ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Claim Status Request and Response (276/277)

Change Log: 005010 - 007030

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Location	X329 | Health Care Claim Status Request and Response 1.3 Implementation Limitations
Action	**Modify Chapter 1** 1.3.2.1 Real-Time and Batch Transmissions, Real-Time Limitations, bullet 1.
CR 401	Review Bullet 1 under Real Time Limitations. Revise for clarity and accuracy.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Changed Section 1.4.4.1 STC Composite and Code Use Rules, last bullet to "The Information Source must provide detailed status information by making use of the entire Claim Status Code list."
CR 1387	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** 1.4.4.1 STC Composite and Code Use Rules, add bullet An Entity Code may also be identified in conjunction with a Health Care Claim Status code to further clarify the status message when the code does not specifically require its use.
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** 1.4.3.2 The Service, paragraph 2.
CR 405	Strengthen the verbiage in Section 1.4.2.2 to require the return of service line details.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** 1.4.4.2 Status Response Levels, Loop 2200B - Information Receiver paragraph.
CR 407	Review the Status Respsonse levels and modify as needed to increase consistency.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage

Action	**Modify Chapter 1** 1.4.4.2 Status Response Levels, last paragraph.
CR 1387	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Section 1.4 Business Usage, paragraph 1 changed to "The ASC X12 Health Care Claim Status Request and Response (276/277) implementation guide addresses the paired usage of the 276 as a request for claim status and the 277 as a response to that request. The 276 is used to transmit request(s) to obtain the status of specific health care claim(s) within a payer's adjudication process. It can also be used to request status information on a previously submitted predetermination. The payer uses the 277 to transmit the current system status of those requested claims or predeterminations. Claim history parameters may vary by payers and systems.
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Add Chapter 1** Section 1.4.7 Predeterminations
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Add Chapter 1** 1.4.4.3 Status Messaging for Subscriber Direct Paid Claims/Services
CR 1315	Add a new front matter section with guidance on standard category/status code and payment information for subscriber paid claims.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** 1.4 Business Usage, Figure 1.1, Remove reference to "997", changed to (999 or other format)
CR 1118	The 997 is no longer appropriate for healthcare transactions and should be removed from the front matter in the Claim Status Guides.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage

Action	**Modify Chapter 1** 1.4.6 277 Transaction Uses, Figure 1.2, Remove the "997" reference , changed to (999 Acknowledgment)
CR 1118	The 997 is no longer appropriate for healthcare transactions and should be removed from the front matter in the Claim Status Guides.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Add Chapter 1** Section 1.4.8 - Payer Claim Control Number Search and Response
CR 418	Establish request and response consistency by developing a standard search criteria and response.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Modify 1.4.3.1 The Claim, Paragraph 1 The 276 and 277 Loop 2200 may contain different segments, with the exception of the TRN Segment (Claim Status Trace Number). However, the intent of the loop is similar in both transactions. The provider and payer may identify the claim within their respective system using different data. As a result, the segments used for the request (276) may differ from the segments returned in the response (277).
CR 418	Establish request and response consistency by developing a standard search criteria and response.

Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Modify 1.4.3.1 The Claim, Paragraph 3 Reassociation of the response to the original request is a necessity of the 276/277 paired transaction. The reassociation is accomplished with a unique trace or reference number identified in the TRN Segment (Claim Status Trace Number), Data Element (TRN02). This number is determined by the originator (Information Receiver) of the 276 and must be returned in the 277 by the sender (Information Source). The 277 response TRN02 must contain the same value that was submitted in the 276 request. The only exception for not returning the 2200D or 2200E TRN segment in the 277 is when a rejection status is reported at the Information Receiver Level. In this instance, the lower level (child) HL is not used. See Section 1.4.4.2 - Status Response Levels, for details on an Information Receiver Level rejection.

CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Modify 1.4.3.2 The Service, Paragraph 1 The service information follows the claim data in Loop 2210 (Service Line Information) of the 276 and Loop 2220 (Service Line Information) of the 277. Some payers' adjudication systems support service line information. When the requester is inquiring on the status of a specific service, Loop 2210 must be populated in the 276. When the payer is reporting the status of a specific service, Loop 2220 must be populated in the 277.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Modify 1.4.3.2 The Service, Paragraph 2, Add Paragraph 3 and 4. Similar to the claim level, the provider may send general service data such as dates of service, amount and procedure codes in an effort to receive status on multiple services and claim with those same attributes. When the provider includes a service specific identifier, i.e. Service Line Item Identification (Line Item Control Number), they are indicating to the payer that the search and response be narrowed to a very specific service line on a previously submitted claim. Use of the Service Line Item Identification (Line Item Control Number) in the payer's service level search and matching criteria may be helpful in narrowing the response to the specific services for which the provider has requested status. For Service line status requests and responses, the SVC segment (Service Line Information) is used to report the actual service (procedure) data. The SVC Segment is returned by the payer indicating the adjudicated procedure code. Due to the payer's adjudication processes and policies, service line data may be changed as a result of bundling or unbundling. In this case, the service line(s) returned in the 277 may be different than those submitted in the 276. Procedure code bundling or unbundling occurs when a payer believes the actual services performed and reported for claim payment can be represented by a different group of procedure codes. Bundling occurs when two or more

