish to send a statement even if the address is identified as undeliverable can “force” mail the statement (no buy back available for “forced” mail, if they are returned undeliverable).
  - Patients that have a change of address on file with a forwarding address will have their address automatically updated by Availity RCM and mailed.
  - Clients can view the automatically forwarded, updated addresses by using the Patient Statement Address Correction Report in the Reports Library.

- Availity RCM offers a Return Mail Buy Back Guarantee for any mail returned to the practice as undeliverable after Availity RCM's comprehensive address scrubbing has been completed. Clients can report their returned mail volume for the previous month and get reimbursed on their invoice for the cost of these returned statements. All Availity RCM clients are able to participate in this program. (see Buy Back rules)
- Patient Statement Reporting uses the same technology and screen design for managing patient statements as for managing claims. Reports are available that help a practice track address updates automatically updated by Availity RCM and corrections that have been made to undeliverable addresses within the Availity RCM application.
- Each client can choose to put a logo on their statements (logo will be in black print). Standard color stock is available without cost to all clients. Custom color is available at no additional cost to clients submitting over 6,000 individual statements per month, per office.
- All patient statement deployments begin with a sample inbound file, patient statement checklist, and a sample of a client's current patient statement.
- There are three patient statement file formats:
  - Print Image – usually a text file which contains an image of the statement as generated from the client's PM system. This image may or may not match pre-agreed upon statement format.
  - PM output file – usually a data file with defined record types and fields containing data to be mapped to a pre-agreed upon statement format.
  - Common Patient Statement File – this format was developed by Availity RCM and contains all the data necessary to create a patient statement. This requires special programming on the client's part to generate this format.
- Patient statements have several elements that ensure quality printing and processing:
  - Quality Control (QC) Codes – These codes are listed directly above the patient address and at the top of each printed page. The QC Running number shows the following number - 0 1 2 3 4 5 6 7 8 9. This number is replaced by a unique identifier during the processing of patient statements. The QC Bar Code is placed at the top of each page of a patient statement to indicate the page breaks. These codes are utilized by the printing machinery to detect out-of-sequence or missing statements during processing. If an issue is detected, the machinery stops so an operator can review the problem.
  - Pre-Sort Quality Checks – Once statements have been placed in envelopes and are ready to be mailed an additional check is performed to ensure the envelopes are properly sealed, envelopes are not stuck together, and information is displayed correctly within the envelope windows according to Postal Service guidelines.
- Patient Friendly Billing™ means:
  - Clearly Defined Practice Identity and Branding
  - Calculated Payment Due Date based on statement date
  - No information that might confuse patients (CPT Codes, Diagnosis Codes, etc.)
  - No aging buckets from patient statements.
  - Highlighted message area that includes timely information. (Dunning messages, etc)
- Availity RCM also provides pre-collection letters and collection letters.
- Availity RCM provides automatic calculation of a payment due date from 0 to 30 days from the date the statement is generated. Or can be populated with verbiage, such as; "DUE UPON RECEIPT".
- Custom client rules are available that can provide the following additional patient statement

functionality:

- Ability to prevent statements with balances below or above a certain patient amount due from being processed. (e.g. all statements with a amount due below \$5.00 can be suppressed)
- Ability to prevent all statements submitted from being mailed until a review of the statement is completed.
- An online version of the patient statements mailed to patients is available through Availity RCM for 18 months.
- Availity RCM has several reports available in the Report Analysis area of the application which provides valuable information for the practice. The following reports are currently available:
  - Patient Statement Address Correction Report
  - Patient Statements Edit/Error Management Report
  - Patient Statement Force Mail Report
  - Patient Statement Progress Report
  - Patient Statement Summary Report
- Online patient payment portal. Availity RCM has developed an online payment process that is integrated with our patient statement process. Availity RCM will provide an internet address (URL) on the statement that will link to the Availity RCM branded portal. This portal would allow practices to offer an easy way for patients to pay. Patients could use their bank account (debit) or credit card to pay quickly and securely from anywhere. (refer to payment process)
- Rules for Color Patient Statements:
  - Custom color statements are available at no additional charge to clients with statement volumes in excess of 6,000/month each per office.
  - Each color statement design (branding, logos and colors) is considered unique. In order to qualify for color statements at no additional cost, each color stock design requested must have a minimum of 6,000 statements a month.
  - Custom color statements will have only the first page printed on the full color stock, second and subsequent pages will be printed in black and white.
  - All color elements on a patient statement are pre-printed on paper by a paper supplier. This pre-printed paper is then ordered in bulk by our vendor.
  - Only static elements of a patient statement can be in color (headings, logos, borders/boxes, etc). All dynamic elements (patient due amounts, service line items, all dates, etc.) are printed on the pre-printed color stock with black ink.
  - Clients that desire color can have customized stock created that uses their logo, colors and any other branding. We offer free graphic design services for these clients to create the best statement possible for their needs. Custom color statements also include (see sample provided):
    - Highlighting in red of amount due and payment due date areas
    - Special coloring behind messages to draw attention to them
    - Color logos of credit cards
  - The custom, color stock is ordered on behalf of the client with no upfront deposit for the purchase of the paper. Our vendor keeps a three-month supply of stock on hand for each custom color stock client. If client requests any changes to this custom stock after it is in production, the client will have the option to purchase the current stock or destroy current stock or they can simply use it, before switching to the new stock.
  - If a client chooses to terminate Availity RCM patient statement services prior to the end the first 12 month period, the client will be responsible for purchasing any “leftover” stock which remains unused. After the initial 12 month period there is no fee upon termination.

## **Standard Statement Formats File Definition**

The Standard Patient Statement file must be generated using pipe | delimited format. Fields not populated should be blank and the file should still contain a place on each row for that specific data element.

All currency amounts use implied decimal points where a value of "100" would be printed as "\$1.00".

Each row must have its own carriage return and line feed.

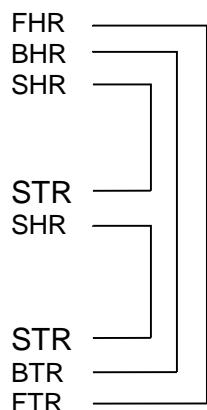
Invalid characters such as carriage returns, lines feeds, pipes |, and other non-visible characters are not permitted within the data other than standard spaces.

### ***Structure***

Each transmission must contain a single set of file control records beginning with an FHR – File Header and ending with the FTR – File Trailer control records.

Within the file control records must be one set of batch control records beginning with a BHR – Batch Header and ending with a BTR – Batch Trailer control records.

Within the batch control is one or more statement sets which begin with a SHR – Statement Header and end with a STR – Statement Trailer control records. Each statement will have its own statement control records.



## **FHR – File Header Record**

The File Header segment is used to provide information about the entire file transmission.  
 Repeat: Once per file

ID	Field Name	Data type	Size	Required	Comments
FHR01	Record Type	Character	3	Y	“FHR”
FHR02	Date Time Generate	Date/Time	14	Y	YYYYMMDDHHMMSS
FHR03	Version	Character	5	Y	“1.0”
FHR04	File ID	Character	100		File ID for tracking

### **Sample**

FHR|20100223104017|1.0|ID00321

## **BHR – Batch Header Record**

The Batch Header segment is used to provide information about the batch within the file.  
 Repeat: Once per file

ID	Field Name	Data type	Size	Required	Comments
BHR01	Record Type	Character	3	Y	“BHR”
BHR02	Statement Type	Character	5		
BHR03	Batch ID	Character	30		
BHR04	Facility ID	Character	30		
BHR05	File Name	Character	100		

### **Sample**

BHR||||PS\_20100223104002.dat

## **SHR – Statement Header Record**

The Statement Header segment is used to wrap the contents of a single statement.  
 Repeat: Multiple per file      Once per statement

ID	Field Name	Data type	Size	Required	Comments
SHR01	Record Type	Character	3	Y	“SHR”
SHR02	Statement ID	Character	23	Y	Unique ID for each statement. This ID is used to link all sub records for this statement.

### **Sample**

SHR|38822188

## ADM – Administrative Data

The administrative segment is used to provide information that is needed once per patient statement such as addresses, balances, due dates, and provider information.

Repeat:      Multiple per file      Once per statement

ID	Field Name	Data type	Size	Required	Comments
ADM01	Record Type	Character	3	Y	"ADM"
ADM02	Logo/Client Number	Character	30	Y	
ADM03	Statement ID	Character	23	Y	Unique ID for each statement. Must match the SHR02 value.
ADM04	Statement Date	Date	8	Y	YYYYMMDD
ADM05	Statement Number	Numeric	15		
ADM06	Patient Account Number	Character	15	Y	
ADM07	Balance Forward	Currency	13		
ADM08	Current Charges	Currency	13		
ADM09	Current Payment or Adjustments	Currency	13		
ADM10	Total Balance	Currency	13	Y	
ADM11	Amount Due	Currency	13	Y	
ADM12	Patient Payment Last Received Date	Date	8	Y	YYYYMMDD
ADM13	Patient Payment Last Received Amount	Currency	13	Y	
ADM14	Insurance Payment Last Received Date	Date	8		YYYYMMDD
ADM15	Insurance Payment Last Received Amount	Currency	13		
ADM16	Past Due Current	Currency	13	Y	
ADM17	Past Due 31-60	Currency	13	Y	
ADM18	Past Due 61-90	Currency	13	Y	
ADM19	Past Due 91-120	Currency	13	Y	
ADM20	Past Due Over 120	Currency	13	Y	
ADM21	Last Charge Date	Date	8		YYYYMMDD
ADM22	Last Charge Amount	Currency	13		
ADM23	Insurance Pending	Currency	13	Y	
ADM24	Tax ID	Character	9		
ADM25	Return Name	Character	50	Y	
ADM26	Return Address 1	Character	30	Y	
ADM27	Return Address 2	Character	30		
ADM28	Return City	Character	30	Y	
ADM29	Return State	Character	2	Y	
ADM30	Return Zip	Character	10	Y	
ADM31	Registration Date	Date	8		
ADM32	Patient Name	Character	50		
ADM33	Patient Address 1	Character	30		
ADM34	Patient Address 2	Character	30		
ADM35	Patient City	Character	30		

ID	Field Name	Data type	Size	Required	Comments
ADM36	Patient State	Character	2		
ADM37	Patient Zip	Character	10		
ADM38	Insured Name	Character	50		
ADM39	Payer 1 Name			NU	
ADM40	Payer 1 Type			NU	
ADM41	Payer 1 Address 1			NU	
ADM42	Payer 1 Address 2			NU	
ADM43	Payer 1 City			NU	
ADM44	Payer 1 State			NU	
ADM45	Payer 1 Zip			NU	
ADM46	Payer 1 Group Number			NU	
ADM47	Payer 1 Policy Number			NU	
ADM48	Payer 1 Subscriber Name			NU	
ADM49	Payer 2 Name			NU	
ADM50	Payer 2 Type			NU	
ADM51	Payer 2 Address 1			NU	
ADM52	Payer 2 Address 2			NU	
ADM53	Payer 2 City			NU	
ADM54	Payer 2 State			NU	
ADM55	Payer 2 Zip			NU	
ADM56	Payer 2 Group Number			NU	
ADM57	Payer 2 Policy Number			NU	
ADM58	Payer 2 Subscriber Name			NU	
ADM59	Customer Svc Phone	Character	10		
ADM60	Cust Svc Phone - Toll Free	Character	10		
ADM61	Cust Svc Fax	Character	10		
ADM62	Web address	Character	50		
ADM63	Total Charges	Currency	13		
ADM64	Total Payments/Adjustment	Currency	13		
ADM65	Deposit	Currency	13		
ADM66	Unapplied Credit/Prepayments	Currency	13		
ADM67	Lockbox				
ADM68	Filler		0	NU	
ADM69	Filler		0	NU	

### Sample

ADM|12079|38822188|20100223||1381|1798|11500|9702|81193|1798|||20091229|¤  
 7190|81193|0|0|0|0|20091210|11500|11500|123456789|Return Name|PO Box 636||¤  
 Cincinnati|OH|45263||Jane Doe|1382 Main Street||Milford|OH|45150|¤  
 Jane Doe|||||||||312-372-9823|800-993-4488||www.url.com|¤  
 11500|||||

## **BDY – Body**

Repeating detailed line information for each patient statement. The number of detail lines per page will vary depending on the size of any messages or comments included in the statement. Paging will occur automatically.

Repeat:      Multiple per file      Multiple per statement

ID	Field Name	Data type	Size	Required	Comments
BDY01	Record Type	Character	3	Y	"BDY"
BDY02	Record Number	Numeric	3	Y	Record sequence number 1-999
BDY03	Statement ID	Character	23	Y	Unique ID for each statement. Must match the SHR02 value.
BDY04	Invoice Number	Character	13		
BDY05	Detail line type	Character	1		C – Charge P – Payment A – Adjustment
BDY06	Patient Name + Patient ID	Character	50		
BDY07	Date	Date	8	Y	YYYYMMDD
BDY08	Provider Name	Character	50		
BDY09	Procedure Code	Character	5		
BDY10	Description (Charges or Payment/Adjustment)	Character	255	Y	
BDY11	Individual Charges	Currency	13		
BDY12	Adjustment (Adjustment / Payment / Pending Insurance)	Currency	13		
BDY13	Payment (Insurance Paid Primary)	Currency	13		
BDY14	Balance	Currency	13		
BDY15	Payment Activity Date	Date	8		YYYYMMDD
BDY16	Payment Activity Payer Name	Character	50		
BDY17	Copay Amount Due	Currency	13		
BDY18	Charge SubTotal Amount	Currency	13		
BDY19	Physician's Number	Numeric	13		
BDY20	Physician's Organization	Numeric	50		
BDY21	Referring Physician's Name	Character	50		
BDY22	Referring Physician's Number	Character	13		
BDY23	Units	Numeric	5		
BDY24	Diagnosis Code	Character	7		
BDY25	Diagnosis Description	Character	255		

ID	Field Name	Data type	Size	Required	Comments
BDY26	Location of Service	Character	30		
BDY27	Individual Transaction Amount	Currency	13	NU	
BDY28	Sum of Transactions	Currency	13	NU	
BDY29	Insurance Pending	Currency	13	NU	
BDY30	Unpaid Amount	Currency	13	NU	Unpaid Amount if Insurance Pending is not at Bill Line and/or Insurance not posted
BDY31	Amount Due Now	Currency	13	NU	Amount Due if Insurance Pending is at Bill Line or Statement not issued until Insurance posted
BDY32	Insurance Pending Amount	Currency	13		
BDY33	Insurance Balance (Line)	Currency	13		
BDY34	Patient Balance (Line)	Currency	13		
BDY35	Insurance Pending Indicator	Character	3		
BDY36	Insurance Balance (Line)	Currency	13		
BDY37	Insurance Payment	Currency	13	NU	
BDY38	New Activity	Character	3		
BDY39	Patient Paid	Currency	13		
BDY40	Filler	Character	0	NU	

### Sample

BDY|1|38822188||A||20091229|||Adj MCAREOH-Ohio Medicare (230)||2512|||¤  
 20091229|MCAREOH-Ohio Medicare (230)|||||||2512||||||¤  
 2512|0|||

## **CPN – Coupon**

Information used to complete the coupon section of each patient statement.

Repeat:      Multiple per file      Once per statement

ID	Field Name	Data type	Size	Required	Comments
CPN01	Record Type	Character	3	Y	"CPN"
CPN02	Statement ID	Character	23	Y	Unique ID for each statement. Must match the SHR02 value.
CPN03	Statement Date	Date	8		YYYYMMDD
CPN04	Account Number	Character	15		
CPN05	Balance Due	Currency	13		
CPN06	Insurance Amount	Currency	13		
CPN07	Payment Amount	Currency	13		
CPN08	Bill-To Name	Character	50	Y	
CPN09	Bill-To Address 1	Character	30	Y	
CPN10	Bill-To Address 2	Character	30		
CPN11	Bill-To City	Character	30	Y	
CPN12	Bill-To State	Character	2	Y	
CPN13	Bill-To Zip	Character	10	Y	
CPN14	Pay-To Name	Character	50	Y	
CPN15	Pay-To Address 1	Character	30	Y	
CPN16	Pay-To Address 2	Character	30		
CPN17	Pay-To City	Character	30	Y	
CPN18	Pay-To State	Character	2	Y	
CPN19	Pay-To Zip	Character	10	Y	
CPN20	Display Credit (Y/N)	Character	1	Y	
CPN21	Visa (Y/N)	Character	1		Required if BDY20 = Y
CPN22	MC (Y/N)	Character	1		Required if BDY20 = Y
CPN23	Discoverer (Y/N)	Character	1		Required if BDY20 = Y
CPN24	Amex (Y/N)	Character	1		Required if BDY20 = Y
CPN25	Filler		0	NU	
CPN26	Filler		0	NU	

### **Sample**

CPN|38822188|20100223||0|0|1798|Jane Doe|1382 Main Street||Milford|OH|45150|  
Ima Doctor, MD.|PO Box 39510||Cincinnati|OH|45263|Y|Y|Y|N|N||

## **COM – Comments**

Optional comment text areas that can be printed at various locations within the patient statement.  
 Repeat:      Multiple per file      Between zero and two per statement

ID	Field Name	Data type	Size	Required	Comments
COM01	Record Type "COM"	Character	3	Y	"COM"
COM02	Statement ID	Character	23	Y	Unique ID for each statement. Must match the SHR02 value.
COM03	Comment Number	Character	2	Y	R1 – R9 – Each tag will be mapped to a specific text area on the patient statement.
COM04	Comment Text	Character	500	Y	
COM05	Filler	Character	0	NU	
COM06	Filler	Character	0	NU	

### **Sample**

COM|38822188|R9|A SELF PAY DISCOUNT HAS BEEN APPLIED.||

## **STR – Statement Trailer Record**

The Statement Header segment is used to wrap the contents of a single statement.  
 Repeat:      Multiple per file      Once per statement

ID	Field Name	Data type	Size	Required	Comments
STR01	Record Type	Character	3	Y	"STR"
STR02	Statement ID	Character	23	Y	Unique ID for each statement. This ID is used to link all sub records for this statement.
STR03	Total Charges	Currency	13	Y	Total charges for statement from ADM11.
STR04	Filler	Character	0	NU	

### **Sample**

STR|38822188|103568|

## **BTR – Batch Trailer Record**

The Batch Trailer segment is used to verify information within the batch.  
Repeat: Once per file

ID	Field Name	Data type	Size	Required	Comments
BTR01	Record Type	Character	3	Y	"BTR"
BTR02	Batch ID	Character	30		
BTR03	Statements Count	Numeric	10	Y	Count of statements within the batch.
BTR04	Total Charges	Currency	13	Y	Total charges for statements within the batch from ADM11.
BTR05	Filler	Character	0	NU	

### **Sample**

BTR|001|7|103568|

## **FTR – File Trailer Record**

The File Trailer segment is used to verify information about the entire file transmission.  
Repeat: Once per file

ID	Field Name	Data type	Size	Required	Comments
FTR01	Record Type	Character	3	Y	"FTR"
FTR02	Batch Count	Numeric	10	Y	1
FTR03	Statement Count	Numeric	10	Y	Count of statements within the file.
FTR04	Total Charges	Currency	13	Y	Total charges for statements within the file from ADM11.
FTR05	Filler	Character	0	NU	

### **Sample**

FTR|1|7|103568|

## **Standard Statement Style Samples**

### **Blank Color Stock – Front (8.5 X 11)**

																		
PLEASE DETACH AT THE PERFORATION AND MAIL THIS PORTION WITH YOUR PAYMENT																		
<input type="checkbox"/> Please check box if address is incorrect or if insurance information has changed and indicate change(s) on reverse.																		
<table border="1"><tr><td>CARD NUMBER</td><td>3 DIGIT CODE</td><td>AMOUNT PAID</td></tr><tr><td>SIGNATURE</td><td colspan="2">EXP DATE</td></tr><tr><td>NAME</td><td colspan="2">STATEMENT ID</td></tr><tr><td>AMOUNT DUE</td><td>ACCOUNT NUMBER</td><td>PAYMENT DUE DATE</td></tr><tr><td></td><td></td><td></td></tr></table>				CARD NUMBER	3 DIGIT CODE	AMOUNT PAID	SIGNATURE	EXP DATE		NAME	STATEMENT ID		AMOUNT DUE	ACCOUNT NUMBER	PAYMENT DUE DATE			
CARD NUMBER	3 DIGIT CODE	AMOUNT PAID																
SIGNATURE	EXP DATE																	
NAME	STATEMENT ID																	
AMOUNT DUE	ACCOUNT NUMBER	PAYMENT DUE DATE																

**Blank Color Stock – Back (8.5 X 11)**

FOR CHANGE OF ADDRESS, MISSPELLINGS OR OTHER ERRORS, PLEASE PRINT CORRECTIONS.			
Guarantor's Name		Phone # (      )	
Guarantor's Address		City	State
Zip Code			
IF YOU HAVE NOT SUPPLIED INSURANCE INFORMATION, PLEASE DO SO HERE:			
PRIMARY INSURANCE COVERAGE		Patient's Relationship to Insured <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	SECONDARY INSURANCE COVERAGE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
Insurance Company Name		Phone # (      )	Insurance Company Name
Insurance Company Address		Phone # (      )	
Policyholders Name		Birthdate /      /	Policyholders Name
Policy & Group #		Policy Effective Date /      /	Policy & Group #
Employer's Name		Phone # (      )	Employer's Name
Employer's Address		Phone # (      )	
Employer's Address		Employer's Address	

**Sample with Data – Front (8.5 X 11)**

 REALMED MEDICAL CENTER P.O. BOX 123 ANYCITY, IN 12345  1 / 1	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">STATEMENT DATE</td> <td style="width: 50%;">04/09/09</td> </tr> <tr> <td>ACCOUNT NUMBER</td> <td>123456789</td> </tr> <tr> <td>BALANCE FORWARD</td> <td>\$1082.50</td> </tr> <tr> <td>PAY THIS AMOUNT</td> <td style="background-color: #ffcccc;">\$1226.50</td> </tr> </table> <p style="margin-top: 10px;">0 1 2 3 4 5 6 7 8 9      #####      RANDALL BEAMAN      123 ANY STREET      ANYCITY, ST 12345</p> <p style="text-align: right; margin-top: 10px;">Billing Questions? Call 317-580-0027</p> <p style="text-align: center; margin-top: 10px;">   </p> <p style="text-align: center; margin-top: 10px;"><b>STATEMENT -REALMED MEDICAL CENTER, INC.</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Date</th> <th>Patient Name</th> <th>Physician</th> <th>Description</th> <th>Charge</th> <th>Payments/ Adjustments</th> <th>Patient Amount Due</th> </tr> </thead> <tbody> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>OFFICE/OUTPATIENT VISIT, E</td><td>75.00</td><td></td><td>75.00</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>DRAWING BLOOD, ROUTINE</td><td>15.00</td><td></td><td>15.00</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>SYPHILIS TEST;QUALITATIVE(</td><td>6.80</td><td></td><td>6.80</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>ASSAY THYROID STIMULATING</td><td>6.80</td><td></td><td>6.80</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>AUTOMATED HEMOGLOBIN (CBC)</td><td>6.60</td><td></td><td>6.60</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>BLOOD LIPOPROTEIN ASSAY, H</td><td>6.60</td><td></td><td>6.60</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>GLYCOPROTEIN ELECTROPHORES</td><td>6.60</td><td></td><td>6.60</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>DRAWING BLOOD, ROUTINE</td><td>15.00</td><td></td><td>15.00</td></tr> <tr><td>04/02/09</td><td>RANDALL B</td><td>37</td><td>LIPID PANEL</td><td>6.00</td><td></td><td>6.00</td></tr> </tbody> </table>	STATEMENT DATE	04/09/09	ACCOUNT NUMBER	123456789	BALANCE FORWARD	\$1082.50	PAY THIS AMOUNT	\$1226.50	Date	Patient Name	Physician	Description	Charge	Payments/ Adjustments	Patient Amount Due	04/02/09	RANDALL B	37	OFFICE/OUTPATIENT VISIT, E	75.00		75.00	04/02/09	RANDALL B	37	DRAWING BLOOD, ROUTINE	15.00		15.00	04/02/09	RANDALL B	37	SYPHILIS TEST;QUALITATIVE(	6.80		6.80	04/02/09	RANDALL B	37	ASSAY THYROID STIMULATING	6.80		6.80	04/02/09	RANDALL B	37	AUTOMATED HEMOGLOBIN (CBC)	6.60		6.60	04/02/09	RANDALL B	37	BLOOD LIPOPROTEIN ASSAY, H	6.60		6.60	04/02/09	RANDALL B	37	GLYCOPROTEIN ELECTROPHORES	6.60		6.60	04/02/09	RANDALL B	37	DRAWING BLOOD, ROUTINE	15.00		15.00	04/02/09	RANDALL B	37	LIPID PANEL	6.00		6.00
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PLEASE DETACH AND MAIL THIS PORTION WITH YOUR PAYMENT

 <input type="checkbox"/> MASTERCARD	 <input type="checkbox"/> VISA	
CARD NUMBER	3 DIGIT CODE	AMOUNT PAID
SIGNATURE	EXP. DATE	
PATIENT NAME	STATEMENT ID	
BEAMAN, RANDALL	445653	
AMOUNT DUE	ACCOUNT NUMBER	PAYMENT DUE DATE
\$1226.50	123456789	04/24/09

Please check box if address is incorrect or if insurance information has changed and indicate change(s) on reverse.

Please remit payments to:

REALMED MEDICAL CENTER  
P.O. BOX 123  
ANYCITY, IN 12345

## Design Features

**Patient Friendly Design Features**

**Logo**  
Prints in gray scale

**Intelligent Mail Barcode**  
Ensure 100% delivery accuracy

**Perforation**  
Easy separation of coupon

**Change Checkbox**  
Prompt for changed information

**Payment Summary**  
Select credit cards to display

**Payment Due Boxes**  
Customize up to 4 boxes

**Service Message**  
Customize up to 10 lines

**Detail Section**  
Customizable columns based on information available in your statement file

**Custom Messaging**  
Customizable messages based on information available in your statement file

**Online Payment Portal**  
Patients can pay online (optional)

**Bank Lockbox Scanline**  
Faster payment processing

**Advanced Features**

**Manage Statements Online**  
Use RealMed to send patient statement files 24 hours a day/7 days a week. View statements online from the moment they are uploaded. Track statements through address checking and mailing process. Address scrubbing returns undeliverable statements online through RealMed for Correction/Review before they are mailed.

**NCOA<sup>Link48</sup> - Address Correction**  
Over 40 million Americans change addresses annually. NCOA<sup>Link48</sup> matches addresses to 48 months of change of address information for families, individuals and businesses.

**Learn More at [www.realmmed.com](http://www.realmmed.com)**

**Outgoing Envelope (No. 10)**  
Double window, security tint, vegetable-based film

**Payment Return Coupon**  
Optional Lockbox speeds accurate payment posting

**Remit Envelope (No. 9)**  
Single window, security tint, vegetable-based film

## Patient Statement Reporting File Definition

### ***Address Correction Report***

Tracks patient statement address changes that occur based on manual intervention or automated matching and adjustment. This report can be used as reference to update the providers Practice Management system. The data is available in CSV format and can be scheduled for creation and delivery via Secure File Exchange or FTP.

Field Name	Data Type	Size	Nullable	Comments
ExecutionTime	Date/Time	16	N	MM/DD/YYYY HH:MM
ReportParameters	Character		N	
GroupBy	Character		N	
textbox90	Character		N	
OfficeName	Character	60	N	
BatchName	Character	30	N	
BillToName	Character	50	N	
AcctNum	Character	30	N	
StmtID	Number	(9,0)	N	
DateSubmitted	Date	10	N	MM/DD/YYYY
Auto_Addr_Update_YN		9	N	Automatic Manual
SubAddress	Character	150	N	Submitted address
NewAddress	Character	150	N	New address

### ***Edit/Error Management Report***

This report allows the practice to track errors that occur within Patient Statement Edit/Error Management. This report provides information on the type of error that occurred and how many errors occurred within a given time period. It can be used by managers to monitor how many statements are currently in Patient Statement Edit/Error management. The data is available in CSV format and can be scheduled for creation and delivery via Secure File Exchange or FTP.

Field Name	Data type	Size	Nullable	Comments
textbox109	Character		N	
textbox113	Character		N	
GroupBy	Character		N	
GroupByTotal	Character		N	
OfficeName	Character	60	N	
BatchName	Character	30	N	
BillToName	Character	50	N	
AcctNum	Character	30	N	
StmtID	Number	(9,0)	N	
DateSubmitted	Date	10	N	MM/DD/YYYY
SubmittedAddress	Character	150	N	
ReturnCode	Numeric	(2,0)	N	
DPVFootnote	Character	250	N	

## **Force Mail Report**

Allows the practice to track patient statements that have been forced mailed from Patient Statement Edit/Error Management. This report provides the return code and description of rejection from USPS. This report can be used as reference to update the providers Practice Management system and track patient statements that were force mailed. The data is available in CSV format and can be scheduled for creation and delivery via Secure File Exchange or FTP.

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Nullable</b>	<b>Comments</b>
ExecutionTime	Date/Time	16	N	MM/DD/YYYY HH:MM
ReportParameters	Character		N	
GroupBy	Character		N	
GroupByTotal	Character		N	
OfficeName	Character	60	N	
BatchName	Character	30	N	
BillToName	Character	50	N	
AcctNum	Character	30	N	
StmtID	Number	(9,0)	N	
DateSubmitted	Date	10	N	MM/DD/YYYY
DateForced	Date	10	N	MM/DD/YYYY
User	Character	100	N	
SubmittedAddress	Character	150	N	
ReturnCode	Numeric	(2,0)	N	
DPVFootnote	Character	250	N	

## Progress Report

Provides a way for practices to quickly determine how many statement batches are progressing through Availity RCM system and being mailed. It is particularly useful for practices that possess multiple office hierarchies and want to see the overall performance of statement batches. The data is available in CSV format and can be scheduled for creation and delivery via Secure File Exchange or FTP.

Field Name	Data type	Size	Nullable	Comments
ExecutionTime	Date/Time	16	N	MM/DD/YYYY HH:MM
ReportParameters	Character		N	
GroupBy	Character		N	
GroupSubtotal	Character		N	
GroupSubtotalCharges	Currency	(9,2)	N	
GroupSubtotalClaimsInBatch	Numeric	(9,0)	N	
GroupSubtotalReturnToProvider	Numeric	(9,0)	N	
GroupSubtotalTranslated	Numeric	(9,0)	N	
GroupSubtotalAddressCheck	Numeric	(9,0)	N	
GroupSubtotalSuspended	Numeric	(9,0)	N	
GroupSubtotalReady	Numeric	(9,0)	N	
GroupSubtotalFailed	Numeric	(9,0)	N	
GroupSubtotalTotalNotSubmitted	Numeric	(9,0)	N	
GroupSubtotalSentToPrint	Numeric	(9,0)	N	
GroupSubtotalMailed	Numeric	(9,0)	N	
GroupSubtotalTotalSubmitted	Numeric	(9,0)	N	
GroupSubtotalTotalStatements	Numeric	(9,0)	N	
OfficeName	Character	60	N	
BatchName	Character	30	N	
BatchFileName	Character	100	N	
SubmissionDate	Date	10	N	MM/DD/YYYY
TotalCharges	Currency	(9,2)	N	
ClaimsInBatch	Numeric	(9,0)	N	
ReturnedToProvider	Numeric	(9,0)	N	
Translated	Numeric	(9,0)	N	
AddressCheck	Numeric	(9,0)	N	
Suspended	Numeric	(9,0)	N	
Ready	Numeric	(9,0)	N	
Failed	Numeric	(9,0)	N	
TotalNotSubmitted	Numeric	(9,0)	N	
SentToPrint	Numeric	(9,0)	N	
Mailed	Numeric	(9,0)	N	
TotalSubmitted	Numeric	(9,0)	N	
TotalStatements	Numeric	(9,0)	N	

## **Summary Report**

This report allows the practice to track patient statement processing over a period of time. This report provides detailed data such as the duration of time to receive, process and mail patient statements as well as dates received and mailed to patients. It can be filtered by office. This report does not reflect the patient statements for which a practice is billed. The data is available in CSV format and can be scheduled for creation and delivery via Secure File Exchange or FTP.

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Nullable</b>	<b>Comments</b>
ExecutionTime	Date/Time	16	N	MM/DD/YYYY HH:MM
ReportParameters	Character		N	
GroupBy	Character		N	
textbox6	Character		N	
OfficeName	Character	60	N	
BatchID	Numeric	(9,0)	N	
ClientFileName	Character	100	N	
ReceivedDate	Date	10	N	MM/DD/YYYY
MailDate	Date	10	N	MM/DD/YYYY
ProcessingDays	Numeric	(9,0)	N	
BatchStatus	Character	100	N	Address Check – Address is being validated by clearinghouse. Translated – Patient statement successfully translated. Rtn to Prov – Patient statement deleted from application. Suspended – Patient statement contains an error that needs to be fixed. Ready – Patient statement ready for transfer to clearinghouse. Failed – An internal error occurred during processing of the patient statement. Sent to Print – Patient statement has been sent to clearinghouse for printing. Deleted – Patient statement removed from system by Availity RCM. Mailed – Patient statement has been mailed.

## NCOA<sup>Link</sup> Return Codes

NCOA<sup>Link</sup> will provide a return code for each record that is processed. The value of this return code can be used to determine:

- If a match has been made, and if so if a new address will be returned or not
- What elements of the name or address prevented a match from being made
- No match found

A new forwarding address will only be provided for the following return codes:

- A, 91 & 92

The following return codes indicate that a match was found on the NCOA<sup>Link</sup> file, however no forwarding address is available:

- 01, 02, 03, 05, 14, 19

The following table shows the possible value of each return code, and provides a description for each code.

Return Code	Description
A	<b>COA Match</b> - The input record matched to a business, individual or family type master file record. A new address is furnished.
00	<b>NO Match</b> - The input record COULD NOT BE matched to a master file record. A new address could not be furnished.
01	<b>Found COA: Foreign Move</b> – The input record matched to a business, individual or family type master file record but the new address was outside the USPS delivery area.
02	<b>Found COA: Moved Left No Address(MLNA)</b> - The input record matched to a business, individual or family type master file record and the new address was not provided to USPS.
03	<b>Found COA: Box Closed No Order(BCNO)</b> – The Input record matched to a business, individual or family type master file record which contains an old address of PO BOX that has been closed without a forwarding address provided.
04	<b>Cannot match COA: Street Address with Secondary</b> – The input record matched to a family record type on the COA file with an address that contains secondary information. The input record does not contain secondary information. This address match situation requires individual name matching logic to obtain a match and individual names do not match.
05	<b>Found COA: New 11-digit DPBC is Ambiguous</b> – The input record matched to a business, individual or family type master file record. The new address on the master file record could not be converted to a deliverable address because the DPBC represents more than one delivery point.
06	<b>Cannot Match COA: Conflicting Directions: Middle Name Related</b> –There is more than one COA (individual or family type) record for the match algorithm and the middle names or initials on the COAs are different. Therefore, a single match result could not be determined.
07	<b>Cannot Match COA: Conflicting Directions: Gender Related</b> –There is more than one COA (individual or family type) record for the match algorithm and the genders of the names on the COAs are different. Therefore, a single match result could not be determined.
08	<b>Cannot Match COA: Other Conflicting Instructions</b> – The input record matched to two COA (business, individual or family type) records. The two records in the master file were compared and due to differences in the new addresses, a match could not be made.
09	<b>Cannot Match COA: High-rise Default</b> – The input record matched to a family record on the master file from a High-rise address ZIP+4 coded to the building default. This address match situation requires individual name matching logic to obtain a match and individual names do not match.

Return Code	Description
10	<b>Cannot Match COA: Rural Default</b> - The input record matched to a family record on the master file from a Rural Route or Highway Contract Route address ZIP+4 coded to the route default. This address situation requires individual name matching logic to obtain a match and individual names do not match.
11	<b>Cannot Match COA: Individual Match: Insufficient COA Name for Match</b> – There is a COA (individual or family type) record with the same surname and address but there is insufficient name information on the COA record to produce a match using individual matching logic. This return code is only obtained when using individual matching logic. Family matching (if appropriate) was also attempted but failed.
12	<b>Cannot Match COA: Middle Name Test Failed</b> - The input record matched to an individual or family record on the master file with the same address and surname. However, a match cannot be made because the input name contains a conflict with the middle name or initials on the master file record.
13	<b>Cannot Match COA: Gender Test Failed</b> – The input record matched to a master file (individual or family type) record. A match cannot be made because the gender of the name on the input record conflicts with the gender of the name on the master file record. Family matching (if appropriate) was also attempted but failed.
14	<b>Found COA: New Address Would Not Convert at Run Time</b> - The input record matched to a master file (business, individual or family type) record. The new address could not be converted to a deliverable address.
15	<b>Cannot Match COA: Individual Name Insufficient</b> – There is a master file record with the same address and surname. A match cannot be made because the input record does not contain a first name or contains initials only. Family matching (if appropriate) was also attempted but failed.
16	<b>Cannot Match COA: Secondary Number Discrepancy</b> – The input record matched to a street level individual or family type record. However, a match is prohibited based on 1 of the following reasons: 1) There is conflicting secondary information on the input and master file record; 2) the input record contained secondary information and matched to a family record that does not contain secondary information. In item 2, this address match situation requires individual name matching logic to obtain a COA match and individual names do not match.
17	<b>Cannot Match COA: Other Insufficient Name</b> – The input record matched to an individual or family master file record. The input name is different or not sufficient enough to produce a match. Family matching (if appropriate) was also attempted but failed.
18	<b>Cannot Match COA: General Delivery</b> – The input record matched to a family record on the master file from a General Delivery address. This address situation requires individual name matching logic to obtain a match and individual names do not match. Family matching (if appropriate) was also attempted but failed.
19	<b>Found COA: New Address not ZIP+4 coded</b> – There is a change of address on file but the new address cannot be ZIP+4 coded and therefore there is no 11-digit DPBC to store or return.
20	<b>Cannot Match COA: Conflicting Directions after re-chaining</b> – Multiple master file records were potential matches for the input record. The master file records contained different new addresses and a single match result could not be determined.
66	<b>Daily Delete</b> – The input record matched to a business, individual or family type master file record with an old address that is present in the daily delete file. The presence of an address in the daily delete file means that a COA with this address is pending deletion from the master file and that no mail may be forwarded from this address at this time.

Return Code	Description
91	<b>COA Match: Secondary Number dropped from COA</b> – The input record matched to a master file record. The master file record has a secondary number and the input address does not.
92	<b>COA Match: Secondary Number Dropped from input address</b> – The input record matched to a master file record, but the input address had a secondary number and the master file record did not.