	submitted procedures are processed using one procedure code. Unbundling occurs when one submitted procedure code is processed and reported back as two or more procedure codes.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response 1.4 Business Usage
Action	**Modify Chapter 1** Modify 1.4.3.1 The Claim, Paragraph 2 When claim status is requested, the provider supplies data that helps the payer locate the claim(s). The provider may send general claim data such as dates of service, claim amount or bill type in an effort to receive status on multiple claims with those same attributes. When the provider includes claim specific identifiers, such as the Provider's Assigned Claim Identifier or the Payer Claim Control Number, they are indicating to the payer that the search and response be narrowed to very specific claims. Use of the Provider's Assigned Claim Identifier in the payer's search and matching criteria may be helpful in narrowing the response to specific claims for which the provider has requested status. See Section 1.4.8 - Payer Claim Control Number Search and Response for specific search and response requirements when the Payer Claim Control Number is submitted in the 276 request.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response 1.5 Business Terminology
Action	**Add Chapter 1** Section 1.5 Business Terminology Predetermination Status Request A request for status on a claim that was submitted prior to services being rendered. The predetermination request would include all data necessary to find the predetermination within the payers system, except for date(s) of service. See the 837 TR3 for a definition of a predetermination.
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.
Location	X329 | Health Care Claim Status Request and Response 1.7 Related Transactions

Action	**Modify Chapter 1** Modify 1.7.1 The Claim (837), Paragraph 2 Submitting a claim, whether by using the 837 or another format, is the first step in the claim status request/response process. Certain data elements (e.g., the Provider's Assigned Claim Identifier, type of bill, dates of service, insured identifier, service provider identifier, and payer's claim number when available) found on the claim help locate a claim within a payer's adjudication system. When the provider initiates a claim status request, as many of these data elements as possible should be forwarded to the payer. With the exception of the payer's claim number, the source of this information is the provider's billing system.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 ST - Transaction Set Header
Action	**Modify Data Element Note** Transaction Set Header/ST02 Transaction Set Control Number Changed to "The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there. The number also aids in error resolution research."
CR 999	Revise the ST02 notes across the TR3's to make them consistent.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 ST - Transaction Set Header
Action	**Modify Data Element Note** Transaction Set Header/ST02 Transaction Set Control Number Changed to "The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). For example, start with the number 0001 and increment from there. The number also aids in error resolution research."
CR 999	Revise the ST02 notes across the TR3's to make them consistent.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Note** BHT01 Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL

	parent loop at the same hierarchical level.
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Modify Data Element Usage** Header/BHT06 Transaction Type Code Changed from Not Used to Situational.
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Situational Rule** Header/BHT06 Transaction Type Code Required when the request is for status on a predetermination of benefits. If not required by this implementation guide, do not send.
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Code Value** Header/BHT06 Transaction Type Code P5 - Predetermination - Medical P6 - Predetermination - Dental
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Code Note** Header/BHT06 Transaction Type Code P5 - Predetermination - Medical Use when the transaction is for a medical related predetermination (Professional or Institutional).

CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Note** BHT01 Used to specify the sequential order of HL segments. The HL loops in the data stream must comply with this sequential order. An HL parent loop must be followed by any subordinate child loops prior to commencing a new HL parent loop at the same hierarchical level.
CR 1153	To clarify intended use.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Modify Data Element Usage** BHT03 Changed from Required to Situational.
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Note** BHT03 Added Element Note.
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000A HL - Information Source Level
Action	**Modify Data Element Note** Loop ID 2000A/HL01 Element Note Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000A HL - Information Source Level
Action	**Modify Data Element Note** Loop ID 2000A/HL01 Element Note

	Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0900 | 2200A TRN - Information Source Application Trace Identifier
Action	**Add Segment** 277 Loop ID 2200A TRN - Information Source Application Trace Identifier
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000B HL - Information Receiver Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000B HL - Information Receiver Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000B HL - Information Receiver Level
Action	**Delete Data Element Code Note** Loop ID 2000B/HL04 Hierarchical Child Code 0 - No Subordinate HL Segment in This Hierarchical Structure

	"Required when rejecting the status request for errors at the Information Source or Information Receiver levels."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000B HL - Information Receiver Level
Action	**Delete Data Element Code Note** Loop ID 2000B/HL04 Hierarchical Child Code 1 - Additional Subordinate HL Data Segment in This Hierarchical Structure. "Required when reporting status responses at the lower hierarchical levels (i.e. Subscriber or Dependent)."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100B NM1 - Information Receiver Name
Action	**Modify Data Element Situational Rule** NM103 Changed to " Required when the identifier in NM109 is not sufficient for identification. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100B NM1 - Information Receiver Name
Action	**Modify Data Element Situational Rule** NM103 Changed to " Required when the identifier in NM109 is not sufficient for identification. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0900 | 2200B TRN - Information Receiver Trace Identifier
Action	**Modify Segment Situational Rule** Required when an entire 276 transaction is rejected for errors at the Information Source or Information Receiver level. If not required by this implementation guide, do not send.