# Self-pay Eligibility Verification

## Overview

The Self-Pay Eligibility Verification feature allows clients to submit a file of self-pay requests using a proprietary format to Availity RCM and have that request sent to multiple payers. These inquiries use the payers' name/DOB search for matching eligibility. The client uses a configuration tool within Availity RCM to setup the membership coverage search on up to five payers. In the "background" Availity RCM will use the single eligibility request to "spawn" the requests to all configured payers.

The product can be utilized by both Professional and Institutional clients that are able to submit eligibility requests to the Availity RCM Application.

All results are posted in the Availity RCM Application Portal. No results are retuned electronically to the host system.

## Implementation

Self-Pay Eligibility Verification request must be submitted using the [Availity RCM Proprietary – Batch Eligibility Verification](#).

## Scheduling

Self-Pay Eligibility Verification request may begin process immediately, depending on the payer, however most will be submitted during off peak hours and can take up to five days before being processed.

## Payers

Self-Pay Eligibility Verification is available through a limited number of payers. Clients should work with their Availity Client Account Manager to ensure that needed payers are available and configured properly.

## File Transfer

The Self-Pay Eligibility Verification request files can be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

# Report Analysis Data Download

## Overview

The Availity RCM Application Portal contains a very robust Report Analysis reporting tool which is capable of generating a number of existing reports in pdf format, delimited text data files, or Excel spreadsheets. The majority of these reports can be scheduled on a recurring basis and available for transferred to the client for processing.

A large number of reports currently exist in the library and may be used to supplement any data needs not covered by the integration data files currently available. Most of these reports can be modified to meet the specific needs of a client and their unique reporting requirements.

## Scheduling

Reports can be scheduled on a recurring basis for daily, weekly, and monthly with morning, afternoon, or evening delivery. Specific time specifications are not available due to the variable nature of the time required to generate a report, other running reports, and database load.

## Implementation

### *File Transfer*

The Reporting Analysis output file can be transferred using a secure FTP method or via Availity RCM Secure File Exchange and will be delivered to the \REPORTS directory on the client side.

Files will be compressed into a zip file for quicker transfer.

# Edit/Error Management Pending Claims Error Postback

## Overview

The Edit & Error Management Pending Claims Error file allows for reporting of any claim which is pending within the Availity RCM application and provides the error information associated with each claim. This information can be used in the originating Practice Management System to correct the claim and resubmit it for processing thus providing a closed loop system.

Availity RCM can also schedule the automatic deletion of pending claims from the Availity RCM application so that manual processing is not required to remove these items from the system.

See Appendix D – Error Mapping for an explanation of Availity RCM Error code mapping.

## Scheduling

The Edit & Error Management Pending Claims Error file is generated each morning at approximately 9:00 AM EST. This file will then contain all claims with pending errors which were submitted on the previous day.

## Implementation

### *File Transfer*

The Edit/Error Management Pending Claims Error file can be transferred using a secure FTP method or via Availity RCM Secure File Exchange. This file is also available for direct download via the Availity RCM application.

Files will be compressed into a zip file for quicker transfer.

### *Automatic Claim Delete*

Optionally, in association with the generation of the Edit/Error Management Pending Claims Error file each claim can be automatically marked as deleted and no longer active within the Availity RCM application. By implementing the file download and automatic claim deletion, complete control of the claim lifecycle can be managed by the practice management system. Once the claim has been deleted in Availity RCM it is the responsibility of the practice management system to resubmit the corrected claim.

## File Definition

The Edit & Error Management Pending Claims Error file can be generated using either tab, comma, or pipe | delimited formats.

Field Name	Data type	Size	Nullable	Comments
Account Number	Numeric	(9,0)	N	Availity RCM Unique identifier for Claims
Batch File Name	Character	100	Y	
Batch Name	Character	30	N	
Date of Service	Date	10	N	MM/DD/YYYY
Days in E/E	Numeric	3	N	
Error Date	Date	10	N	MM/DD/YYYY
Error Description	Character	4000	N	
Error Number	Character	21	N	1st Node - Error Category 2nd Node - Sub-Category 3rd Node - Trading Partner 4th Node - Unique Error Number
Major Category	Character	100	N	
Minor Category	Character	100	N	
Office Name	Character	60	Y	The Office submitting the claim
Patient Name	Character	40	N	
Payer Name	Character	100	Y	The Payer the Claim is being submitted to
Availity RCM Claim ID	Character	36	N	Availity RCM unique GUID for each claim.
Rendering Provider Name	Character	80	Y	
Status in EE Mgmt	Character	100	N	
Still in E/E	Character	3	N	Yes – Still in E/E Management No – Not in E/E Management
Submission Date	Date	10	N	MM/DD/YYYY
Total Charges	Numeric	(18,2)	N	Amount of this claim.

# Claim Change Report Postback

## Overview

The Claim Change Report file allows for reporting of any changes made to a claim through the Availity RCM application. The changes can then be posted to the originating practice management system to reduce or eliminate the need for double entry of modifications. This report shows the actual before and after values for each field being changed.

The Claim Change Report does not report changes made by the payer due to eligibility verification or from the implementation of a custom client rule.

See Appendix D – Error Mapping for an explanation of Availity RCM Error code mapping.

## Scheduling

The Claim Change Report file is generated each morning at approximately 9:00 AM EST. This file will then contain all claims with pending errors which were submitted on the previous day.

## Implementation

### *File Transfer*

The Claim Change Report file can be transferred using a secure FTP method or via Availity RCM Secure File Exchange. This file is also available for direct download via the Availity RCM application.

Files will be compressed into a zip file for quicker transfer.

## File Definition

The Claim Change Report Postback file can be generated using either tab, comma, or pipe | delimited formats. The file will contain one or more rows for each claim and include any existing claims errors as well as the before and after image of the change. It is may be necessary to sort the by Claim Instance ID, Change Date and Change Time so that a logical sequence of events can be presented for a single claim.

Field Name	Data type	Size	Nullable	Comments
Batch File Name	Character	100	Y	
Batch Name	Character	30	N	
Change Date	Date	10	N	MM/DD/YYYY
Change Time	Time	11	N	HH:MM:SS AM
Claim Instance ID	Numeric	(9,0)	N	
Claim Number	Character	36	Y	
Date of Birth	Date	10	Y	MM/DD/YYYY
Error Description	Character	4000	Y	
Error Number	Character	21	Y	1st Node - Error Category 2nd Node - Sub-Category 3rd Node - Trading Partner 4th Node - Unique Error Number
Field Name	Character	80	Y	
Major Category	Character	100	Y	
Minor Category	Character	100	Y	
New Value	Character	1000	Y	
Office Name	Character	60	N	
Old Value	Character	1000	Y	
Patient Account Number	Character	25	Y	
Patient First Name	Character	25	Y	
Patient Last Name	Character	25	Y	
Patient Name	Character	60	Y	
Payer Name	Character	100	Y	
Availility RCM Claim ID	Character	36	N	Availility RCM unique GUID for each claim.
User First Name	Character	25	N	
User Last Name	Character	25	N	
User Name	Character	25	N	

## Patient Payments

### Overview

The Patient Payment Postback file allows for reporting of patient payment data processed through the Payment Management module within the Availity RCM application. This file can be used to deliver payment information into a Practice Management system. The file uses Practice ID and Account ID fields to for a unique match within the PM system

### Scheduling

The Patient Payments Report file is generated each morning at approximately 12:00 AM EST. This file will then contain all patient payments which were submitted on the previous day.

### Implementation

#### *File Transfer*

The Patient Payments Report file can be transferred using a secure FTP method or via Availity RCM Secure File Exchange. This file is also available for direct download via the Availity RCM application.

Files will be compressed into a zip file for quicker transfer.

## File Definition

The Patient Payments file fixed width text file. The file will contain one row for each patient payment.

Field Name	Data type	Location	Size	Comments
Line ID	Character	1	1	1st byte for each transaction begins with "S"
Practice ID	Numeric	2-5	4	Practice ID
Account ID	Numeric	6-17	12	Account ID. Format: Right Justified, Zero Filled
Filler	Character	18-24	7	Filler (Zero Filled)
Transaction Date	Date	25-30	6	The system date will be used instead of the transaction date. Date of Deposit. Format: MMDDYY
Stub Amount	Numeric	31-39	9	2 Decimal Point Float Amount due from Scan line -- excluding decimals
Check Amount	Numeric	40-48	9	Amount of check --excluding decimals (Required: amount that will post in NextGen.)
Statement Amount	Numeric	49-57	9	Additional remaining balances can be reflected. If not used Zero Fill.
Tracking Description (Check)	Character	58-71	14	Check Number
Tracking Description (Credit Card)	Character	58-71	14	Credit Card Tracking Number. Redefinition of Checking Tracking Description.
• Type	Character	58	1	V-Visa M-MasterCard D-Discover O-Other A-Amex
• CC Auth #	Character	59-65	7	Credit Card Authorization Number, or filled with zeroes.
• Filler	Character	66	1	\$
• CC Fee Amount	Numeric	67-71	5	Credit Card Fee Amount – 0.00 if not applicable.
Filler	Character	72-79	8	Not Used – Filled with spaces.

### Sample

S12340000001234560000000070913      12312      1231200000000M000000\$ 0.00

# Edit/Error Management Change Postback

## Overview

The Edit & Error Management Postback file allows for changes which are made in the Availity RCM application to be communicated and applied to the originating practice management system. By applying changes which were made in the Availity RCM application to the practice management system, the workload required to administer a claim will be reduced. Depending on the nature of the practice management system and its workflow, every effort should be made to automate as much of the postback processing as possible.

The EEM Postback file does not identify the changed items but provides the current snapshot of the claim. It is the responsibility of the PM system to compare the EEM Postback file to the values available within the PM system and take appropriate processing actions.

The Edit/Error Management file does report changes made by the payer due to eligibility verification or from the implementation of a custom client rule if another claim is changed in Edit and Error Management for another reason. If the claim is not changed in Edit and Error Management, these changes will not be reported.

## Scheduling

The EEM Postback file is generated each evening at approximately 6:00 PM EST. This file will then contain an image of the claim as of the run time. All claims which are edited since the last run will be included in the Postback file.

## Implementation

### File Transfer

The EEM Postback file can be transferred using a secure FTP method or via Availity RCM Secure File Exchange. The Postback file is not available for direct download via the Availity RCM application. The EEM Postback file will be delivered to its own directory structure on the client side.

### Implementation Approach

Depending on the nature of the PM system, its associated workflow capabilities, and the needs of a practice or specialty; implementing various levels of Postback automation may be required. Enabling the practice with to configure which Postback items are applied and how, can provide great flexibility to meet the specific business needs of a practice. Some PM systems will need to apply a great number of data elements while other may only need a limited number of items.

Implementation of three groups of changes is recommended to facilitate automation. Items should be able to be moved from group to group depending on the needs of a specific practice.

**Ignore** – Items in this group are not applied to the originating PM system and are automatically discarded.

**Process** – Items in this group are automatically applied to the origination PM system without any human interaction required. Items in this group should be considered very carefully as the processing is intended to be automatic without human review. If the PM system provides logging capabilities, the log should be updated to reflect the automatically applied changes.

**Review** – Items in this group should be placed on a work queue for review and action by a user. Depending on the nature of the PM system and the specific implementation, accepting the changes may simply require a button click to apply/discard the change or require the user navigate to the appropriate screen where the changes can be applied manually. If the PM system provides logging capabilities, the log should be updated to reflect the applied changes.

## File Definition

The EEM Postback file is actually composed of three CSV files representing specific area of interest within claims processing. Each file contains the current snapshot of the claim, not the before and after image.

### Claims

Data elements associated with the claim submission such as charge amounts, diagnosis codes, procedure codes, service dates, etc.

Field Name	Data type	Size	Nullable	Comments
Claim Instance Id	Numeric	(9,0)	N	Availity RCM Unique identifier for Claims
Document Number	Character	25	Y	The office provided document number for the claim
Line Item Num	Numeric	(3,0)	Y	Line Item Sequence Number (1,2,3...)
Payer Name	Character	100	Y	The Payer the Claim is being submitted to
Claim Status Type Code	Character	100	N	The Current Status of the Claim. See <a href="#">Claim Status Type Code Cross Reference</a> .
Billing Provider Number	Character	30	Y	Billing Provider Num
Patient Account Number	Character	25	Y	Patient Account Num
Total Charge Amt	Numeric	(18,2)	Y	Total Charge Amt
Claim Type	Character	2	Y	Claim Type (MD)
POS	Character	2	Y	Place of Service (11, 12, 21, 22, 23)
Provider Signature	Character	1	Y	Provider Signature (Y or N)
Accept Assign	Character	1	Y	Accept Assign (Y or N)
Homebound Ind	Character	1	Y	Homebound Indicator (Y or N)
User Name	Character	25	Y	The user who created the claim.
Office Name	Character	60	Y	The Office submitting the claim
Claim Status Date	DateTime		Y	The last date the claim status was updated within Availity RCM
Principal Diagnosis Code	Character	30	Y	The Principal Diagnosis Code
Diagnosis Code 2	Character	30	Y	Diagnosis Code 2
Diagnosis Code 3	Character	30	Y	Diagnosis Code 3
Diagnosis Code 4	Character	30	Y	Diagnosis Code 4
Diagnosis Code 5	Character	30	Y	Diagnosis Code 5
Diagnosis Code 6	Character	30	Y	Diagnosis Code 6
Diagnosis Code 7	Character	30	Y	Diagnosis Code 7
Diagnosis Code 8	Character	30	Y	Diagnosis Code 8
Onset Date	DateTime		Y	ANSI date type '431', "onset of current symptoms".
Admission Date	DateTime		Y	ANSI date type '435', "admission".
Discharge Date	DateTime		Y	ANSI date type '096', "discharge".
Onset Similar Date	DateTime		Y	ANSI date type '438', "onset of similar symptoms or illness".
Last Menstrual Period Date	DateTime		Y	ANSI date type '484', "last menstrual period".
Accident Date	DateTime		Y	ANSI date type '439', "accident"
Ref Claim Number	Character	30	Y	ANSI referral number type 'D9', "claim number"

Field Name	Data type	Size	Nullable	Comments
Ref Orig Ref Number	Character	30	Y	ANSI referral number type 'F8', "original reference number"
Ref Prior Auth Number	Character	30	Y	ANSI referral number type 'G1', "prior authorization number"
Ref Referral Number	Character	30	Y	ANSI referral number type '9F', "referral number"
Pat Paid Amt	Numeric	(15,2)	Y	ANSI claim amount type 'F5', "Patient Paid Amount"
Procedure Qualifier	Character	2	Y	Procedure Qualifier (HC - HCPCS and CPT codes)
Procedure Code	Character	6	Y	Procedure Code
Procedure Modifier Code1	Character	2	Y	Procedure Modifier Code1
Procedure Modifier Code2	Character	2	Y	Procedure Modifier Code2
Procedure Modifier Code3	Character	2	Y	Procedure Modifier Code3
Procedure Modifier Code4	Character	2	Y	Procedure Modifier Code4
Provider Billed Amt	Numeric	(18,2)	Y	Provider Billed Amt
Uom	Character	2	Y	Unit or Basis of Measurement
Unit Amt	Numeric	(18,2)	Y	Unit Amt
Place Of Service Code	Character	2	Y	Line Item Place Of Service Code
Type Of Service Code	Character	2	Y	Type Of Service Code
Diagnosis Code Pointer1	Character	2	Y	Diagnosis Code Pointer1
Diagnosis Code Pointer2	Character	2	Y	Diagnosis Code Pointer2
Diagnosis Code Pointer3	Character	2	Y	Diagnosis Code Pointer3
Diagnosis Code Pointer4	Character	2	Y	Diagnosis Code Pointer4
Emergency Ind	Character	1	Y	Emergency Indicator (Y or N)
Hospice Employed Prov Ind	Character	1	Y	Hospice Employed Prov Ind
Service From Date	DateTime		Y	ANSI claim detail date type = '472', "Service Date"
Service To Date	DateTime		Y	ANSI claim detail date type = '472', "Service Date"
Expire Date	Date		Y	context_state date
Batch Filename	Character	100	Y	rmb_batch file name

## Claims Status Type Code Cross Reference

RM Status Code	Claim Status Type Name	Description	Claim Status
			(STC01)
1	Print In-Process	Print In-Process	A1:19:40
2	Print Transmitted	Print Transmitted	A0:16:40
3	Print Accepted	Print Accepted	A1:19:AY
4	Failed	Failed Claim	N/A
5	Payer Accepted	Payer Accepted	A1:19:PR
6	Payer Returned	Payer Rejected	N/A
7	Remit Received	Remit Received	N/A
8	Edit Only	Claim is being edited only and will not be sent to payer	A1:0:40
9	Provider Match	Claim requires provider match	P3:50:40
A	Adjudicated	(null)	F0:3:PR
B	EDI In Process	Claim needs to be submitted via batch	A1:19:40
C	Cancelled	Claim was cancelled by provider/insured	N/A
D	EDI Rejected	Claim rejected by EDI receiver	N/A
E	Error	(null)	N/A
F	Resubmission	Claim is being resubmitted	A8:21:40
G	EDI Accepted	Good claim accepted by EDI receiver	A0:17:AY
H	EDI Returned	Claim returned by EDI receiver	N/A
I	Paid	Designates the claim as being paid	F1:1:PR
J	EDI Transmission	Claim was submitted to a trading partner via Tibco.	N/A
K	Saved	Claim was saved	N/A
L	Payer Match	Claim requires payer match	P3:677:40
M	Mailed	Claim was mailed to payer	A0:277:AY
N	New	(null)	A1:19:40
O	PPO Review	The claim should be passed through to the PPO, not to the PAYER.	N/A
P	Posted to PM	The claim was only submitted to the practice management system	N/A
R	Repriced	Availity RCM Hold for Investigation	N/A
S	Disabled	Payer option to designate a accepted claim to NOT pay	N/A
T	EDI Transmitted	Claim was submitted via batch	A0:16:40
U	Unknown	Unknown	E1:18:PR
V	Voided	Claim was voided in payer system.	N/A
W	Waiting	The claim is waiting to be transmitted	N/A
X	Deleted	Claim was deleted	D0:23:40
Y	Pended	Pended	P2:46:PR
Z	In Process	FEP Pended Claim	P1:19:PR

## Eligibility

Data elements associated with the patient or responsible party.

Field Name	Data type	Size	Nullable	Comments
Claim Instance Id	NUMBER	(9,0)	N	Availity RCM Unique identifier for Claims
Patient Account Num	Character	25	Y	Patient Account Num
Payer Sequence	NUMBER	(3,0)	Y	Payer Sequence, 1 or 2
Payer Responsibility	Character	1	Y	Payer Responsibility ( P - primary, S - secondary)
Relationship	Character	2	Y	Relationship ( 01, 18, 19, 21 )
Group Name	Character	60	Y	Group Name
Medicare Secondary Type	Character	3	Y	Medicare Secondary Type
Cob Code	Character	1	Y	Coordination of Benefits Code
Employment Status	Character	2	Y	Employment Status. See <a href="#">Employment Status Cross Reference</a> .
Type Of Residence	Character	1	Y	NOT CURRENTLY IN USE, all values null
Student Status	Character	1	Y	Student Status ( P, F, N )
Death Date	DATE		Y	Death Date
Weight UOM	Character	2	Y	Weight Unit of Measure
Patient Weight	NUMBER	(10,2)	Y	Patient Weight
Pregnancy Ind	Character	1	Y	Pregnancy Indicator
Filing Indicator	Character	2	Y	Filing Indicator ( BL, ZZ CI, MB ) See <a href="#">Filing Indicator Cross Reference</a> for complete list.
Submission Reason	Character	2	Y	Submission Reason
Assignment Benefit	Character	1	Y	Assignment Benefit ( Y or N )
Patient Signature	Character	1	Y	Patient Signature. See <a href="#">Patient Signature Cross Reference</a> .
Release Of Information	Character	1	Y	Release Of Information ( Y or N )
Reimbursement Rate	NUMBER	(10,0)	Y	Reimbursement Rate
HCPCS Payable Amount	NUMBER	(18,2)	Y	HCPCS Payable Amount
Remark Code1	Character	30	Y	ANSI coded remarks field 1
Remark Code2	Character	30	Y	ANSI coded remarks field 2
Remark Code3	Character	30	Y	ANSI coded remarks field 3
Remark Code4	Character	30	Y	ANSI coded remarks field 4
Remark Code5	Character	30	Y	ANSI coded remarks field 5
EsrD Paid Amount	NUMBER	(18,2)	Y	EsrD Paid Amount
Non Payable Amount	NUMBER	(18,2)	Y	Non Payable Amount
Group Number	Character	30	Y	Group Number
Patient Employment	Character	2	Y	Patient Employment. See <a href="#">Employment Status Cross Reference</a> .
Qd Last Name	Character	35	Y	Responsible Party Last Name

Field Name	Data type	Size	Nullable	Comments
Qd First Name	Character	25	Y	Responsible Party First Name
Qd Middle Name	Character	25	Y	Responsible Party Middle Name
Qd Prefix Name	Character	10	Y	Responsible Party Prefix Name
Qd Suffix Name	Character	10	Y	Responsible Party Suffix Name
Qd Identifier Type	Character	2	Y	Responsible Party Identifier Type
Qd Identifier	Character	80	Y	Responsible Party Identifier
Qd Address 1	Character	55	Y	Responsible Party Address 1
Qd Address 2	Character	55	Y	Responsible Party Address 2
Qd City	Character	30	Y	Responsible Party City
Qd State	Character	2	Y	Responsible Party State
Qd Zip Code	Character	15	Y	Responsible Party Zip Code
Qd Dob	DATE		Y	Responsible Party Dob
Qd Gender	Character	1	Y	Responsible Party Gender
Qd Marital Status	Character	1	Y	Responsible Party Marital Status. See <a href="#">Marital Status Cross Reference</a> .
Qc Last Name	Character	35	Y	Patient Last Name
Qc First Name	Character	25	Y	Patient First Name
Qc Middle Name	Character	25	Y	Patient Middle Name
Qc Prefix Name	Character	10	Y	Patient Prefix Name
Qc Suffix Name	Character	10	Y	Patient Suffix Name
Qc Identifier Type	Character	2	Y	Patient Identifier Type
Qc Identifier	Character	80	Y	Patient Identifier
Qc Address 1	Character	55	Y	Patient Address 1
Qc Address 2	Character	55	Y	Patient Address 2
Qc City	Character	30	Y	Patient City
Qc State	Character	2	Y	Patient State
Qc Zip Code	Character	15	Y	Patient Zip Code
Qc Dob	DATE		Y	Patient Dob
Qc Gender	Character	1	Y	Patient Gender
Qc Marital Status	Character	1	Y	Patient Marital Status. See <a href="#">Marital Status Cross Reference</a> .
II Last Name	Character	35	Y	Subscriber or Insured Last Name
II First Name	Character	25	Y	Subscriber or Insured First Name
II Middle Name	Character	25	Y	Subscriber or Insured Middle Name
II Prefix Name	Character	10	Y	Subscriber or Insured Prefix Name
II Suffix Name	Character	10	Y	Subscriber or Insured Suffix Name
II Identifier Type	Character	2	Y	Subscriber or Insured Identifier Type
II Identifier	Character	80	Y	Subscriber or Insured Identifier
II Address 1	Character	55	Y	Subscriber or Insured Address 1
II Address 2	Character	55	Y	Subscriber or Insured Address 2
II City	Character	30	Y	Subscriber or Insured City
II State	Character	2	Y	Subscriber or Insured State
II Zip Code	Character	15	Y	Subscriber or Insured Zip Code
II Dob	DATE		Y	Subscriber or Insured Dob
II Gender	Character	1	Y	Subscriber or Insured Gender
II Marital Status	Character	1	Y	Subscriber or Insured Marital Status. See <a href="#">Marital Status Cross Reference</a> .
Office Name	Character	60	Y	The Office submitting the eligibility
Payer Name	Character	100	Y	Payer name

<b>Field Name</b>	<b>Data type</b>	<b>Size</b>	<b>Nullable</b>	<b>Comments</b>
Payer Reference Number	Character	80	Y	payer's identifier for this claim from claim_sbr_name
Expire Date	Date		Y	context_state date
Batch Filename	Character	100	Y	rmb_batch file name

#### Patient Signature Cross Reference

<b>Code</b>	<b>Description</b>
Blank	
B	Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file
C	Signed HCFA-1500 Claim Form on file
M	Signed signature authorization form for HCFA-1500 Claim Form block 13 on file
P	Signature generated by provider because the patient was not physically present for services
S	Signed signature authorization form for HCFA-1500 Claim Form block 12 on file

#### Marital Status Cross Reference

<b>Code</b>	<b>Description</b>
Blank	
D	Divorced
S	Single
K	Unknown
M	Married
R	Unreported
S	Separated
U	Unmarried
W	Widowed
X	Legally Separated

## Employment Status Cross Reference

Code	Description
Blank	
AA	Leave of Absence with Pay
AB	Leave of Absence without Pay
AC	Active
AF	Flexible Work Plan
AO	Active Military Overseas
AU	Active Military USA
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CT	Continued
DC	Discharged or Terminated for Cause
DI	Deceased
DQ	Disqualified: Medical or Physical Condition
DR	Disqualified: Other
DS	Disabled
FA	Furloughed: Job Abolished Force Reduction
FB	Furloughed: Bumped or Displaced
FC	Furloughed: Facility Closed
FO	Furloughed: Other
FT	Full-time
IA	Inactive
L1	Leave of Absence
LA	Leave of Absence: Personal
LE	Leave of Absence: Education
LM	Leave of Absence: Maternity
LS	Leave of Absence: Sickness
LU	Leave of Absence: Union
LW	Leave of Absence: Without Permission Unauthorized
NE	Not Employed
PT	Part-time
RA	Resigned: Retired
RI	Resigned: Injury
RM	Retired Military Overseas
RP	Resigned: Personal Reasons
RT	Retired
RU	Retired Military USA
RW	Dual Retired Status
SA	Resigned: Accepted Separation Allowance
SE	Self-Employed
SU	Suspended
TE	Terminated
UK	Unknown
ZZ	Mutually Defined

## Filing Indicator Cross Reference

<b>Code</b>	<b>Description</b>
9	Self-pay
10	Central Certification
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan
WC	Workers Compensation Health Claim
ZZ	Mutually Defined

## Error

Description of the errors for each claim which may have caused the need to edit the claim submission.

Rows from each file are associated using the 'Claim Instance ID'.

<b>Field Name</b>	<b>Datatype</b>	<b>Size</b>	<b>Nullable</b>	<b>Comments</b>
Claim Instance Id	NUMBER	(9,0)	N	Availity RCM Unique identifier for Claims
Document Num	Character	25	Y	The office provided document number for the claim
Reason	Character	30	Y	The high-level error category
Error Num	Character	25	Y	The error number associated with the error
Description	Character	4000	Y	A detailed description of the error
Office Name	Character	60	Y	

# Workers Compensation Bulk Attachments

## Overview

Availity RCM allows for the automatic attachment of supporting documentation required for Workers Compensation claims. Once the required documents for a claim have been attached, the claim will be sent to payers as an ANSI 837 and the documents as ANSI 275 transactions for payers that are able to accept them.

Claims requiring supporting documentation must have special handling codes set, must be transferred using Secure File Exchange or FTP, require special naming conventions, and must be packaged within a single ZIP file.

## Implementation

### **File Transfer**

Workers Compensation bulk attachments must be transferred using a secure FTP method or via Availity RCM Secure File Exchange.

### **File Formats**

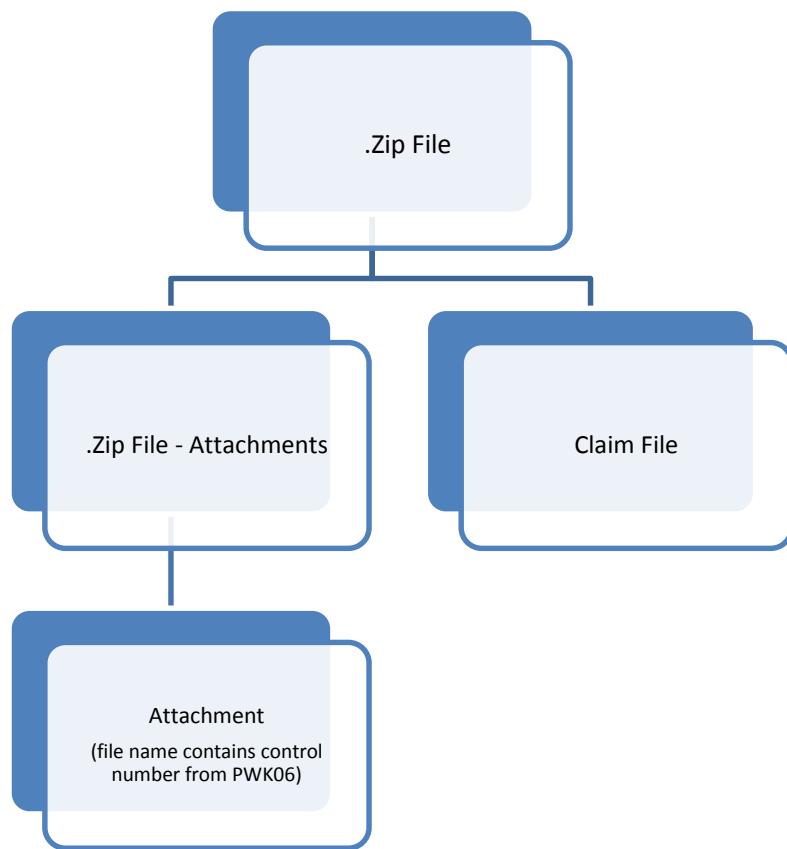
**Zip Files** – The client will send Availity RCM one .Zip file containing a single ANSI 837 claims file and a single zip file with all attachments.

**Attachments** – Documents within the attachment zip file must be .pdf or .jpeg format.

## Details

1. The file name of the attachment is the control number from (Loop 2300), the PWK06 segment.
2. Matching Logic:
  - The PWK segments are pulled from the Claim File for each claim.
  - The PWK06 – Control Numbers – are pulled from the PWK segments.
  - The logic then looks through the Attachment .Zip File and finds a corresponding control number from the attachment file name.
  - Once the matching Control Number is found, Availity RCM pulls the attachment from the .zip file and attaches it to the matching claim.
  - If an attachment is sent that does not match back to a claim, then the attachment stays in the directory. If another claim file is sent (in a separate zip file or on a separate day) then the matching logic will review new attachments as well as orphaned attachments to find a match.

## **Zip File Structure**



## Resources

### **Health Care Eligibility Benefit Inquiry and Response 270/271**

Full copies of the HIPAA EDI Implementation Guides can be obtained from [www.wpc-edi.com](http://www.wpc-edi.com). These guides provide detailed information on the format and structure of the HIPAA EDI transactions available for exchange with clearinghouses, providers, payers, and other healthcare related entities. These guides are available in both 4010 and 5010 versions.

### **Availity RCM Specific HIPAA Implementation Guides**

Availity RCM has developed HIPAA Implementation Guides which reflect any specific coding or structure requirements to successfully exchange EDI transaction with Availity RCM. These guides are available on request and must be used in association with a specific client or ongoing implementation.



# Appendix A – 270/271 Quick Start Guide (5010)

## Overview

### Purpose

The Availity RCM 270/271 Quick Start Guide is intended to provide a basic understanding of how to format and build a 270, eligibility request, and how to parse and map a 271, eligibility response. This guide is not intended to define every detail of the 270/271 transaction, only the basics. Full ANSI standards of the 270/271 transaction can be obtained from [www.wpc-edi.com](http://www.wpc-edi.com). These standards provide detailed information on the format and structure of the request and response used in HIPAA 270 & 271 transactions.

This guide is specific to the interpretation and implementation used by Availity RCM. Payers, providers, and software vendors may have custom usage of these transactions that are specific to their business practices.

### Usage

The 270 transaction is used to request benefit eligibility information from a service provider to a payer for a subscriber or dependent. The 270 transaction can be transmitted using either batch or real time communication methods depending on the capabilities of the payer to receive and process the transaction. Batch processing is better suited for large quantities such as verifying benefits for all of tomorrow's scheduled patients. Real time processing is best suited for verifying benefits of a single patient when response time is important such as would be the case for a walkup patient.

The 271 transaction is the response received from the payer that corresponds to an eligibility request. The 271 transaction will be transmitted back to the requestor using the same method as the original eligibility request. Depending on the configuration of a practice at Availity RCM, the 271 response may not be transmitted to the practice and will only be available for viewing in the Availity RCM application.

### Version

This document is intended for use with version 5010 of the X12 standard.

## Conventions

### Format

270/271 request and responses are composed of a series of text based segments nested within loops to form a complete transaction set. Each segment begins with a two or three character identifier which describes the segment and contains one or more additional fields separated by an asterisk. Each segment must end with a delimiter, typically the tilde ~.

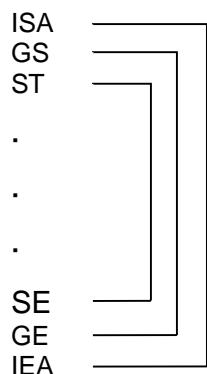
```
BHT*0022*13*7099*20081028*1421~
```

### Structure

Each transmission must contain a single transmission control beginning with an ISA, Interchange Control Header, and end with an IEA, Interchange Control Trailer.

Within the transmission control must be one or more functional groups which begin with a GS, Functional Group Header, and end with a GE, Functional Group Trailer.

Each functional group must contain one or more transaction sets which begin with a ST, Transaction Set Header, and end with a SE, Transaction Set Trailer. Within the transaction set are the detail segments for the eligibility request or response.



## 270 Eligibility Request

### Loop Structure

Loop	Segment	Name	Usage	Repeat	Loop Repeat
	ISA	Interchange Control Header	R	1	
	GS	Functional Group Header	R	1	>1
	ST	Transaction Set Header	R	1	
	BHT	Beginning of Hierarchical Transaction	R	1	
2000A	HL – 20	Information Source Level	R	1	>1
2100A	NM1	Information Source Name	R	1	
2000B	HL – 21	Information Receiver Level	R	1	>1
2100B	NM1	Information Receiver Name	R	1	
	REF	Information Receiver Additional Information	S	9	
2000C	HL – 22	Information Subscriber Level	R	1	>1
	TRN	Subscriber Trace Number	S	2	
2100C	NM1	Subscriber Name	R	1	
	REF	Subscriber Additional Information	S	9	
	N3	Subscriber Address	S	1	
	N4	Subscriber City/State/Zip	S	1	
	PRV	Subscriber Provider Information	S	1	
	DMG	Subscriber Demographics Information	S	1	
	INS	Subscriber Relationship	S	1	
	DTP	Subscriber Date	S	2	
2110C	EQ	Subscriber Eligibility Inquiry	S	1	99
2000D	HL - 23	Information Dependent Level	S	1	>1
	TRN	Dependent Trace Number	S	2	
2100D	NM1	Dependent Name	R	1	
	REF	Dependent Additional Information	S	9	
	N3	Dependent Address	S	1	
	N4	Dependent City/State/Zip	S	1	
	PRV	Dependent Provider Information	S	1	
	DMG	Dependent Demographics Information	S	1	
	INS	Dependent Relationship	S	1	
	DTP	Dependent Date	S	2	
2110D	EQ	Dependent Eligibility Inquiry	S	1	99
	SE	Transaction Set Trailer	R	1	
	GE	Functional Group Trailer	R	1	
	IEA	Interchange Control Trailer	R	1	

## Segment Definitions

### ISA – Interchange Control Header

The Interchange Control Header is used to identify one or more functional groups and interchange-related control segments.

Field	Field Description	Size	Value	Comment
ISA01	Author Info Qualifier	2	'00'	No authorization information present.
ISA02	Author Information	10		Empty
ISA03	Security Information Qualifier	2	'00'	No security information present.
ISA04	Security Information	10		Empty
ISA05	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA06	Interchange Sender ID	15	Public Office ID	For Real-time the Public Office ID which can be provided by your Customer Account Manager. For Batch – Any text is valid.
ISA07	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA08	Interchange Receiver ID	15	'REALMED'	Constant
ISA09	Interchange Date	6		YYMMDD
ISA10	Interchange Time	4		HHMM
ISA11	Replication Separator	1		'^', '*', '~', or ':'
ISA12	Interchange Control Version Number	5	'00501'	Control number which must match the value in IEA02.
ISA13	Interchange Control Number	9		Control number which must match the value in IEA02. Some payers require unique values for each transaction.
ISA14	Acknowledgement Request	1	'0' or '1'	0 – No Acknowledgement 1 – Acknowledgement requested
ISA15	Usage Indicator	1	'P' or 'T'	P – Production T – Test
ISA16	Component Element Separator	1	:	

#### Sample

ISA\*00\*\*00\*\*ZZ\*1619\*ZZ\*REALMED\*081231\*0944\*^^00501\*12345\*1\*P\*:~

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

## **GS – Functional Group Header**

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GS01	Functional Identifier Code	See List	HS – Eligibility, coverage, or benefit inquiry HB – Eligibility, coverage, or benefit information FA – Functional Acknowledgement
GS02	Application Sender's Code	Public Office ID	The Public Office ID which can be provided by your Customer Account Manager.
GS03	Application Receiver's Code	Availity RCM Tax ID	The Federal Tax Identification Number for Availity RCM which can be provided by your Customer Account Manager or constant REALMED.
GS04	Date		CCYYMMDD
GS05	Time		HHMM
GS06	Group Control Number		Control number which must match the value in GE02.
GS07	Responsible Agency Code	'X'	Accredited Standards Committee X12
GS08	Version	'005010X279A1'	5010 version identifier.

### **Sample**

GS\*HS\*1619\*REALMED\*20081231\*0944\*1234\*X\*005010X279A1~

## **ST – Transaction Set Header**

The Transaction Set Header is used to indicate the start of a transaction set and assign a control number.

Field	Field Description	Value	Comment
ST01	Transaction Set Identifier Code	'270'	Eligibility, coverage, or benefit inquiry.
ST02	Transaction Set Control Number		Control number which must match the value in SE02.
ST03	Implementation Convention Reference	'005010X279A1'	Constant

### **Sample**

ST\*270\*0001\*005010X279A1~

## **BHT – Beginning of Hierarchical Transaction**

The Beginning of Hierarchical Transaction is used to define the business hierarchical structure of the transaction set and identify the business application purpose and reference data.

Field	Field Description	Value	Comment
BHT01	Hierarchical Structure Code	'0022'	Information Source, Information Receiver, Subscriber, Dependent
BHT02	Transaction Set Purpose Code	'13'	Request
BHT03	Reference Identification		Assigned by the originator to identify the transaction within the originator's business applications system. This field is required if the transaction is processed in real time.
BHT04	Date		CCYYMMDD
BHT05	Time		HHMM

### **Sample**

BHT\*0022\*13\*12345\*20081231\*0944~

## **HL – Hierarchical Level – Information Source – Loop 2000A**

The Information Source Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the insurance company or payer.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		Not used
HL03	Hierarchical Level Code	'20'	Information Source
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*1\*\*20\*1~

## **NM1 – Information Source Name – Loop 2100A**

The Information Source Name is used to identify the eligibility or benefit information source such as insurance provider.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'PR'	Payer
NM102	Entity type Qualifier	'1' or '2'	1 – Person 2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		Empty
NM105	Middle Name		Empty
NM106	Name Prefix		Empty
NM107	Name Suffix		Empty
NM108	Identification Code Qualifier	'PI'	Payer Identification
NM109	Identification Code		Public Payer ID as defined by Availity RCM for each payer. The full list of Availity RCM public payer IDs can be provided by your Customer Account Manager.