CR 407	Review the Status Respsonse levels and modify as needed to increase consistency.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0900 | 2200B TRN - Information Receiver Trace Identifier
Action	**Add Segment Note** Added TR3 Note 2.
CR 407	Review the Status Respsonse levels and modify as needed to increase consistency.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Modify Data Element Situational Rule** STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 371	Clarify when Claim Status Codes require the transmission of an Entity Code.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Modify Data Element Situational Rule** STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Add Data Element Code Value** PTP - Pay to Plan Name, TU - Third Party Repricing Organization (TPO).
CR 378	Add Pay to Plan at the Information Receiver level.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Add Data Element Code Value** O4 - Factor
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Add Segment Note** Added TR3 Note 2.
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000C HL - Service Provider Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000C HL - Service Provider Level
Action	**Modify Segment Situational Rule** Changed to "Required when status was not reported at the Information Receiver level (2000B HL04=1). If not required by this implementation guide, do not send."
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000C HL - Service Provider Level
Action	**Delete Data Element Code Value** "0" - No Subordinate HL Segment in This Hierarchical Structure.
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000C HL - Service Provider Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Data Element Situational Rule** NM103 Changed to " Required when the identifier in NM109 is not sufficient for identification. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Segment Repeat** Changed from 2 to 1.
CR 389	Service Provider NM1: Revise the notes and loop repeat as the NPI mandate is now in effect.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100C NM1 - Provider Name
Action	**Add Data Element Code Value** 82 - Rendering Provider and 85 - Billing Provider.
CR 402	Review Provider information requirements across levels. Provider information is often repeated at different levels in the transaciton

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100C NM1 - Provider Name
Action	**Add Data Element Code Note** Loop ID 2100C/NM101/Entity Identifier Code 85 Billing Provider Use when converting from earlier versions of this implementation guide unless the provider is otherwise defined by a Trading Partner Agreement as a Rendering Provider.
CR 1188	Include a qualifier in the 2100C NM101 for use during the transition period between TR3 versions and add use instructions.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Data Element Code Note** NM108 - Identification Code Qualifier XX - Standard Unique Health Identifier for Health Care Providers (NPI)

	Changed to "Use when the provider is in the United States or its territories and is eligible to receive a National Provider Identifier (NPI). OR Use when the provider is not in the United States or its territories and has received an NPI."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Data Element Situational Rule** NM103 Changed to " Required when the identifier in NM109 is not sufficient for identification. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Segment Repeat** Changed from 2 to 1.
CR 389	Service Provider NM1: Revise the notes and loop repeat as the NPI mandate is now in effect.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Data Element Code Value** 82 - Rendering Provider, 85 - Billing Provider.
CR 402	Review Provider information requirements across levels. Provider information is often repeated at different levels in the transaciton

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100C NM1 - Provider Name
Action	**Add Data Element Code Note** Loop ID 2100C/NM101/Entity Identifier Code 85 Billing Provider Use when converting from earlier versions of this implementation guide unless the provider is otherwise defined by a Trading Partner Agreement as a Rendering Provider.

CR 1188	Include a qualifier in the 2100C NM101 for use during the transition period between TR3 versions and add use instructions.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100C NM1 - Provider Name
Action	**Modify Data Element Code Note** NM108 - Identification Code Qualifier XX - Standard Unique Health Identifier for Health Care Providers (NPI) Changed to "Use when the provider is in the United States or its territories and is eligible to receive a National Provider Identifier (NPI). OR Use when the provider is not in the United States or its territories and has received an NPI."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000D HL - Subscriber Level
Action	**Modify Segment Note** Changed to "When requesting and responding to claim status for both a subscriber and dependent(s) of that subscriber without a unique ID, the Subscriber HL Loop 2000D must be followed by the subscriber's claim status data, Loop 2200D. In this instance, HL04=0 would be used. The Subscriber HL Loop 2000D must be repeated prior to one or more of the Dependent HL Loop 2000E and their corresponding claim status data, Loop 2200E. In this instance, Loop 2000D HL04=1 would be used. See Section 1.4.3.3 for an example of this structure."
CR 1153	To clarify intended use.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000D HL - Subscriber Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000D HL - Subscriber Level

Action	**Delete Data Element Code Note** Loop ID 2000D/HL04 Hierarchical Child Code 0 - No Subordinate HL Segment in This Hierarchical Structure "Required when there are no dependent claim status requests for this subscriber."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000D HL - Subscriber Level
Action	**Delete Data Element Code Note** Loop ID 2000D/HL04 Hierarchical Child Code 1 - Additional Subordinate HL Data Segment in This Hierarchical Structure "Required when there are dependent claim status requests for this subscriber."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000D HL - Subscriber Level
Action	**Modify Segment Note** Changed to "When requesting and responding to claim status for both a subscriber and dependent(s) of that subscriber without a unique ID, the Subscriber HL Loop 2000D must be followed by the subscriber's claim status data, Loop 2200D. In this instance, HL04=0 would be used. The Subscriber HL Loop 2000D must be repeated prior to one or more of the Dependent HL Loop 2000E and their corresponding claim status data, Loop 2200E. In this instance, Loop 2000D HL04=1 would be used. See Section 1.4.3.3 for an example of this structure."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000D HL - Subscriber Level
Action	**Modify Segment Usage** Changed from Situational to Required.
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000D HL - Subscriber Level

Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000D HL - Subscriber Level
Action	**Delete Data Element Code Note** Loop ID 2000D/HL04 Hierarchical Child Code 0 - No Subordinate HL Segment in This Hierarchical Structure "Required when there are no dependent claim status responses for this subscriber."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000D HL - Subscriber Level
Action	**Delete Data Element Code Note** Loop ID 2000D/HL04 Hierarchical Child Code 1 - Additional Subordinate HL Data Segment in This Hierarchical Structure "Required when there are dependent claim status responses for this subscriber."
CR 1563	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0400 | 2000D DMG - Subscriber Demographic Information
Action	**Modify Segment Situational Rule** "Required when the 2000D HL04 = 0. If not required by this implementation guide, do not send."
CR 1549	Base the situational rules on the HL04 value, supporting non-subjective editing.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100D NM1 - Subscriber Name
Action	**Modify Data Element Code Note** Loop ID 2100D/NM102 Entity Type Qualifier

	2 - Non-person Entity Changed to "Use when reporting a non-person entity in an employer-subscriber situation, such as Workers' Compensation or any other Property & Casualty claims."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100D NM1 - Subscriber Name
Action	**Modify Data Element Code Note** Loop ID 2100D/NM108 Identification Code Qualifier Code Value 24 - Employer's Identification Number Changed to "Use when reporting the Employer's Identification Number for Workers' Compensation or any other Property & Casualty claims."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100D NM1 - Subscriber Name
Action	**Modify Data Element Code Note** Loop ID 2100D/NM108 Identification Code Qualifier II - Standard Unique Health Identifier for each Individual in the United States Changed to "Use when the HIPAA Individual Patient Identifier is mandated for use."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100D NM1 - Subscriber Name
Action	**Modify Data Element Code Note** Loop ID 2100D/NM102 Entity Type Qualifier 2 - Non-person Entity Changed to "Use when reporting a non-person entity in an employer-subscriber situation, such as Workers' Compensation or any other Property & Casualty claims."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100D NM1 - Subscriber Name

Action	**Modify Data Element Code Note** Loop ID 2100D/NM108 Identification Code Qualifier Code Value 24 - Employer's Identification Number Changed to "Use when reporting the Employer's Identification Number for Workers' Compensation or any other Property & Casualty claims."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100D NM1 - Subscriber Name
Action	**Modify Data Element Code Note** Loop ID 2100D/NM108 Identification Code Qualifier II - Standard Unique Health Identifier for each Individual in the United States Changed to "Use when the HIPAA Individual Patient Identifier is mandated for use."
CR 1563	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 276 | 0900 | 2200D TRN - Claim Status Trace Number
Action	**Modify Segment Situational Rule** "Required when the 2000D HL04 = 0. If not required by this implementation guide, do not send."
CR 1549	Base the situational rules on the HL04 value, supporting non-subjective editing.
Location	X329 | Health Care Claim Status Request and Response | 277 | 0900 | 2200D TRN - Claim Status Trace Number
Action	**Modify Segment Situational Rule** "Required when the 2000D HL04 = 0. If not required by this implementation guide, do not send."
CR 1549	Base the situational rules on the HL04 value, supporting non-subjective editing.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Payer Claim Control Number
Action	**Add Segment Note** See Section 1.4.8 for Payer Claim Control Number Search and Response requirements.

CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 371	Clarify when Claim Status Codes require the transmission of an Entity Code.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Code Value** Loop ID 2200D / STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim and Service Levels.
CR 419	STC: Standardize use of the same Entity Codes across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Add Data Element Code Value** O4 - Factor.
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Add Data Element Code Value** Loop ID 2200D/STC01-03 OOP - Other Operating Physician

CR 952	Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Note** STC06 Adjudication Finalized Date Changed to "This is the date of denial or approval for the claim. This date may or may not be the same as the payment effective date from the remittance advice (STC08). In the 835, the payment effective date is BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC08 Remittance Date and STC09 Remittance Trace Number Changed to "Required when the remittance cycle is complete and this claim is included on a payment that is reported in an 835 or paper remittance to the provider. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Note** STC08 Remittance Date Changed to "This is the payment effective date from the remittance advice. In the 835, this is the value in BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information

Action	**Modify Data Element Note** STC09 Remittance Trace Number Changed to "This is the unique identification number assigned to the payment in the remittance advice for tracking purposes. In the 835, this is the value from TRN02."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Add Data Element Code Value** AY - Clearinghouse
CR 1120	Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Add Data Element** Loop ID 2200D / STC13 (Predetermination of Benefits Code)
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Institutional Bill Type Identification
Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Institutional Bill Type Identification