### **Sample**

NM1\*PR\*2\*ACME INSURANCE\*\*\*\*\*PI\*00299~

## **HL – Hierarchical Level – Information Receiver – Loop 2000B**

The Information Receiver Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID	'1'	
HL03	Hierarchical Level Code	'21'	Information Receiver
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*2\*1\*21\*1~

## **NM1 – Information Receiver Name – Loop 2100B**

The Information Receiver Name is used to identify the eligibility or benefit information receiver such as provider, medical group, lab, or hospital.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	See List	1P – Provider 2B – Third-Party Administrator 80 – Hospital FA – Facility
NM102	Entity type Qualifier	See List	1 – Person 2 – Non-Person Entity
NM103	Last Name or Organization Name		This element may be required by the payer for both Person and Non-Person Entities.
NM104	First Name		This element may be required by the payer for Persons.
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	See List	FI – Federal Taxpayer ID XX – National Provider ID
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*1P\*2\*SOME BIG PRACTICE\*\*\*\*\*XX\*0123456789~

## **REF – Information Receiver Additional Information – Loop 2100B**

The optional Information Receiver Additional Information segment is used to provide identification numbers not provided on the name segment. Multiple segments are allowed as needed to describe the information receiver. Many payers do not accept the 1C, TJ, Q4, and EO REF segments and will return various errors. Availity RCM will remove these segments for all payers. To expedite processing of your request, do not include these segments.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	See List	HPI – National Provider ID Full list available in X12 specifications.
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*HPI\*0123456789~

## ***HL – Hierarchical Level – Subscriber – Loop 2000C***

The Subscriber Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID	'2'	
HL03	Hierarchical Level Code	'22'	Subscriber
HL04	Hierarchical Child Code	See List	0 – No subordinate HL data segments in the structure. 1 – Additional subordinate HL data segments in this hierarchical structure.

### **Sample**

HL\*3\*2\*22\*0~

## ***TRN – Subscriber Trace Number – Loop 2000C***

The optional Subscriber Trace Number is used to provide a trace number which can be used by the originator to uniquely identify this request. This information will be returned on the 271 response.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
TRN01	Trace Type Code	'1'	Current Transaction Trace Numbers
TRN02	Reference Identification		Trace or reference number assigned by the information receiver.
TRN03	Originating Company Identifier		Identification number of the company that assigned the trace or reference number.
TRN04	Reference Identification		Optional field allows the origination company to further identify a specific division or group within an organization.

### **Sample**

TRN\*1\*1234\*5678\*ADMISSION~

## **NM1 – Subscriber Name – Loop 2100C**

The Subscriber Name segment is used to identify the insured or subscriber.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	See List	IL – Insured or Subscriber 03 – Dependent
NM102	Entity type Qualifier	'1'	Person
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	'MI'	Member Identification Number
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*IL\*1\*LastName\*FirstName\*M\*\*\*MI\*YRP11122233~

## **REF – Subscriber Additional Information – Loop 2100C**

The optional Subscriber Additional Information segment is used to provide identification numbers not provided on the name segment. Multiple segments are allowed as needed to describe the subscriber.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	See List	18 – Plan Number IL – Group or Policy Number 1W – Member Identification Number 6P – Group Number A6 – employee Identification Number CT – Contract Number EA – medical Record ID Number EJ – Patient Account Number F6 – Health Insurance Claim Number IG – Insurance Policy Number N6 – Plan Network ID Number NQ – Medicaid Recipient ID Number SY – Social Security Number
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*SY\*333224444~

REF\*A6\*07477~

REF\*EJ\*1Z00342Q~

### **N3 – Subscriber Address – Loop 2100C**

The Subscriber Address segment is used to provide the address information for the subscriber.

Field	Field Description	Value	Comment
N301	Address Information		

#### **Sample**

N3\*101 MAIN STREET~

### **N4 – Subscriber City/State/Zip Code – Loop 2100C**

The Subscriber City/State/Zip Code segment is used to provide the city, state, and zip code information for the subscriber.

Field	Field Description	Value	Comment
N401	City Name		
N402	State or Province Code		Standard state/province codes as defined by appropriate government agency.
N403	Postal Code		Zip Code
N404	Country Code		Option code to specify the country if other than the United States.

#### **Sample**

N4\*COLUMBUS\*OH\*34567~

## **PRV – Provider Information – Loop 2100C**

The Provider Information segment is used to identify a specific provider or associate a specialty type related to a service.

Field	Field Description	Value	Comment
PRV01	Provider Code	See List	AD – Admitting AT – Attending BI – Billing CO – Consulting CV – Covering H – Hospital HH – Home Health Care LA – Laboratory P1 – Pharmacist P2 – Pharmacy PC – Primary Care Physician PE – Performing R – Rural Health Clinic RF – Referring SB – Submitting SK – Skilled Nursing Facility
PRV02	Reference Identification Qualifier	See List	9K – Servicer D3 – Boards of Pharmacy Number EI – Employer's ID Number HPI – National Provider ID Number SY – Social Security Number TJ – Federal Taxpayer ID Number
PRV03	Reference Identification		ID Number defined in PRV02.

### **Sample**

PRV\*RF\*HPI\*0123456789~

## **DMG – Subscriber Demographic Information – Loop 2100C**

The Subscriber Demographic Information segment is used to provide birth date and gender information for the subscriber.

Field	Field Description	Value	Comment
DMG01	Date Time Period Qualifier	'D8'	CCYYMMDD
DMG02	Date Time Period		Subscriber Birth Date
DMG03	Gender Code	See List	F – Female M – Male

### **Sample**

DMG\*D8\*19050101\*F~

## **INS – Insured Benefit – Loop 2100C**

The optional Insured Benefit segment is used to uniquely identify the birth sequence of the subscriber in the case of multiple births with the same birth date.

Field	Field Description	Value	Comment
INS01	Insured Indicator	'Y'	Yes
INS02	Individual Relationship Code	'18'	Self
INS03 – INS16			Not Used
INS17	Birth Sequence Number		Number assigned to each family member born with the same date.

### **Sample**

INS\*Y\*18\*\*\*\*\*1~

## **DTP – Subscriber Date – Loop 2100C**

The Subscriber Date segment is used to provide the eligibility, service, or admission date(s). Absence of the subscriber date implies the request is for the date the transaction is processed.

Field	Field Description	Value	Comment
DPT01	Date/Time Qualifier	See List	291 – Plan
DPT02	Date Time Period Qualifier	'D8'	CCYYMMDD
DPT03	Date Time Period		Date as qualified by DPT01 and DPT02.

### **Sample**

DTP\*472\*D8\*20081231~

## ***EQ – Subscriber Eligibility or Benefit Inquiry – Loop 2110C***

The Subscriber Eligibility or Benefit Inquiry segment is used to identify the type of eligibility or benefit inquiry requested.

Field	Field Description	Value	Comment
EQ01	Service Type Code	See List	30 – Health Benefit Plan Coverage Full list available in X12 specifications.  Note - Only one STC will be transmitted to payers. For batch processing this is the first STC in alphanumeric sequence, for RTE it is the first STC in the transaction.
EQ02	Medical Procedure		Optional - Composite Field
EQ02-1	Product/Service ID Qualifier	See List	CJ – CPT Codes HC – HCPCS
EQ02-2	Product/Service ID		ID Number defined in EQ02-1.

### **Sample**

EQ\*30~

## ***HL – Hierarchical Level – Dependent – Loop 2000D***

The Dependent Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		The hierarchical ID number for the subscriber of this dependent.
HL03	Hierarchical Level Code	'23'	Dependent
HL04	Hierarchical Child Code	'0'	No subordinate HL data segments in the structure.

### **Sample**

HL\*4\*3\*23\*0~

The Dependent loop may contain TRN, NM1, REF, N3, N4, PRV, DMG, INS, DTP, and EQ segments as defined under the subscriber loop.

## ***SE – Transaction Set Trailer***

The Transaction Set Trailer is used to indicate the end of a transaction set and provide a count of the segments transmitted including the header and trailer.

Field	Field Description	Value	Comment
SE01	Number of included Segments		The number of segments included in the transaction set including the ST and SE segments.
SE02	Transaction Set Control Number		Control number which must match the value in ST02.

### **Sample**

SE\*999\*0001~

## ***GE – Functional Group Trailer***

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GE01	Number of transaction sets included		Count of the number of transaction sets included in the functional group.
GE02	Group control number		Control number which must match the value in GS06.

### **Sample**

GE\*1\*1234~

## IEA – Interchange Control Trailer

The Interchange Control Trailer is used to identify the end of one or more functional groups and interchange-related control segments.

Field	Field Description	Value	Comment
IEA01	Number of included Functional Groups		Count of the number of functional groups within this interchange.
IEA02	Interchange Control Number		Control number which must match the value in ISA13.

### Sample

IEA\*1\*12345~

### Sample

```
ISA*00*          *00*          *ZZ*12345          *ZZ*REALMED
*120306*0626*^*00501*000001578*0*P*:~
GS*HS*12345*REALMED*20120306*0626*1578*X*005010X279A1~
ST*270*1578*005010X279A1~
BHT*0022*13*12345*20081231*0944~
HL*1**20*1~
NM1*PR*2*ACME INSURANCE*****PI*00299~
HL*2*1*21*1~
NM1*1P*2*SOME BIG PRACTICE*****XX*0123456789~
HL*3*2*22*0~
NM1*IL*1*LastName*FirstName****MI*123549474A~
DMG*D8*19360729~
DTP*291*D8*20120306~
EQ*30~
SE*12*1578~
GE*1*1578~
IEA*1*000001578~
```

## 271 Eligibility Response

### Loop Structure

Loop	Segment	Name	Usage	Repeat	Loop Repeat
	ISA	Interchange Control Header	R	1	
	GS	Functional Group Header	R	1	>1
	ST	Transaction Set Header	R	1	
	BHT	Beginning of Hierarchical Transaction	R	1	
2000A	HL – 20	Information Source Level	R	1	>1
	AAA	Request Validation	S	9	
2100A	NM1	Information Source Name	R	1	
	AAA	Request Validation	S	9	
2000B	HL – 21	Information Receiver Level	R	1	>1
2100B	NM1	Information Receiver Name	R	1	
	REF	Information Receiver Additional Information	S	9	
	AAA	Information Receiver Request Validation	S	9	
2000C	HL – 22	Information Subscriber Level	R	1	>1
	TRN	Subscriber Trace Number	S	2	
2100C	NM1	Subscriber Name	R	1	
	REF	Subscriber Additional Information	S	9	
	N3	Subscriber Address	S	1	
	N4	Subscriber City/State/Zip	S	1	
	AAA	Subscriber Request Validation	S	9	
	DMG	Subscriber Demographics Information	S	1	
	INS	Subscriber Relationship	S	1	
	DTP	Subscriber Date	S	2	
2110C	EB	Subscriber Eligibility or Benefit Information	S	1	>1
	HSD	Health Care Services Delivery	S	9	
	AAA	Subscriber Request Validation	S	9	
	MSG	Message Text	S	10	
	LS	Loop Header	S	1	
2120C	NM1	Subscriber Benefit Name	R	1	
	N3	Subscriber Benefit Address	S	1	
	N4	Subscriber Benefit City/State/Zip	S	1	
	PRV	Subscriber Benefit Provider Information	S	1	
	LE	Loop Trailer	S	1	
2000D	HL - 23	Information Dependent Level	S	1	>1
	TRN	Dependent Trace Number	S	3	
2100D	NM1	Dependent Name	R	1	
	REF	Dependent Additional Information	S	9	
	N3	Dependent Address	S	1	
	N4	Dependent City/State/Zip	S	1	
	AAA	Dependent Request Validation	S	9	
	DMG	Dependent Demographics Information	S	1	

	INS	Dependent Relationship	S	1	
	DTP	Dependent Date	S	2	
2110D	EB	Dependent Eligibility or Benefit Information	S	1	>1
	HSD	Health Care Services Delivery	S	9	
	AAA	Subscriber Request Validation	S	9	
	MSG	Message Text	S	10	
	LS	Loop Header	S	1	
2120D	NM1	Subscriber Benefit Name	R	1	
	N3	Subscriber Benefit Address	S	1	
	N4	Subscriber Benefit City/State/Zip	S	1	
	PRV	Subscriber Benefit Provider Information	S	1	
	LE	Loop Trailer	S	1	
	SE	Transaction Set Trailer	R	1	
	GE	Functional Group Trailer	R	1	
	IEA	Interchange Control Trailer	R	1	

## Segment Definitions

### ***ISA, GS, ST, SE, GE, IEA – Control Headers and Trailers***

See the 270 definition for the ISA, GS, ST, SE, GE, IEA control header and trailer definitions.

#### ***BHT – Beginning of Hierarchical Transaction***

The Beginning of Hierarchical Transaction is used to define the business hierarchical structure of the transaction set and identify the business application purpose and reference data.

Field	Field Description	Value	Comment
BHT01	Hierarchical Structure Code	'0022'	Information Source, Information Receiver, Subscriber, Dependent
BHT02	Transaction Set Purpose Code	'11'	Response
BHT03	Reference Identification		Assigned by the originator to identify the transaction within the originator's business applications system. This field is required if the transaction is processed in real time.
BHT04	Date		CCYYMMDD
BHT05	Time		HHMM

#### **Sample**

BHT\*0022\*11\*12345\*20081231\*0944~

## **AAA – Request Validation – Loop 2000A**

The Request Validation segment is used when a request could not be processed and to indicate what action the originator should take. A request validation segment may appear within any HL loops and will contain error information specific to that loop.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
AAA01	Valid Request Indicator	See List	N – Request is not valid. Y – Request is valid but the transaction has been rejected. See AAA03 for more details.
AAA02	Agency Qualifier Code		Not Used
AAA03	Reject Reason Code	See List	04 – Authorization Quantity Exceeded 15 – Required application data missing 41 – Authorization/Access Restrictions 42 – Unable to respond at current time 43 – Invalid/Missing provider ID 44 – Invalid/Missing provider name 45 – Invalid/Missing provider specialty 46 – Invalid/Missing provider phone 47 – Invalid/Missing provider state 48 – Invalid/Missing referring provider ID Number 49 – Provider is not primary care physician 50 – Provider ineligible for inquiries 51 – Provider not on file 52 – Service date not within provider plan enrollment 53 – Inquired benefit inconsistent with provider type 54 – Inappropriate product/service ID qualifier 55 – Inappropriate product/service ID 56 – Inappropriate date 57 – Invalid/Missing date of service 58 – Invalid/Missing date-of-birth 60 – date of birth follows date of service 61 – Date of death precedes date of service 62 – Date of service not within allowable inquiry period 63 – Date of service in future 64 – Invalid/Missing patient ID 65 – Invalid/Missing patient name 66 – Invalid/Missing patient gender 67 – Patient not found 68 – Duplicate patient ID number 69 – Inconsistent with patient's age

			70 – Inconsistent with patient's gender 71 – Patient birth date does not match date on database 72 – Invalid/Missing subscriber ID 73 – Invalid/Missing subscriber Name 74 – Invalid/Missing subscriber gender 75 – Subscriber not found 76 – Duplicate subscriber ID number 77 – Subscriber found, Patient not found 78 – Subscriber not in group/plan 79 – Invalid participant identification 80 – No response received from Payer 97 – Invalid/Missing provider address T4 – Payer name or identifier missing
AAA04	Follow-up Action Code	See List	C – Correct and resubmit N – Submission not allowed P – Resubmit original transaction R – Resubmission allowed S – Do not resubmit – Sent to 3rd party W – Wait 30 days and resubmit X – Wait 10 days and resubmit Y – Do not resubmit – We will hold your request and respond again shortly.

### Sample

AAA\*Y\*79\*C~

## ***HL – Hierarchical Level – Information Source – Loop 2100A***

The Information Source Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the insurance company or payer.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		Not used
HL03	Hierarchical Level Code	'20'	Information Source
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*1\*\*20\*1~

## ***NM1 – Information Source Name – Loop 2100A***

The Information Source Name is used to identify the eligibility or benefit information source such as insurance provider.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'PR'	Payer
NM102	Entity type Qualifier	'1' or '2'	1 – Person 2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		Empty
NM105	Middle Name		Empty
NM106	Name Prefix		Empty
NM107	Name Suffix		Empty
NM108	Identification Code Qualifier	'PI'	Payer Identification
NM109	Identification Code		Public Payer ID as defined by Availity RCM for each payer. The full list of Availity RCM public payer IDs can be provided by your Customer Account Manager.

### **Sample**

NM1\*PR\*2\*ACME INSURANCE\*\*\*\*\*PI\*00299~

## **HL – Hierarchical Level – Information Receiver – Loop 2000B**

The Information Receiver Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID	'1'	
HL03	Hierarchical Level Code	'21'	Information Receiver
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*2\*1\*21\*1~

## **NM1 – Information Receiver Name – Loop 2100B**

The Information Receiver Name is used to identify the eligibility or benefit information receiver such as provider, medical group, lab, or hospital.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	See List	1P – Provider 2B – Third-Party Administrator 80 – Hospital FA – Facility
NM102	Entity type Qualifier	See List	1 – Person 2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	See List	FI – Federal Taxpayer ID XX – National Provider ID
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*1P\*2\*SOME BIG PRACTICE\*\*\*\*\*XX\*0123456789~

## **REF – Information Receiver Additional Information – Loop 2100B**

The optional Information Receiver Additional Information segment is used to provide identification numbers not provided on the name segment. Multiple segments are allowed as needed to describe the information receiver.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	See List	HPI – National Provider ID TJ – Federal Taxpayer ID Q4 – Prior Identification Number Full list available in X12 specifications.
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*TJ\*0123456789~

## **HL – Hierarchical Level – Subscriber – Loop 2000C**

The Subscriber Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID	'2'	
HL03	Hierarchical Level Code	'22'	Subscriber
HL04	Hierarchical Child Code	See List	0 – No subordinate HL data segments in the structure. 1 – Additional subordinate HL data segments in this hierarchical structure.

### **Sample**

HL\*3\*2\*22\*0~

## **TRN – Subscriber Trace Number – Loop 2000C**

The optional Subscriber Trace Number is used to provide a trace number which can be used by the originator to uniquely identify this request. This information will be returned on the 271 response.

Field	Field Description	Value	Comment
TRN01	Trace Type Code	'1'	Current Transaction Trace Numbers
TRN02	Reference Identification		Trace or reference number assigned by the information receiver.
TRN03	Originating Company Identifier		Identification number of the company that assigned the trace or reference number.
TRN04	Reference Identification		Optional field allows the origination company to further identify a specific division or group within an organization.