Action	**Add Segment Note** Use of this data as search criteria may vary by information source.
CR 415	Review the usage for Institutional Bill Type.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Name** From: Patient control number To: Provider's Assigned Claim Identifier
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Situational Rule** Changed To: Required when the Provider's Assigned Claim Identifier was submitted on the claim. If not required by this implementation guide, do not send.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Data Element Code Value** X1 - Provider Claim Number
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** REF02 This is the value from CLM01 of the 837.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Provider's Assigned Claim Identifier

Action	**Add Data Element Note** REF02 The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Pharmacy Prescription Number
Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Claim Identifier For Transmission Intermediaries
Action	**Modify Segment Situational Rule** Changed To: Required when a transmission intermediary (clearinghouse or other) needs to attach their own unique tracking number. If not required by this implementation guide, do not send.
CR 392	Create a shared situational rule for REF*D9.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200D REF - Property & Casualty Claim Number
Action	**Add Segment** 276 LOOP ID 2200D REF - Property & Casualty Claim Number
CR 385	Support the Property and Casualty industry need for a P&C Claim Number.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1100 | 2200D AMT - Claim Submitted Charges Amount
Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1100 | 2200D AMT - Claim Submitted Charges Amount

Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Payer Claim Control Number
Action	**Add Segment Note** See Section 1.4.8 for Payer Claim Control Number Search and Response requirements.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Payer Claim Control Number
Action	**Modify Segment Situational Rule** Changed To: Required when a claim is located in the Information Source's system or when a payer claim control number was submitted on the 276, but did not result in a found claim for the submitted number. If not required by this implementation guide, do not send.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Institutional Bill Type Identification
Action	**Modify Segment Situational Rule** Changed to "Required when an institutional claim is located in the Information Source's system. If not required by this implementation guide, do not send."
CR 415	Review the usage for Institutional Bill Type.
Location	X267 | Health Care Claim Status Request and Response TRN - Provider of Service Trace Identifier
Action	**Delete Segment** PROVIDER OF SERVICE TRACE IDENTIFIER
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.
Location	X267 | Health Care Claim Status Request and Response STC - Provider Status Information

Action	**Delete Segment** PROVIDER STATUS INFORMATION
CR 398	Add guidance for how to link Claim Status Reject Responses back to the submitted claims.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Name** From: Patient control number To: Provider's Assigned Claim Identifier
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Situational Rule** Required when the Provider's Assigned Claim Identifier was submitted on the claim(s) found in the information source's system or if no claims are located, the value from the 276 request is returned. If not required by this implementation guide, do not send.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Modify Data Element Code Value** X1 - Provider Claim Number
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** REF02 This is the value from CLM01 of the 837.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Provider's Assigned Claim Identifier

Action	**Add Data Element Note** REF02 The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200D REF - Property & Casualty Claim Number
Action	**Add Segment** 277 Loop ID 2200D REF - Property & Casualty Claim Number
CR 385	Support the Property and Casualty industry need for a P&C Claim Number.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200D DTP - Service Date
Action	**Modify Segment Note** Update Segment Note: For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200D DTP - Service Date
Action	**Modify Segment Situational Rule** Update Situational Rule to: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200D DTP - Service Date
Action	**Modify Data Element Code Note** RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD)

	Changed to: Use when the "From and To" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "From and To" dates are the same.
CR 1558	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200D DTP - Service Date
Action	**Modify Segment Note** Update Segment Note: For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200D DTP - Service Date
Action	**Modify Segment Situational Rule** Update Situational Rule to: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200D DTP - Claim Received Date
Action	**Add Segment** 277 Loop ID 2200D DTP - Claim Received Date
CR 399	Add Claim Received Date to support the timely filing requirements of states and payer contracts.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210D SVC - Service Line Information
Action	**Delete Data Element Code Value** Loop ID 2210D/SVC01-01

	WK - Advanced Billing Concepts (ABC) Codes
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210D SVC - Service Line Information
Action	**Add Data Element Note** Loop 2210D Service Line Information/SVC07 Units of Service Count "The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed."
CR 1410	Negative values are being submitted in the Claim Status Amount and Service Unit data elements of the Claim Status transactions where they do not make business sense. Such negative values should be disallowed.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210D SVC - Service Line Information
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210D SVC - Service Line Information
Action	**Modify Data Element Code Note** HC (Healthcare Common Procedure Coding System (HCPCS) Codes) Changed to: Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.
CR 1542	Improve the consistency of the code value notes within and across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210D REF - Line Item Control Number
Action	**Modify Data Element Code Value** REF01 Replaced code value FJ with 6R - Provider Control Number.
CR 1562	For consistency across all guides

Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210D REF - Line Item Control Number
Action	**Modify Segment Situational Rule** Changed to "Required when submitted on the 837 and sending a request for status at the line level. If not required by this implementation guide, do not send."
CR 413	2210D/E REF*6R 276: Clarify intention for searching.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210D REF - Line Item Control Number
Action	**Modify Segment Name** From: Service Line Item Identification Changed to: Line Item Control Number
CR 1539	Modify the 2000A REF segment situational rule and the segment name in 275, 276 and 277 guides.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210D DTP - Service Date
Action	**Add Segment Situational Rule** Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210D DTP - Service Date
Action	**Modify Segment Usage** Changed from Required to Situational
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210D DTP - Service Date
Action	**Modify Data Element Code Note** RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Changed to: Use when the "From and To" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "From and To" dates are the same.

CR 1558	Format code notes consistently.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1550 | 2210D TOO - Tooth Information
Action	**Add Segment** 276 Loop ID 2210D TOO - TOOTH INFORMATION
CR 1516	For consistency across guides.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Modify Segment Situational Rule** Changed to "Required when service line level status varies by service line or is different than the claim-level status. If not required by this implementation guide, may be provided at the sender's discretion but can not be required by the receiver."
CR 405	Strengthen the verbiage in Section 1.4.2.2 to require the return of service line details.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Delete Data Element Code Value** Loop ID 2220D/SVC01-01 WK - Advanced Billing Concepts (ABC) Codes
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Add Data Element Note** Loop ID 2220D Service Line Information/SVC07 Units of Service Count "The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed."
CR 1410	Negative values are being submitted in the Claim Status Amount and Service Unit data elements of the Claim Status transactions where they do not make business sense. Such negative values should be disallowed.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220D SVC - Service Line Information

Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Modify Data Element Code Note** HC (Healthcare Common Procedure Coding System (HCPCS) Codes) Changed to: Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.
CR 1542	Improve the consistency of the code value notes within and across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Situational Rule** STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 371	Clarify when Claim Status Codes require the transmission of an Entity Code.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Situational Rule** STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Code Value** STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim and Service Levels.
CR 419	STC: Standardize use of the same Entity Codes across the TR3s.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Usage** STC06, STC08, STC09 Changed from Not Used to Situational
CR 416	2220 D/E STC: Review business use to evaluate the need for line level payment information.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Add Data Element Code Value** O4 - Factor
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Add Data Element Code Value** OOP - Other Operating Physician
CR 952	Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Note** STC08 Remittance Date Changed to "This is the payment effective date from the remittance advice. In the 835, this is the value in BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Note** STC09 Remittance Trace Number Changed to "This is the unique identification number assigned to the payment in the remittance advice for tracking purposes. In the 835, this is the value from TRN02."

CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Add Data Element Situational Rule** STC06, STC08, STC09 Required when the remittance cycle is complete, this service is included on a payment that is reported in an 835 or paper remittance to the provider AND the payment information for this service is different from the claim level payment information. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Note** STC06 Adjudication Finalized Date Changed to "This is the date of approval or denial for the service. This date may or may not be the same as the payment effective date from the remittance advice (STC08). In the 835, the payment effective date is BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Add Data Element Code Value** AY - Clearinghouse
CR 1120	Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Add Data Element** Loop ID 2220D / STC13 (Service Line Predetermination of Benefits Code)
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2000 | 2220D REF - Line Item Control Number
Action	**Modify Data Element Code Value** REF01 Replaced code value FJ with 6R - Provider Control Number.
CR 1562	For consistency across all guides

Location	X329 | Health Care Claim Status Request and Response | 277 | 2000 | 2220D REF - Line Item Control Number
Action	**Modify Segment Name** From: Service Line Item Identification Changed to: Line Item Control Number
CR 1539	Modify the 2000A REF segment situational rule and the segment name in 275, 276 and 277 guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2100 | 2220D DTP - Service Date
Action	**Add Segment Situational Rule** Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2100 | 2220D DTP - Service Date
Action	**Modify Segment Usage** Changed from Required to Situational
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2150 | 2220D TOO - Tooth Information
Action	**Add Segment** 277 Loop ID 2220D TOO - TOOTH INFORMATION
CR 1516	For consistency across guides.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000E HL - Dependent Level

Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0100 | 2000E HL - Dependent Level
Action	**Modify Segment Situational Rule** Required when Loop 2000D HL04 = 1. If not required by this implementation guide, do not send.
CR 1550	Base the situational rule on the HL04 value, supporting non-subjective editing.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000E HL - Dependent Level
Action	**Modify Data Element Note** HL01 Changed to "The first HL01 within each ST-SE envelope must begin with "1", and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01."
CR 1109	For consistency, consider restricting HL01 to numeric values and requiring that enumeration of HL01 begin with 1 and be incremented by 1 for each iteration.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0100 | 2000E HL - Dependent Level
Action	**Modify Segment Situational Rule** Required when Loop 2000D HL04 = 1. If not required by this implementation guide, do not send.
CR 1550	Base the situational rule on the HL04 value, supporting non-subjective editing.

Location	X329 | Health Care Claim Status Request and Response | 276 | 0500 | 2100E NM1 - Dependent Name
Action	**Modify Data Element Situational Rule** Changed to "Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 0500 | 2100E NM1 - Dependent Name

Action	**Modify Data Element Situational Rule** Changed to "Required when the person has a middle name or initial that is known. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.