### **Sample**

TRN\*1\*1234\*5678\*ADMISSION~

## **NM1 – Subscriber Name – Loop 2100C**

The Subscriber Name segment is used to identify the insured or subscriber.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'IL'	Insured or Subscriber
NM102	Entity type Qualifier	'1'	Person
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	'MI'	Member Identification Number
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*IL\*1\*LastName\*FirstName\*M\*\*\*MI\*YRP11122233~

## **REF – Subscriber Additional Information – Loop 2100C**

The optional Subscriber Additional Information segment is used to provide identification numbers not provided on the name segment. Multiple segments are allowed as needed to describe the subscriber.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	See List	18 – Plan Number IL – Group or Policy Number 1W – Member Identification Number 49 – Family Unit Number 6P – Group Number 9F – Referral Number A6 – employee Identification Number CT – Contract Number EA – medical Record ID Number EJ – Patient Account Number F6 – Health Insurance Claim Number G1 – Prior Authorization Number IG – Insurance Policy Number N6 – Plan Network ID Number NQ – Medicaid Recipient ID Number SY – Social Security Number
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*SY\*333224444~  
REF\*A6\*07477~  
REF\*EJ\*1Z00342Q~

## **N3 – Subscriber Address – Loop 2100C**

The Subscriber Address segment is used to provide the address information for the subscriber.

Field	Field Description	Value	Comment
N301	Address Information		

### **Sample**

N3\*101 MAIN STREET~

## **N4 – Subscriber City/State/Zip Code – Loop 2100C**

The Subscriber City/State/Zip Code segment is used to provide the city, state, and zip code information for the subscriber.

Field	Field Description	Value	Comment
N401	City Name		
N402	State or Province Code		Standard state/province codes as defined by appropriate government agency.
N403	Postal Code		Zip Code
N404	Country Code		Option code to specify the country if other than the United States.

### **Sample**

N4\*COLUMBUS\*OH\*34567~

## **DMG – Subscriber Demographic Information – Loop 2100C**

The Subscriber Demographic Information segment is used to provide birth date and gender information for the subscriber.

Field	Field Description	Value	Comment
DMG01	Date Time Period Qualifier	'D8'	CCYYMMDD
DMG02	Date Time Period		Subscriber Birth Date
DMG03	Gender Code	See List	F - Female M – Male

### **Sample**

DMG\*D8\*19050101\*F~

## ***INS – Insured Benefit – Loop 2100C***

The optional Insured Benefit segment is used to uniquely identify the birth sequence of the subscriber in the case of multiple births with the same birth date.

Field	Field Description	Value	Comment
INS01	Insured Indicator	'Y'	Yes
INS02	Individual Relationship Code	'18'	Self
INS03 – INS16			Not Used
INS17	Birth Sequence Number		Number assigned to each family member born with the same date.

### **Sample**

INS\*Y\*18\*\*\*\*\*1~

## ***DTP – Subscriber Date – Loop 2100C***

The Subscriber Date segment is used to provide the eligibility, service, or admission date(s). Absence of the subscriber date implies the request is for the date the transaction is processed.

Field	Field Description	Value	Comment
DPT01	Date/Time Qualifier	See List	102 – Issue 307 – Eligibility 346 – Plan Begin 347 – Plan End 356 – Eligibility Begin 357 – Eligibility End 435 – Admission 472 – Service 539 – Policy Effective 540 – Policy Expiration Full list available in X12 specifications.
DPT02	Date Time Period Qualifier	'D8'	CCYYMMDD
DPT03	Date Time Period		Date as qualified by DPT01 and DPT02.

### **Sample**

DTP\*540\*D8\*20081231~

## **EB – Subscriber Eligibility or Benefit Information – Loop 2110C**

The Subscriber Eligibility or Benefit Information segment is used to provide the eligibility or benefit information for the subscriber.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
EB01	Eligibility or Benefit Information	See List	1 – Active Coverage 6 - Inactive Full list available in X12 specifications.
EB02	Coverage Level Code	See List	CHD – Children only DEP – Dependents only ECH – Employee and children EMP – Employee only ESP – Employee and spouse FAM – Family IND – Individual SPC – Spouse and children SPO – Spouse only
EB03	Service Type Code	See List	30 – Health benefit plan coverage Full list available in X12 specifications.
EB04	Insurance Type Code		Full list available in X12 specifications.
EB05	Plan Coverage Description		Description of coverage
EB06	Time Period Qualifier		Full list available in X12 specifications.
EB07	Monetary Amount		Benefit amount
EB08	Percent		Benefit percent
EB09	Quantity Qualifier		Full list available in X12 specifications.
EB10	Quantity		Benefit quantity
EB11	Authorization or Certification Indicator	See List	N – No Y – Yes U – Unknown
EB12	In Plan Network Indicator	See List	N – No Y – Yes U – Unknown
EB13	Composite Medical Procedure Identifier		See full description in X12 specifications

### **Sample**

EB*1*FAM*96*GP~	←Active family group coverage
EB*B**98***27*10**VS*1~	←\$10 per visit co-pay
EB*C*IND****23*200~	←\$200 per year individual deductible

## **HSD – Health Care Services Delivery – Loop 2110C**

The Health Care Services Delivery segment is used to provide information when benefits have a specific delivery or usage pattern.

Field	Field Description	Value	Comment
HSD01	Quantity Code	See List	DY – Days FL – Units HS – Hours MN – Months VS – Visits
HSD02	Quantity		Benefit Quantity
HSD03	Unit or Basis for Measurement code	See List	DA – Days MO – Months VS – Visits WK – Week YR – Year
HSD04	Sample Selection Modulus		
HSD05	Time Period Qualifier	See List	6 – Hour 7 – Day 21 – Year 27 – Visit 31 – Not Exceed 32 – Lifetime 34 – Month 35 – Week Full list available in X12 specifications.
HSD06	Number of Periods		
HSD07	Delivery Frequency Code		Full list available in X12 specifications.
HSD08	Delivery Pattern Time Code		Full list available in X12 specifications.

### **Sample**

HSD\*VS\*12\*WK\*3\*34\*1~

←Twelve visits, three per week, for 1 month

## **MSG – Message Text – Loop 2110C**

The Message Text segment is used to provide free form text information that does not fit into existing data elements. Use of free form message text is discouraged.

Field	Field Description	Value	Comment
MSG01	Free-Form Message Text		

### **Sample**

MSG\*FREE FORM TEXT HERE~

## **LS – Loop Header & LE Loop Trailer – Loop 2120C**

The Loop Header along with the Loop Trailer segments are used differentiate the name and address segments for a subscriber benefit entity from the actual subscriber. The LS/LE loop may contain NM1, N3, N4, PER, and PRV segments.

Field	Field Description	Value	Comment
LS01	Loop Identifier Code	'2120'	

### **Sample**

LS\*2120~

Field	Field Description	Value	Comment
LE01	Loop Identifier Code	'2120'	

### **Sample**

LE\*2120~

## ***HL – Hierarchical Level – Dependent – Loop 2000D***

The Dependent Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		The hierarchical ID number for the subscriber of this dependent.
HL03	Hierarchical Level Code	'23'	Dependent
HL04	Hierarchical Child Code	'0'	No subordinate HL data segments in the structure.

### **Sample**

HL\*4\*3\*23\*0~

The Dependent loop may contain TRN, NM1, REF, N3, N4, AAA, PRV, DMG, INS, DTP, EB, HSD, and MSG segments as well as a LS/LE loops as defined under the subscriber loop.

## Sample

ISA\*00\* \*00\* \*ZZ\*REALMED \*ZZ\*12345 ⚡  
\*120614\*0949\*^^\*00501\*000000001\*0\*P\*:~  
GS\*HB\*98765\*REALMEDX12\*20120614\*09492854\*1\*X\*005010X279A1~  
ST\*271\*0001\*005010X279A1~  
BHT\*0022\*11\*12345\*20120614\*1050~  
HL\*1\*\*20\*1~  
NM1\*PR\*2\*UNITEDHEALTHCARE\*\*\*\*\*PI\*87726~  
PER\*IC\*\*UR\*WWW.UNITEDHEALTHCAREONLINE.COM~  
HL\*2\*1\*21\*1~  
NM1\*1P\*2\*REALMED\*\*\*\*\*FI\*1122091331~  
HL\*3\*2\*22\*1~  
NM1\*IL\*1\*LASTNAME\*FIRSTNAME\*M\*\*\*MI\*123456789~  
REF\*6P\*123456~  
N3\*100 MAIN STREET~  
N4\*CARMEL\*IN\*46033~  
DMG\*D8\*19540619\*M~  
HL\*4\*3\*23\*0~  
TRN\*2\*TT5412140\*1352091331~  
NM1\*03\*1\*LASTNAME\*FIRSTNAME\*M~  
DMG\*D8\*19580502\*F~  
INS\*N\*01~  
DTP\*346\*D8\*20110301~  
EB\*1\*\*30\*C1\*CHOICE PLUS~  
LS\*2120~  
NM1\*PR\*2\*UNITEDHEALTHCARE\*\*\*\*\*PI\*87726~  
N3\*P.O. BOX 30555~  
N4\*SALT LAKE CITY\*UT\*841300555~  
PER\*IC\*\*UR\*WWW.UNITEDHEALTHCAREONLINE.COM~  
LE\*2120~  
EB\*C\*IND\*30\*\*\*23\*0.0\*\*\*\*\*W~  
MSG\*ADDITIONAL COVERED PER OCCURRENCE~  
EB\*U\*\*88~  
LS\*2120~  
NM1\*VN\*2\*MEDCO~  
LE\*2120~  
EB\*X~  
LS\*2120~  
NM1\*1P\*2\*REALMED~  
LE\*2120~  
SE\*37\*0001~  
GE\*1\*1~  
IEA\*1\*000000001~

## 997 Functional Acknowledgment (4010 Batch Only)

### Loop Structure

Segment	Name	Usage	Repeat	Loop Repeat
ISA	Interchange Control Header	R	1	
GS	Functional Group Header	R	1	>1
ST	Transaction Set Header	R	1	
AK1	Functional Group Response Header	M	1	
AK2	Transaction Set Response Header	O	1	99999
AK3	Data Segment Note	O	1	
AK4	Data Element Note	O	99	
AK5	Transaction Set Response Trailer	M	1	
AK9	Functional Group Response Trailer	M	1	
SE	Transaction Set Trailer	R	1	
GE	Functional Group Trailer	R	1	
IEA	Interchange Control Trailer	R	1	

## Segment Definitions

### ***ISA, GS, ST, SE, GE, IEA – Control Headers and Trailers***

See the 270 definition for the ISA, GS, ST, SE, GE, IEA control header and trailer definitions.

#### ***AK1 – Functional Group Response Header***

The Functional Group Response Header is used to identify the start of a functional group.

Field	Field Description	Value	Comment
AK101	Functional ID Code	See List	HB – Benefit Information (271) HS – Benefit Inquiry (270)
AK102	Group Control Number		This is the functional group control number found in the GS segment of the functional group being acknowledged, IE the 270 request.

#### **Sample**

AK1\*HS\*1234~

#### ***AK2 – Transaction Set Response Header***

The Transaction Set Response Header is used to identify the start of a transaction set.

Field	Field Description	Value	Comment
AK201	Transaction Set ID	See List	270 – Benefit Inquiry 271 – Benefit Information
AK202	Transaction Set Control Number		This is the transaction set control number found in the ST segment of the transaction set being acknowledged, IE the 270 request.

#### **Sample**

AK2\*270\*00001~

## **AK3 – Data Segment Note**

The Data Segment Note is used to identify the errors in the data segment and identify the location of the data segment.

Field	Field Description	Value	Comment
AK301	Segment ID Code		2 or 3 character identifier for the segment.
AK302	Segment Position in the Transaction Set		The numerical position within the data element within the segment.
AK303	Loop Identifier code		The loop ID number on the transaction set for this data element in segments LS and LE.
AK304	Segment Syntax Error Code	See List	1 – Unrecognized Segment ID 2 – Unexpected segment 3 – Mandatory segment missing 4 – Loop occurs over max times 5 – Segments exceed max times 6 – Segment not in transaction set 7 – Segment not in proper sequence 8 – Segment has data element errors

### **Sample**

AK3\*TRN\*12\*2000C\*8~

## **AK4 – Data Element Note**

The Data Element Note is used to identify errors in data elements within a segment.

Field	Field Description	Value	Comment
AK401	Position in Segment		Relative position of the data element within the segment.
AK402	Data Element Reference Number		The Data Element ID for the element in error. The Data Element ID will identify the element in the X12 specifications.
AK403	Data Element Syntax Error Code	See List	1 – Mandatory data element missing 2 – Conditional required data element missing 3 – Too many data elements 4 – Data element too short 5 – Data element too long 6 – Invalid character in data element 7 – Invalid code value 8 – Invalid date 9 – Invalid time 10 – Exclusion condition violated
AK404	Copy of Bad Data Element		A copy of the data element in error.

### **Sample**

AK4\*3\*509\*4\*2568745~

## **AK5 – Transaction Set Response Trailer**

The Transaction Set Response Trailer is used to identify the end of a transaction set.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
AK501	Transaction Set Acknowledgment Code	See List	A – Accepted E – Accepted but errors were noted M – Rejected, Message Authentication Code failed R – Rejected W – Rejected, Assurance failed validity test X – Rejected, content after decryption could not be Analyzed
AK502	Transaction Set Syntax Error Code	See List	1 – Transaction set not supported 2 – Transaction set trailer missing 3 – Transaction set control numbers do not match 4 – Number of included segments does not match actual count 5 – One or more segments in error 6 – Missing or invalid transaction set identifier 7 – Missing or invalid transaction set control number 8 – Authentication key name unknown 9 – Encryption key name unknown 10 – Requested service unavailable 11 – Unknown security recipient 12 – Incorrect message length 13 – Message authentication code failed 15 – Unknown security originator 16 – Syntax error in decrypted text 17 – Security not supported 23 – Transaction set control number not unique

### **Sample**

AK5\*R~

## AK9 – Functional Group Response Trailer

The Functional Group Response Trailer is used to identify the end of a functional group.

Field	Field Description	Value	Comment
AK901	Functional Group Acknowledge Code	See List	A – Accepted E – Accepted but errors were noted M – Rejected, Message Authentication Code failed P – Partially Accepted, At least one transaction set was rejected R – Rejected W – Rejected, Assurance failed validity test X – Rejected, content after decryption could not be Analyzed
AK902	Number of Transaction Sets Included		Total number of transaction sets within the functional group found in the GE01 segment of the original request.
AK903	Number of Received Sets		The total number of transaction sets received.
AK904	Number of Accepted Transaction Sets		The total number of transaction sets accepted.
AK905	Transaction Set Syntax Error Code	See List	1 – Functional group not supported 2 – Functional group version not supported 3 – Functional group trailer missing 4 – Group control numbers do not match 5 – Number of included transactions does not match actual count 6 – Group control number violates syntax 10 – Authentication key name unknown 11 – Encryption key name unknown 12 – Requested service unavailable 13 – Unknown security recipient 14 – Unknown security originator 15 – Syntax error in decrypted text 16 – Security not supported 17 – Incorrect message length 18 – Message authentication code failed

### Sample

AK9\*R\*1\*1\*0~

## Sample

```
ISA*00***00**ZZ*12345*30*0123456789*081231*0944*U*00401*12345*0*p*:~  
GS*FA*12345*0123465789*20081231*0944*1234*X*004010X092A1~  
ST*997*0001~  
AK1*HS*7~  
AK2*270*0007~  
AK5*A~  
AK9*A*1*1*1~  
SE*6*0001~  
GE*1*1234~  
IEA*1*12345~
```

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

## TA1 Interchange Acknowledgment (4010)

### Loop Structure

Segment	Name	Usage	Repeat	Loop Repeat
TA1	Interchange Acknowledgment	R	1	

## Segment Definitions

### ISA, IEA – Control Headers and Trailers

See the 270 definition for the ISA, GS, ST, SE, GE, IEA control header and trailer definitions. Only the ISA and IEA segments are required for the Interchange Acknowledgement.

### TA1 – Interchange Acknowledgment

The Interchange Acknowledgment is used to report the status of processing for a received interchange header/trailer or non-delivery by a network provider.

Field	Field Description	Value	Comment
TA101	Interchange Control Number		A control number assigned by the interchange sender.
TA102	Interchange Date		YYMMDD
TA103	Interchange Time		HHMM
TA104	Interchange Acknowledgment Code	See List	A – Accepted with no errors E – Accepted with errors R – Rejected because of errors
TA105	Interchange Note Code	See List	000 – No error 001 – Header/Trailer control number does not match 003 – This version of the controls is not supported 004 – The segment terminator is invalid 005 – Invalid Interchange ID Qualifier for Sender 006 – Invalid Interchange Sender ID 007 – Invalid Interchange ID Qualifier for Receiver 008 – Invalid Interchange Receiver ID 017 – Invalid interchange version ID 018 – Invalid interchange control Number 020 – Invalid Test indicator value 021 – Invalid number of included groups 022 – Invalid control structure 023 – Improper End-of-file 025 – Duplicate interchange control number 026 – Invalid data element separator Full list available in X12 specifications.

#### Sample

TA1\*000000000\*081231\*0750\*R\*022~



# Appendix B – 277U Quick Start Guide (5010)

## Overview

### Purpose

The Availity RCM 277U Quick Start Guide is intended to provide a basic understanding of how to parse and map a 277U status response. This guide is not intended to define every detail of the 277U transaction, only the basics. Full ANSI standards of the 277U transaction can be obtained from [www.wpc-edi.com](http://www.wpc-edi.com). These standards provide detailed information on the format and structure of the response used in HIPAA 277U transactions.

This guide is specific to the interpretation and implementation used by Availity RCM. Payers, providers, and software vendors may have custom usage of these transactions that are specific to their business practices.

### Usage

The 277U transaction is used to provide unsolicited status updates to existing claims transactions. The 277U transaction will be transmitted to the practice using the established EDI data transmission method.

### Version

This document is intended for use with version 5010 of the X12 standard.

## Conventions

### Format

277U request and responses are composed of a series of text based segments nested within loops to form a complete transaction set. Each segment begins with a two or three character identifier which describes the segment and contains one or more additional fields separated by an asterisk. Each segment must end with a delimiter, typically the tilde ~.

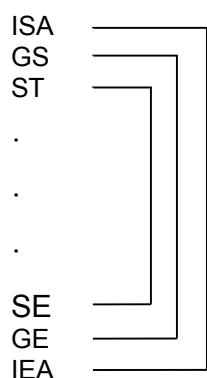
BHT\*0022\*13\*7099\*20081028\*1421~

### Structure

Each transmission must contain a single transmission control beginning with an ISA, Interchange Control Header, and end with an IEA, Interchange Control Trailer.

Within the transmission control must be one or more functional groups which begin with a GS, Functional Group Header, and end with a GE, Functional Group Trailer.

Each functional group must contain one or more transaction sets which begin with a ST, Transaction Set Header, and end with a SE, Transaction Set Trailer. Within the transaction set are the detail segments for the eligibility request or response.



# 277U Health Care Information Status Notification

## Loop Structure

Loop	Segment	Name	Usage	Repeat	Loop Repeat
	ISA	Interchange Control Header	R	1	
	GS	Functional Group Header	R	1	>1
	ST	Transaction Set Header	R	1	
	BHT	Beginning of Hierarchical Transaction	R	1	
2000A	HL – 20	Information Source Level	R	1	>1
2100A	NM1	Information Source Name	R	1	
2200A	TRN	Transmission Receipt Control Identifier	R	1	
	DTP	Information Source Receipt Date	R	1	
	DTP	Information Source Process Date	R	1	
2000B	HL – 21	Information Receiver Level	R	1	>1
2100B	NM1	Information Receiver Name	R	1	
2200B	TRN	Information Receiver Application Trace	R	1	
	STC	Information Receiver Status Information	S	1	
2000C	HL – 19	Billing Provider of Service Level	S	1	>1
2100C	NM1	Billing Provider Name	R	1	
2200C	TRN	Provider of Service Information Trace	S	1	
	STC	Billing Provider Status Information	S	1	
2000D	HL – PT	Patient Level	S	1	>1
2100D	NM1	Patient Name	R	1	
2200D	TRN	Claim Status Tracking Number	R	1	
	STC	Claim Level Status Information	R	1	
	REF	Payer Claim Control Number	S	1	
	REF	Clearinghouse Claim Identifier	R	1	
	REF	Institutional Bill Type Identifier	S	1	
	DTP	Claim Level Service Date	R	1	
2220D	SVC	Service Line Information	O	1	
	STC	Service Line Status Information	O	>1	
	REF	Service Line Item Identification	O	1	
	SE	Transaction Set Trailer	R	1	
	GE	Functional Group Trailer	R	1	
	IEA	Interchange Control Trailer	R	1	

## Segment Definitions

### ISA – Interchange Control Header

The Interchange Control Header is used to identify one or more functional groups and interchange-related control segments.