Location	X267 | Health Care Claim Status Request and Response REF - Application or Location System Identifier
Action	**Delete Segment** LOOP 2200E REF - APPLICATION OR LOCATION SYSTEM IDENTIFIER
CR 412	HPID may make this obsolete. Unable to determine valid business needs for this proprietary routing data which causes provider reporting burdens.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Payer Claim Control Number
Action	**Add Segment Note** See Section 1.4.8 for Payer Claim Control Number Search and Response requirements.
CR 418	Establish request and response consistency by developing a standard search criteria and response.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 371	Clarify when Claim Status Codes require the transmission of an Entity Code.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Code Value** STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim

	and Service Levels.
CR 419	STC: Standardize use of the same Entity Codes across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Add Data Element Code Value** O4 - Factor
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Add Data Element Code Value** OOP - Other Operating Physician
CR 952	Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Note** STC06 Adjudication Finalized Date Changed to "This is the date of denial or approval for the claim. This date may or may not be the same as the payment effective date from the remittance advice (STC08). In the 835, the payment effective date is BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Situational Rule** STC08 Remittance Date and STC09 Remittance Trace Number Changed to "Required when the remittance cycle is complete and this claim is included on a payment that is reported in an 835 or paper remittance to the provider. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."

CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Note** STC08 Remittance Date Changed to "This is the payment effective date from the remittance advice. In the 835, this is the value in BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Modify Data Element Note** STC09 Remittance Trace Number Changed to "This is the unique identification number assigned to the payment in the remittance advice for tracking purposes. In the 835, this is the value from TRN02."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Add Data Element Code Value** AY - Clearinghouse
CR 1120	Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1000 | 2200E STC - Claim Level Status Information
Action	**Add Data Element** Loop ID 2200E / STC13 (Predetermination of Benefits Code)
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Institutional Bill Type Identification
Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Name** From: Patient control number To: Provider's Assigned Claim Identifier
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Situational Rule** Changed To: Required when the Provider's Assigned Claim Identifier was submitted on the claim. If not required by this implementation guide, do not send.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Modify Data Element Code Value** X1 - Provider Claim Number
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** This is the value from CLM01 of the 837.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Pharmacy Prescription Number
Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Claim Identifier For Transmission Intermediaries
Action	**Modify Segment Situational Rule** Changed To: Required when a transmission intermediary (clearinghouse or other) needs to attach their own unique tracking number. If not required by this implementation guide, do not send.
CR 392	Create a shared situational rule for REF*D9.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1000 | 2200E REF - Property & Casualty Claim Number
Action	**Add Segment** 276 Loop ID 2200E REF - Property & Casualty Claim Number
CR 385	Support the Property and Casualty industry need for a P&C Claim Number.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1100 | 2200E AMT - Claim Submitted Charges Amount

Action	**Modify Segment Situational Rule** Changed to "Required when the information receiver wants to further define data related to a specific claim. If not required by this implementation guide may be provided by the sender but cannot be required by the receiver."
CR 415	Review the usage for Institutional Bill Type.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1100 | 2200E AMT - Claim Submitted Charges Amount
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Payer Claim Control Number
Action	**Add Segment Note** See Section 1.4.8 for Payer Claim Control Number Search and Response requirements.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Payer Claim Control Number
Action	**Modify Segment Situational Rule** Changed To: Required when a claim is located in the Information Source's system or when a payer claim control number was submitted on the 276, but did not result in a found claim for the submitted number. If not required by this implementation guide, do not send.
CR 418	Establish request and response consistency by developing a standard search criteria and response.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Institutional Bill Type Identification
Action	**Modify Segment Situational Rule** Changed to "Required when an institutional claim is located in the Information Source's system. If not required by this implementation guide, do not send."
CR 415	Review the usage for Institutional Bill Type.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Provider's Assigned Claim Identifier

Action	**Modify Segment Name** From: Patient control number To: Provider's Assigned Claim Identifier
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Modify Segment Situational Rule** Required when the Provider's Assigned Claim Identifier was submitted on the claim(s) found in the information source's system or if no claims are located, the value from the 276 request is returned. If not required by this implementation guide, do not send.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Modify Data Element Code Value** X1 - Provider Claim Number
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** This is the value from CLM01 of the 837.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Provider's Assigned Claim Identifier
Action	**Add Data Element Note** The maximum number of characters to be supported for this qualifier is 35. Characters beyond the maximum are not required to be stored or returned by the receiving system.
CR 1119	Clearly differentiate between Patient Account Number and the Provider Assigned Claim Identifier in the 276 and 277 TR3s.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1100 | 2200E REF - Property & Casualty Claim Number
Action	**Add Segment** 277 Loop ID 2200E REF - Property & Casualty Claim Number
CR 385	Support the Property and Casualty industry need for a P&C Claim Number.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200E DTP - Service Date
Action	**Modify Segment Note** Update Segment Note: For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200E DTP - Service Date
Action	**Modify Segment Situational Rule** Update Situational Rule to: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1200 | 2200E DTP - Service Date
Action	**Modify Data Element Code Note** RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Changed to: Use when the "From and To" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "From and To" dates are the same.
CR 1558	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200E DTP - Service Date
Action	**Modify Segment Note** Update Segment Note: For Institutional claims, it is the statement period in loop 2300 (DTP01=434). For Professional claims this information is derived from the earliest service level dates in loop 2400 (DTP01=472) to the latest service level date. For Dental claims it is the service date at the claim loop 2300 (DTP01=472) or when not reported at Loop 2300, it is derived from the earliest service level date in loop 2400 (DTP01=472) to the latest service level date.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200E DTP - Service Date
Action	**Modify Segment Situational Rule** Update Situational Rule to: Required when the claim is not a predetermination and service level dates are not reported. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1200 | 2200E DTP - Claim Received Date
Action	**Add Segment** 277 Loop ID 2200E DTP - Claim Received Date
CR 399	Add Claim Received Date to support the timely filing requirements of states and payer contracts.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210E SVC - Service Line Information
Action	**Delete Data Element Code Value** Loop ID 2210E/SVC01-01 WK - Advanced Billing Concepts (ABC) Codes
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210E SVC - Service Line Information