Field	Field Description	Size	Value	Comment
ISA01	Author Info Qualifier	2	'00'	No authorization information present.
ISA02	Author Information	10		Empty
ISA03	Security Information Qualifier	2	'00'	No security information present.
ISA04	Security Information	10		Empty
ISA05	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA06	Interchange Sender ID	15	'RMGATE WAY'	
ISA07	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA08	Interchange Receiver ID	15		Provider
ISA09	Interchange Date	6		YYMMDD
ISA10	Interchange Time	4		HHMM
ISA11	Replication Separator	1		'^', '*', '~', or ':'
ISA12	Interchange Control Version Number	5	'00501'	Control number which must match the value in IEA02.
ISA13	Interchange Control Number	9		Control number which must match the value in IEA02.
ISA14	Acknowledgement Request	1	'0' or '1'	0 – No Acknowledgement 1 – Acknowledgement requested
ISA15	Usage Indicator	1	'P' or 'T'	P – Production T – Test
ISA16	Component Element Separator	1	:	

#### Sample

ISA\*00\*\*00\*\*ZZ\*RMGATEWAY\*ZZ\*TEST\*100312\*1347\*^\*00501\*00000001\*0\*P\*:~

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

## **GS – Functional Group Header**

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GS01	Functional Identifier Code	See List	HN – Health Care Information Status Notification.
GS02	Application Sender's Code		
GS03	Application Receiver's Code		
GS04	Date		CCYYMMDD
GS05	Time		HHMM
GS06	Group Control Number		Control number which must match the value in GE02.
GS07	Responsible Agency Code	'X'	Accredited Standards Committee X12
GS08	Version	'005010X214'	5010 version identifier.

### **Sample**

GS\*HN\*RMGATEWAY\*TEST\*20100312\*1347\*1\*X\*005010X214~

## **ST – Transaction Set Header**

The Transaction Set Header is used to indicate the start of a transaction set and assign a control number.

Field	Field Description	Value	Comment
ST01	Transaction Set Identifier Code	'277'	Health Care Information Status Notification
ST02	Transaction Set Control Number		Control number which must match the value in SE02.
ST03	Implementation Convention Reference	'005010X214'	5010 version identifier.

### **Sample**

ST\*277\*0001\*005010X214~

## **BHT – Beginning of Hierarchical Transaction**

The Beginning of Hierarchical Transaction is used to define the business hierarchical structure of the transaction set and identify the business application purpose and reference data.

Field	Field Description	Value	Comment
BHT01	Hierarchical Structure Code	'0085'	Information Source, Information Receiver, Provider of Service, Patient
BHT02	Transaction Set Purpose Code	'08'	Status
BHT03	Reference Identification		Assigned by the originator to identify the transaction within the originator's business applications system. This field is required if the transaction is processed in real time.
BHT04	Date		CCYYMMDD
BHT05	Time		HHMM
BHT06	Transaction Type Code	'TH'	TH – Receipt Acknowledgment Advice

### **Sample**

BHT\*0085\*08\*12345\*20081231\*0944\*TH~

## **HL – Hierarchical Level – Information Source – Loop 2000A**

The Information Source Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the insurance company or payer.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		Not used
HL03	Hierarchical Level Code	'20'	Information Source
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*1\*\*20\*1~

## **NM1 – Information Source Name – Loop 2100A**

The Information Source Name is used to identify the eligibility or benefit information source such as insurance provider.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'AY' or 'PR'	AY – Clearinghouse – If the status is derived from Availity RCM. PR – Payer – If the status response is derived from the Payer.
NM102	Entity type Qualifier	'2'	2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		Empty
NM105	Middle Name		Empty
NM106	Name Prefix		Empty
NM107	Name Suffix		Empty
NM108	Identification Code Qualifier	'FI' or 'PI'	FI – Federal Taxpayer ID PI – Payer ID
NM109	Identification Code		If the status is derived from Availity RCM, FI is used in NM108 and Availity RCM's Tax ID in NM109. If the status is derived from the payer, PI is used in NM108 and the payers ID in NM109.

### **Sample**

NM1\*PR\*2\*PAYER NAME\*\*\*\*\*PI\*12345~

## **TRN – Transmission Receipt Control Identifier – Loop 2200A**

To uniquely identify a transaction to an application.

Field	Field Description	Value	Comment
TRN01	Trace Type Code	'1'	Current Transaction Trace Numbers
TRN02	Reference Identification		Trace or reference number assigned by the information source.

### **Sample**

TRN\*1\*6701407~

## **DTP – Information Source Receipt Date – Loop 2200A**

The Information Source Receipt Date segment is used to provide the receipt date of the 837 transaction.

Field	Field Description	Value	Comment
DPT01	Date/Time Qualifier	'050'	050 - Received
DPT02	Date Time Period Qualifier	'D8'	CCYYMMDD
DPT03	Date Time Period		Date as qualified by DPT01 and DPT02.

### **Sample**

DTP\*050\*D8\*20100131~

## **DTP – Information Source Process Date – Loop 2200A**

The Information Source Process Date segment is used to provide the date the 837 transaction was processed.

Field	Field Description	Value	Comment
DPT01	Date/Time Qualifier	'009'	009 - Processed
DPT02	Date Time Period Qualifier	'D8'	CCYYMMDD
DPT03	Date Time Period		Date as qualified by DPT01 and DPT02.

### **Sample**

DTP\*009\*D8\*20100201~

## **HL – Hierarchical Level – Information Receiver – Loop 2000B**

The Information Receiver Hierarchical Level is used to identify the information source loop within the transaction set. This will normally be the provider or practice.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID	'1'	
HL03	Hierarchical Level Code	'21'	Information Receiver
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*2\*1\*21\*1~

## **NM1 – Information Receiver Name – Loop 2100B**

The Information Receiver Name is used to identify the eligibility or benefit information receiver such as provider, medical group, lab, or hospital.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'41'	41 – Submitter
NM102	Entity type Qualifier	'2'	2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	'46'	46 – Electronic Transmitter ID
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*41\*2\*SOME BIG PRACTICE\*\*\*\*\*46\*TESTOFFICE~

## **TRN – Information Receiver Application Trace Number – Loop 2200B**

The Information Receiver Application Trace Number is used to uniquely identify a transaction to an application.

Field	Field Description	Value	Comment
TRN01	Trace Type Code	'2'	2- Referenced Transaction Trace Numbers
TRN02	Reference Identification		Batch Id associated with EDI claims. If not available a fixed value of 11111 will be used.

### **Sample**

TRN\*2\*11111~

## **STC – Information Receiver Status Information – Loop 2200B**

The Information Receiver Status Information is used to report the status, required action, and paid information for a claim or service.

Field	Field Description	Value	Comment
STC01	Health Care Claim Status		
STC02	Status Information Effective Date		CCYYMMDD
STC03	Action Code	See List	U – Reject WQ – Accept
STC04	Submitted Charges		Sum of all CLM02 charges from the 837 claim being acknowledged.

### **Sample**

STC\*A1:19\*20100219\*WQ\*432.55~

## **HL – Hierarchical Level – Billing Provider of Service Level – Loop 2000C**

The Billing Provider Service Hierarchical Level is used to identify the Billing Provider loop within the transaction set.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		
HL03	Hierarchical Level Code	'19'	19 – Provider of Service
HL04	Hierarchical Child Code	'1'	Additional subordinate HL data segments in the structure.

### **Sample**

HL\*3\*2\*19\*1~

## **NM1 – Billing Provider Name – Loop 2100C**

The Billing Provider Name is used to identify the billing provider as submitted on the 837 2010AA loop.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'85'	85 – Billing Provider
NM102	Entity type Qualifier	'2'	1 – Person 2 – Non-Person Entity
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	See List	XX – NPI FI – Federal Tax Payer ID  <b>Note:</b> If an invalid NPI was sent on a claim to Availity RCM it will be returned in the 277U transaction as it was sent to Availity RCM.
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*85\*2\*SOME BIG PRACTICE\*\*\*\*\*XX\*1234567890~

## **TRN – Provider of Service Information Trace Identifier – Loop 2200C**

The Provider of Service Tracking Number is used to identify a transaction to an application.

Field	Field Description	Value	Comment
TRN01	Trace Type Code	'1'	1 – Current Transaction Trace Numbers
TRN02	Reference Identification		

### **Sample**

TRN\*1\*098089672~

## **STC – Billing Provider Status Information – Loop 2200C**

The Billing Provider Status Information is used to report the status, required action, and paid information for a claim or service.

Field	Field Description	Value	Comment
STC01	Health Care Claim Status		
STC02	Status Information Effective Date		CCYYMMDD
STC03	Action Code	See List	U – Reject WQ – Accept
STC04	Submitted Charges		Sum of all CLM02 charges from the 837 claim being acknowledged.

### **Sample**

STC\*A1:19\*20100219\*WQ\*432.55~

## **HL – Hierarchical Level – Patient Level – Loop 2000D**

The Patient Hierarchical Level is used to identify the patient loop within the transaction set.

Field	Field Description	Value	Comment
HL01	Hierarchical ID Number		Sequential number used to identify each HL segment within the transaction set beginning with one and increment by one for each occurrence.
HL02	Hierarchical Parent ID		
HL03	Hierarchical Level Code	'PT'	PT – Patient

### **Sample**

HL\*4\*3\*PT~

## **NM1 – Patient Name – Loop 2100D**

The Patient Name is used to identify the patient as submitted on the 837.

Field	Field Description	Value	Comment
NM101	Entity Identifier Code	'QC'	QC – Patient
NM102	Entity type Qualifier	'1'	1 – Person
NM103	Last Name or Organization Name		
NM104	First Name		
NM105	Middle Name		
NM106	Name Prefix		Empty
NM107	Name Suffix		
NM108	Identification Code Qualifier	'MI'	MI – Member ID
NM109	Identification Code		ID Number defined in NM108.

### **Sample**

NM1\*QC\*1\*DOE\*JANE\*\*\*\*MI\*YRP100293~

## **TRN – Claim Status Tracking Number – Loop 2200D**

The Claim Status Tracking Number is used to uniquely identify a status to the CLM01 of the 837 claims submission.

Field	Field Description	Value	Comment
TRN01	Trace Type Code	'2'	2- Referenced Transaction Trace Numbers
TRN02	Reference Identification		Patient Account Number from the 837 CLM01. If a patient account number is not available, the Availity RCM generated internal tracking ID will be used.

### **Sample**

TRN\*2\*098089672~

## **STC – Claim Level Status Information – Loop 2200D**

The Claim Level Status Information is used to report the status, required action, and paid information for a claim or service line.

Field	Field Description	Value	Comment
STC01	Health Care Claim Status		
STC02	Status Information Effective Date		CCYYMMDD
STC03	Action Code	See List	U – Reject WQ – Accept
STC04	Submitted Charges		Sum of all CLM02 charges from the 837 claim being acknowledged.
STC05	Not Used		
STC06	Not Used		
STC07	Not Used		
STC08	Not Used		
STC09	Not Used		
STC10	Not Used		
STC11	Not Used		
STC12	Message Text		Availity RCM Error ID and message text. Format 999.999.999.999 – Error Text.

### **Sample**

STC\*A8:21:41\*20100219\*U\*432.55\*\*\*\*\*020.010.001.4591 – Error Message~

## **REF – Payer Claim Control Number – Loop 2200D**

The optional Payer Claim Control Number segment is used to provide the Payer's control number if available.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	1K	1K – Payer's Claim Number
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*1K\*0123456789~

## **REF – Clearinghouse Claim Identifier – Loop 2200D**

The Clearinghouse Claim Identifier segment is used to provide the Clearinghouse's trace number for the claim.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	D9	D9 – Clearinghouse Claim Number
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*D9\*0123456789~

## **REF – Institutional Bill Type Identifier – Loop 2200D**

The optional Institutional Bill Type Identifier segment is used when an institutional claim is submitted.

Field	Field Description	Value	Comment
REF01	Reference Identification Qualifier	BLT	BLT – Billing Type
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*D9\*0123456789~

## **DTP – Claim Level Service Date – Loop 2200D**

The Claim Level Service Date segment is used to provide the earliest date of service to the latest date of service.

Field	Field Description	Value	Comment
DPT01	Date/Time Qualifier	472	472 – Service
DPT02	Date Time Period Qualifier	See List	D8 – CCYYMMDD RD8 – CCYYMMDD – CCYYMMDD
DPT03	Date Time Period		Date as qualified by DPT01 and DPT02.

### **Sample**

DTP\*472\*D8\*20100131~

## **SVC – Service Line Information – Loop 2220D**

The Service Line Information segment is used to provide payment and control information to a provider for a particular service.

Field	Field Description	Value	Comment
SVC01	Medical Procedure Identifier	Composite Field	Identifies a medical procedure by its standardized codes and applicable modifiers.
SVC01-1	Procedure Code		Values: AD, ER, HC, HP, IV, NU, WK.
SVC01-2	Product Service ID		Procedure Code (value submitted on the original claim)
SVC01 3 – 6	Procedure Modifier		Required if submitted on the original claim
SVC02	Line Item Charge Amount		Line Item Charge Amount
SVC03	Not Used		
SVC04	Not Used		
SVC05	Not Used		
SVC06	Not Used		
SVC07	Quantity		Original Units of Service Count

### **Sample**

SVC\*HC:90960\*1092\*\*\*\*\*1~

## **STC – Service Line Status Information – Loop 2220D**

The Service Line Status Information is used to report the status, required action, and paid information for a claim or service line.

See Appendix D – Error Mapping for an explanation of Availity RCM Error code mapping.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
STC01	Status Code	Composite Field	
STC01-1	Status Code		
STC01-2	Status Code		
STC02	Effective Date		CCYYMMDD
STC03	Action Code	See List	U – Reject WQ – Accept
STC04	Not Used		
STC05	Not Used		
STC06	Not Used		
STC07	Not Used		
STC08	Not Used		
STC09	Not Used		
STC10	Not Used		
STC11	Not Used		
STC12	Message Text		Availity RCM Error ID and message text. Format 999.999.999.999 – Error Text.

### **Sample**

STC\*A8:21:41\*\*U\*\*\*\*\*020.010.001.4591 – The adjustment reason is invalid.~

## **REF – Service Line Item Identification – Loop 2220D**

The Service Line Item Identification segment is used to specify identifying information.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
REF01	Reference Identification Qualifier	FJ	FJ – Line Item Control Number
REF02	Reference Identification		ID Number defined in REF01.

### **Sample**

REF\*FJ\*1~

## **SE – Transaction Set Trailer**

The Transaction Set Trailer is used to indicate the end of a transaction set and provide a count of the segments transmitted including the header and trailer.

Field	Field Description	Value	Comment
SE01	Number of included Segments		The number of segments included in the transaction set including the ST and SE segments.
SE02	Transaction Set Control Number		Control number which must match the value in ST02.

### **Sample**

SE\*999\*0001~

## **GE – Functional Group Trailer**

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GE01	Number of transaction sets included		Count of the number of transaction sets included in the functional group.
GE02	Group control number		Control number which must match the value in GS06.

### **Sample**

GE\*1\*1234~

## **IEA – Interchange Control Trailer**

The Interchange Control Trailer is used to identify the end of one or more functional groups and interchange-related control segments.

Field	Field Description	Value	Comment
IEA01	Number of included Functional Groups		Count of the number of functional groups within this interchange.
IEA02	Interchange Control Number		Control number which must match the value in ISA13.

### **Sample**

IEA\*1\*12345~

## Sample

```
ISA*00***00**ZZ*1619*ZZ*REALMED*100131*0944*U*00501*12345*1*P*:~  
GS*HS*1619*REALMED*20081231*0944*1234*X*005010X214~  
ST*277*0001*005010X214~  
BHT*0085*08*6701407*20100127*085124*TH~  
HL*1**20*1~  
NM1*AY*2*REALMED*****FI*352091331~  
TRN*1*6701407~  
DTP*050*D8*20100126~  
DTP*009*D8*20100126~  
HL*2*1*21*1~  
NM1*41*2*TEST CLINIC*****46*TESTOFFICE~  
TRN*2*111111~  
STC*A8:21*20100127*WQ*249~  
HL*3*2*19*1~  
NM1*85*2*TEST CLINIC*****XX*1234567890~  
HL*4*3*PT~  
NM1*QC*1*DOE*JANE*****MI*111222333~  
TRN*2*098089672~  
STC*A8:21*20100127*WQ*249~  
REF*D9*11037965-17-1~  
DTP*472*RD8*20091029-20091029~  
SE*20*0001~  
GE*1*1234~  
IEA*1*12345~
```

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

# Appendix C – 999 Quick Start Guide (5010)

## Overview

### Purpose

The Availity RCM 999 Quick Start Guide is intended to provide a basic understanding of how to parse and map a 999 response. This guide is not intended to define every detail of the 999 transaction, only the basics. Full ANSI standards of the 999 transaction can be obtained from [www.wpc-edi.com](http://www.wpc-edi.com). These standards provide detailed information on the format and structure of the response used in HIPAA 999 transactions.

This guide is specific to the interpretation and implementation used by Availity RCM. Payers, providers, and software vendors may have custom usage of these transactions that are specific to their business practices.

### Usage

The 999 transaction is used to provide syntactical and relational analysis or to acknowledge receipt of error free transactions set. The 999 cannot be used to report any application level validations failures. The 999 transaction will be transmitted to the practice using the established EDI data transmission method.

### Version

This document is intended for use with version 5010 of the X12 standard.

## Conventions

### Format

999 responses are composed of a series of text based segments nested within loops to form a complete transaction set. Each segment begins with a two or three character identifier which describes the segment and contains one or more additional fields separated by an asterisk. Each segment must end with a delimiter, typically the tilde ~.

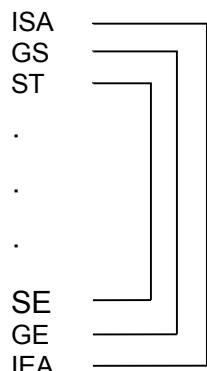
```
GS*HN*RMGATEWAY*TEST*20100312*1347*1*X*005010X231~
```

### Structure

Each transmission must contain a single transmission control beginning with an ISA, Interchange Control Header, and end with an IEA, Interchange Control Trailer.

Within the transmission control must be one or more functional groups which begin with a GS, Functional Group Header, and end with a GE, Functional Group Trailer.

Each functional group must contain one or more transaction sets which begin with a ST, Transaction Set Header, and end with a SE, Transaction Set Trailer. Within the transaction set are the detail segments for the eligibility request or response.



## 999 Implementation Acknowledgement (5010)

### Loop Structure

Loop	Segment	Name	Usage	Repeat	Loop Repeat
	ISA	Interchange Control Header	R	1	
	GS	Functional Group Header	R	1	>1
	ST	Transaction Set Header	R	1	
2000	AK1	Functional Group Response Header	R	1	
2100	AK2	Transaction Set Response Header	S	1	>1
	IK3	Error Identification	S	1	
	CTX	Segment Context	S	9	
	CTX	Business Unit Identifier	S	1	
2110	IK4	Implementation Data Element Name	S	1	>1
	CTX	Element Context	S	10	
	IK5	Implementation Set Response Trailer	R	1	
	AK9	Functional Group Response Trailer	R	1	
	SE	Transaction Set Trailer	R	1	
	GE	Functional Group Trailer	R	1	
	IEA	Interchange Control Trailer	R	1	

## Segment Definitions

### ISA – Interchange Control Header

The Interchange Control Header is used to identify one or more functional groups and interchange-related control segments.

Field	Field Description	Size	Value	Comment
ISA01	Author Info Qualifier	2	'00'	No authorization information present.
ISA02	Author Information	10		Empty
ISA03	Security Information Qualifier	2	'00'	No security information present.
ISA04	Security Information	10		Empty
ISA05	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA06	Interchange Sender ID	15	'RMGATE WAY'	
ISA07	Interchange ID Qualifier	2	'ZZ'	Mutually Defined
ISA08	Interchange Receiver ID	15		Provider
ISA09	Interchange Date	6		YYMMDD
ISA10	Interchange Time	4		HHMM
ISA11	Replication Separator	1		'^', '*', '~', or ':'
ISA12	Interchange Control Version Number	5	'00501'	Control number which must match the value in IEA02.
ISA13	Interchange Control Number	9		Control number which must match the value in IEA02.
ISA14	Acknowledgement Request	1	'0' or '1'	0 – No Acknowledgement 1 – Acknowledgement requested
ISA15	Usage Indicator	1	'P' or 'T'	P – Production T – Test
ISA16	Component Element Separator	1	:	

#### Sample

ISA\*00\*\*00\*\*ZZ\*RMGATEWAY\*ZZ\*TEST\*100312\*1347\*^\*00501\*00000001\*0\*P\*:~

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

## **GS – Functional Group Header**

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GS01	Functional Identifier Code	See List	HN – Health Care Information Status Notification.
GS02	Application Sender's Code		
GS03	Application Receiver's Code		
GS04	Date		CCYYMMDD
GS05	Time		HHMM
GS06	Group Control Number		Control number which must match the value in GE02.
GS07	Responsible Agency Code	'X'	Accredited Standards Committee X12
GS08	Version	'005010X231'	5010 version identifier.

### **Sample**

GS\*HN\*RMGATEWAY\*TEST\*20100312\*1347\*1\*X\*005010X231~

## **ST – Transaction Set Header**

The Transaction Set Header is used to indicate the start of a transaction set and assign a control number.

Field	Field Description	Value	Comment
ST01	Transaction Set Identifier Code	'299'	Implementation Acknowledgment
ST02	Transaction Set Control Number		Control number which must match the value in SE02.
ST03	Implementation Convention Reference	'005010X231'	5010 version identifier.

### **Sample**

ST\*999\*0001\*005010X231~

## **AK1 – Functional Group Response Header**

The Functional Group Response Header is used to start acknowledgment of a functional group.

Field	Field Description	Value	Comment
AK101	Functional Identifier Code		Functional ID of found in the GS01 of the functional group being acknowledged.
AK102	Group Control Number		Group Control Number found in the GS06 of the functional group being acknowledged.
AK103	Version		Version found in the GS08 of the functional group being acknowledged.

### **Sample**

AK1\*HS\*1\*005010X279~

## **AK2 – Transaction Set Response Header – Loop 2000**

The Transaction Set Response Header is used to start the acknowledgment of a single transaction set.

Field	Field Description	Value	Comment
AK201	Transaction Set Identification Code		Transaction Set Identification Code found in the ST01 of the transaction set being acknowledged.
AK202	Transaction Set Control Number		Transaction Set Control Number found in the ST02 of the transaction set being acknowledged.
AK203	Implementation Convention Reference		Transaction Set Identification Code found in the ST03 of the transaction set being acknowledged.

### **Sample**

AK2\*270\*0001\*005010X279~

## **IK3 – Error Identification**

The Error Identification is used to report implementation errors in a data segment and identify the location of the data segment.

<b>Field</b>	<b>Field Description</b>	<b>Value</b>	<b>Comment</b>
IK301	Segment ID Code		Code defining the segment ID of the data segment in error.
IK302	Segment Position in Transaction Set		Numerical count of the data segment from the start of the transaction set.
IK303	Loop ID Code		The loop ID number given on the transaction set diagram.
IK304	Implementation Segment Syntax Error Code	See List	<ul style="list-style-type: none"><li>1 – Unrecognized Segment ID</li><li>2 – Unexpected Segment</li><li>3 – Required Segment Missing</li><li>4 – Loop occurs over max times</li><li>5 – Segment exceeds max use</li><li>6 – Segment not in defined transactions set</li><li>7 – Segment not in proper sequence</li><li>8 – Segment has data element errors</li><li>I4 – Implementation “Not Used” segment present</li><li>I6 – Implementation dependent segments missing</li><li>I7 – Implementation loop occurs under minimum times</li><li>I8 – Implementation segment below minimum use</li><li>I9 – Implementation dependent “Not Used” segments present</li></ul>

### **Sample**

IK3\*NM1\*6\*2100\*8~

## **CTX – Segment Context**

The Segment Context segment is used to identify the data that triggered the situation requirement.

Field	Field Description	Value	Comment
CTX01	Context Identification	'SITUATIONAL TRIGGER'	Constant
CTX02	Segment ID Code		Segment ID of the data segment in error.
CTX03	Segment Position in Transaction Set		Numerical count of the data segment from the start of the transaction set.
CTX04	Loop Identifier Code		The loop ID number given on the transaction set diagram.
CTX05	Position In Segment		Relative position of the element in error within the segment.
CTX06	Reference In Segment		Reference Number of the element in error within the segment.

### **Sample**

CTX\*SITUATIONAL TRIGGER\*NM1\*6\*\*8\*66~

## **CTX – Business Unit Identifier**

The Business Unit Identifier identifies an event context in terms of the application or implementation context in force at the time the event occurred.

Field	Field Description	Value	Comment
CTX01 :1	Context Identification	See List	TRN02 NM109 PATIENT NAME NM109 SUBSCRIBER NAME NM109 ENT01 SUBSCRIBER NUMBER REF02 CLM01
CTX01:2	Context Reference		Contains the value from the business unit identifier specified in CTX01:1.
CTX02	Segment ID Code		Not Used
CTX03	Segment Position in Transaction Set		Not Used
CTX04	Loop Identifier Code		Not Used
CTX05	Position In Segment		Not Used
CTX06	Reference In Segment		Not Used

### **Sample**

CTX\*CLN01:123456789~

## **IK4 – Implementation Data Element Note**

The Information Data Element Note identifies errors in a data element.

Field	Field Description	Value	Comment
IK401	Position in Segment		
IK402	Data Element Reference Number		Reference number used to locate data element in Data Element Dictionary.
IK403	Implementation Data Element Syntax Error Code	See List	<ul style="list-style-type: none"><li>1 – Required Data Element Missing</li><li>2 – Conditional Required Data Element Missing</li><li>3 – Too Many Data Elements</li><li>4 – Data Element Too Short</li><li>5 – Data Element Too Long</li><li>6 – Invalid Character In Data Element</li><li>7 – Invalid Code Value</li><li>8 – Invalid Date</li><li>9 – Invalid Time</li><li>10 – Exclusion Condition Violated</li><li>12 – Too Many Repetitions</li><li>13 – Too Many Components</li><li>I6 – Code Value Not Used in Implementation</li><li>I9 – Implementation Dependent Data Element Missing I10 – Implementation “Not Used” Data Element Present</li><li>I11 – Implementation Too Few Repetitions</li><li>I12 – Implementation Pattern Match Failure</li><li>I13 – Implementation Dependent “Not Used” Data Element Present</li></ul>
IK404	Copy of Bad Data Element		Copy of the actual data element in error.

### **Sample**

IK4\*2\*127\*I12\*0123456789~

## **CTX – Element Context**

The Element Context segment is used to identify the data that triggered the situational requirements.

Field	Field Description	Value	Comment
CTX01	Context Identification	'SITUATIONAL TRIGGER'	Constant
CTX02	Segment ID Code		Segment ID of the data segment in error.
CTX03	Segment Position in Transaction Set		Numerical count of the data segment from the start of the transaction set.
CTX04	Loop Identifier Code		The loop ID number given on the transaction set diagram.
CTX05	Position In Segment		Relative position of the element in error within the segment.
CTX06	Reference In Segment		Reference Number of the element in error within the segment.

### **Sample**

CTX\*SITUATIONAL TRIGGER\*CLM\*43\*\*5:3\*C023:1325~~

## IK5 – Transaction Set Response Trailer

The Transaction Set Response Trailer is used to acknowledge acceptance or rejection and report implementation errors in a transaction set.

Field	Field Description	Value	Comment
IK501	Transaction Set Acknowledgement Code	See List	A – Accepted E – Accepted but errors were noted. M – Rejected, MAC Failed R – Rejected W – Rejected, Assurance Failed X – Rejected, Content could not be analyzed.
IK502	Implementation Transaction Set Syntax Error	See List	1 – Transaction Set Not Supported 2 – Transaction Set Trailer Missing 3 – Transaction Set Control Number in Header and Trailer Do Not Match 4 – Number of Included Segments Does Not Match Actual Count 5 – One or More Segments in Error 6 – Missing or Invalid Transaction Set Identifier 7 – Missing or Invalid Transaction Set Control Number 8 – Authentication Key Name Unknown 9 – Encryption Key Name Unknown 10 – Requested Service (Authentication or Encrypted) Not Available 11 – Unknown Security Recipient 12 – Incorrect Message Length (Encryption Only) 13 – Message Authentication Code Failed 15 – Unknown Security Originator 16 – Syntax Error in Decrypted Text 17 – Security Not Supported 18 – Transaction Set not in Functional Group 19 – Invalid Transaction Set Implementation Convention Reference 23 – Transaction Set Control Number Not Unique within the Functional Group 24 – S3E Security End Segment Missing for S3S Security Start Segment 25 – S3S Security Start Segment

			Missing for S3E Security End Segment 26 – S4E Security End Segment Missing for S4S Security Start Segment 27 – S4S Security Start Segment Missing for S4E Security End Segment I6 – Implementation Convention Not Supported
IK503	Implementation Transaction Set Syntax Error		Additional error codes. See IK502 for list.
IK504	Implementation Transaction Set Syntax Error		Additional error codes. See IK502 for list.
IK505	Implementation Transaction Set Syntax Error		Additional error codes. See IK502 for list.
IK506	Implementation Transaction Set Syntax Error		Additional error codes. See IK502 for list.

#### Sample

IK5\*R\*4\*I5\*5~

#### **AK9 – Functional Group Response Trailer**

The Functional Group Response Trailer is used to acknowledge acceptance or rejection of a functional group.

Field	Field Description	Value	Comment
AK901	Functional Group Acknowledge code	See List	A – Accepted E – Accepted but errors were noted. M – Rejected, MAC Failed P – Partially Accepted R – Rejected W – Rejected, Assurance Failed X – Rejected, Content could not be analyzed.
AK902	Number of Transaction Sets Included		
AK903	Number of Transaction Sets Received		
AK904	Number of Transactions Sets Accepted		
AK905	Functional Group Syntax Error code	See List	1 – Functional Group Not Supported 2 – Functional Group Version Not Supported 3 – Functional Group Trailer Missing 4 – Group Control Number in the Functional Group Header and Trailer Do Not Agree 5 – Number of Included Transaction Sets Does Not Match Actual Count

			<p>6 – Group Control Number Violates Syntax</p> <p>10 – Authentication Key Name Unknown</p> <p>11 – Encryption Key Name Unknown</p> <p>12 – Requested Service (Authentication or Encryption) Not Available</p> <p>13 – Unknown Security Recipient</p> <p>14 – Unknown Security Originator</p> <p>15 – Syntax Error in Decrypted Text</p> <p>16 – Security Not Supported</p> <p>17 – Incorrect Message Length (Encryption Only)</p> <p>18 – Message Authentication Code Failed</p> <p>19 – Functional Group Control Number not Unique within Interchange</p> <p>23 – S3E Security End Segment Missing for S3S Security Start Segment</p> <p>24 – S3S Security Start Segment Missing for S3E End Segment</p> <p>25 – S4E Security End Segment Missing for S4S Security Start Segment</p> <p>26 – S4S Security Start Segment Missing for S4E Security End Segment</p>
AK906	Functional Group Syntax Error Code		Additional error codes. See IK905 for list.
AK907	Functional Group Syntax Error Code		Additional error codes. See IK905 for list.
AK908	Functional Group Syntax Error Code		Additional error codes. See IK905 for list.
AK909	Functional Group Syntax Error Code		Additional error codes. See IK905 for list.

### Sample

AK9\*R\*1\*1\*0~

## **SE – Transaction Set Trailer**

The Transaction Set Trailer is used to indicate the end of a transaction set and provide a count of the segments transmitted including the header and trailer.

Field	Field Description	Value	Comment
SE01	Number of included Segments		The number of segments included in the transaction set including the ST and SE segments.
SE02	Transaction Set Control Number		Control number which must match the value in ST02.

### **Sample**

SE\*999\*0001~

## **GE – Functional Group Trailer**

The Functional Group Header is used to indicate the beginning of a functional group and provide control information.

Field	Field Description	Value	Comment
GE01	Number of transaction sets included		Count of the number of transaction sets included in the functional group.
GE02	Group control number		Control number which must match the value in GS06.

### **Sample**

GE\*1\*1234~

## **IEA – Interchange Control Trailer**

The Interchange Control Trailer is used to identify the end of one or more functional groups and interchange-related control segments.

Field	Field Description	Value	Comment
IEA01	Number of included Functional Groups		Count of the number of functional groups within this interchange.
IEA02	Interchange Control Number		Control number which must match the value in ISA13.

### **Sample**

IEA\*1\*12345~

## Sample

```
ISA*00***00**ZZ*1619*ZZ*REALMED*100131*0944*U*00501*12345*1*P*:~  
GS*FA*RCVR*SNDR*20041117*1024*287*X*005010X231~  
ST*999*2870001*005010X231~  
AK1*HC*17456*004010X098A1~  
AK2*837*0001~  
IK5*A~  
AK2*837*0002~  
IK3*CLM*22**8~  
CTX*CLM01:123456789~  
IK4*2*782*1~  
IK5*R*5~  
AK2*837*0003~  
IK3*REF*57**3~  
CTX*SITUATIONAL TRIGGER*CLM*43**5:3*C023:1325~  
CTX*CLM01:987654321~  
IK5*R*5~  
AK9*P*3*3*1~  
SE*16*2870001~  
GE*1*287~  
IEA*1*12345~
```

Spaces in ISA segment removed due to page limits. Actual ISA requires padded spaces.

## Appendix D – Error Mapping

Availity RCM has the ability to categorize errors using a four node number that groups and identifies the error. This grouping and categorization allows practice management systems to properly direct claim errors to the appropriate work queue or are of the application for correction.

1st Node - Error Category

2nd Node - Sub-Category

3rd Node - Trading Partner

4th Node - Unique Error Number

Example: 020.050.053.23499

### Error Number Cross Reference

Category	Category Description	Sub-Category	Sub-Category Description
010	Eligibility	004	Routing
		010	Data Validation
		020	Insufficient Data
		030	Not Found
		040	Not Matched
		050	HIPAA-Related Edits
		060	Customizable Edits By the Practice
020	Claim	070	Rejected
		010	Data Validation
		020	Insufficient Data
		050	HIPAA-Related Edits
		060	Customizable Edits By the Practice
		080	CCI (Correct Coding Initiative) Edits
030	Provider	090	Medicare Edits, Including LCD and NCD
		010	Data Validation
		020	Insufficient Data
		030	Not Found
		040	Not Matched
		050	HIPAA-Related Edits
040	Payer	060	Customizable Edits By the Practice
		010	Data Validation
		020	Insufficient Data
		050	HIPAA-Related Edits
		070	Rejected
		071	Batch Rejected
090	Other	000	Dead Claim
		001	Unmapped Errors
		002	Saved Claim
		003	Unknown
		999	Failure



# Glossary of Common Terms

**270** – ANSI eligibility verification request transaction.

**271** – ANSI eligibility verification response transaction.

**275** – ANSI claim attachment transaction.

**276** – ANSI claim status request transaction.

**277** – ANSI claim status response transaction.

**277U** – Unsolicited ANSI claim status transaction.

**835** – ANSI remittance advice transaction.

**837** – ANSI claim submission transaction.

**4010** – Previous implementation version of the ANSI EDI standards for healthcare claims transmission.

**5010** – Current implementation version of the ANSI EDI standards for healthcare claims transmission as mandated for usage beginning January 2012.

**ANSI** – The American National Standards Institute is the governing body used to develop the EDI standards for healthcare claims transmission.

**Batch** – Any transaction process that requires the transaction to persist on a file based storage until the transaction can be processed and the result can be returned.

**EDI** – Electronic Data Interchange

**Element** – A single piece of data in a segment of an ANSI transaction. Equivalent to a field or column.

**EMR** – Electronic Medical Records System. Sometimes called and EHR.

**FTP** – File Transfer Protocol

**PM System** – Practice Management System

**Postback** – The ability to send data back to the originating system and have appropriate changes applied.

**Availity RCM Application Portal** – The online application used to submit, review, correct, manage, and report claims and other related transactions.

**Real-time** – Any transaction that can be processed immediately without the need to hold the transaction in a queue for processing. Real-time transactions are typically completed in five to twenty seconds depending on the nature of the transaction and the required connection to a payer. Real-time transactions are commonly implemented through web services.

**Segment** – A collection of elements used to define an ANSI transaction. Equivalent to a row or record.

**Secure File Exchange** – Availity RCM's file transfer and scheduling utility.

**Web Service** – A web based interface provided to support programmatic access to Availity RCM services needed to accomplish a specific task. Web services are commonly used to support real-time processing.



## Revision History

This section is required for documents being placed under formal change control. Its use is optional on all other formal documents.

Revision No.	Date	Managing Editor	Section Affected	Reason for Change
1.0	01/25/2010			
20130703	07/03/2013	Dave Wilcoxson	Entire document	Updated to Availability format. Added 277U claims detail status, RTE Summary Response, removed appendix Z – Root Certification
20130715	07/15/2013	Dave Wilcoxson	Appendix A – 270 Pipe delimited Elig	Additional field
20140124	01/24/2014	Dave Wilcoxson	Patient Payment File. Fixed 277U status codes 837 Claims Edit Matrix	New Update New
20140310	03/10/2014	Dave Wilcoxson	RTCE	New
20141007	10/07/2014	Dave Wilcoxson	RTCE Sample Code	Update
20150115	01/15/2015	Dave Wilcoxson	RTE Payer Rules	Update
20150325	03/25/2015	Dave Wilcoxson	Appendix A – 270/271 Quick Start Guide	Update
20150325	03/25/2015	Dave Wilcoxson	Appendix B – 277U Quick Start Guide	Update
20150325	03/25/2015	Dave Wilcoxson	Capacity-to-Pay API	New
20150325	03/25/2015	Dave Wilcoxson	Self-Pay Eligibility Verification	New
20150401	04/03/2015	Dave Wilcoxson	RTE Response Summary	Update
20150401	04/03/2015	Dave Wilcoxson	Capacity-to-Pay API	Update
20150618	06/18/2015	Dave Wilcoxson	RTCE URL, Self-Pay, 270 ISA	Update

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