Action	**Add Data Element Note** SVC07 Units of Service Count The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed.
CR 1410	Negative values are being submitted in the Claim Status Amount and Service Unit data elements of the Claim Status transactions where they do not make business sense. Such negative values should be disallowed.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210E SVC - Service Line Information
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1300 | 2210E SVC - Service Line Information
Action	**Modify Data Element Code Note** HC (Healthcare Common Procedure Coding System (HCPCS) Codes) Changed to: Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.
CR 1542	Improve the consistency of the code value notes within and across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210E REF - Line Item Control Number
Action	**Modify Data Element Code Value** REF01 Replaced code value FJ with 6R - Provider Control Number.
CR 1562	For consistency across all guides
Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210E REF - Line Item Control Number
Action	**Modify Segment Situational Rule** Changed to "Required when submitted on the 837 and sending a request for status at the line level. If not required by this implementation guide, do not send."
CR 413	2210D/E REF*6R 276: Clarify intention for searching.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1400 | 2210E REF - Line Item Control Number
Action	**Modify Segment Name** From: Service Line Item Identification Changed to: Line Item Control Number
CR 1539	Modify the 2000A REF segment situational rule and the segment name in 275, 276 and 277 guides.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210E DTP - Service Date
Action	**Add Segment Situational Rule** Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210E DTP - Service Date
Action	**Modify Segment Usage** Changed from Required to Situational
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1500 | 2210E DTP - Service Date
Action	**Modify Data Element Code Note** RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Changed to: Use when the "From and To" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "From and To" dates are the same.
CR 1558	Format code notes consistently.

Location	X329 | Health Care Claim Status Request and Response | 276 | 1550 | 2210E TOO - Tooth Information
Action	**Add Segment** 276 Loop ID 2210E TOO - TOOTH INFORMATION

CR 1516	For consistency across guides.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220E SVC - Service Line Information
Action	**Modify Segment Situational Rule** Changed to "Required when service line level status varies by service line or is different than the claim-level status. If not required by this implementation guide, may be provided at the sender's discretion but can not be required by the receiver."
CR 405	Strengthen the verbiage in Section 1.4.2.2 to require the return of service line details.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220E SVC - Service Line Information
Action	**Delete Data Element Code Value** Loop ID 2220E/SVC01-01 WK - Advanced Billing Concepts (ABC) Codes
CR 749	Remove support for Advanced Billing Concept Codes (ABC) across the TR3s as HHS has discontinued the associated pilot project.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220E SVC - Service Line Information
Action	**Add Data Element Note** SVC07 Units of Service Count The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three. A zero or negative value is not allowed.
CR 1410	Negative values are being submitted in the Claim Status Amount and Service Unit data elements of the Claim Status transactions where they do not make business sense. Such negative values should be disallowed.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220E SVC - Service Line Information
Action	**Add Data Element Note** to DE 782 (Monetary Amount): The maximum length of this instance of data element 782 is 10.
CR 1013	Add a consistent element note explaining the maximum length to every monetary amount element.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1800 | 2220E SVC - Service Line Information

Action	**Modify Data Element Code Note** HC (Healthcare Common Procedure Coding System (HCPCS) Codes) Changed to: Use when reporting HCPCS or CPT codes. AMA's CPT codes are level 1 HCPCS codes, they are reported with an HC qualifier.
CR 1542	Improve the consistency of the code value notes within and across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Situational Rule** STC01-03, STC10-03, STC11-03 Changed to "Required when an entity must be identified to further clarify the status code in this composite data element. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver."
CR 371	Clarify when Claim Status Codes require the transmission of an Entity Code.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Situational Rule** STC10 and STC11 Changed to "Required when additional status information is needed. If not required by this implementation guide, do not send."
CR 1153	To clarify intended use.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Code Value** STC01-03 (Entity Type Code) Standardized (Added/Removed) Entity Type Codes in STC Segment at Claim and Service Levels.
CR 419	STC: Standardize use of the same Entity Codes across the TR3s.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Usage** STC06, STC08, STC09 Changed from Not Used to Situational
CR 416	2220 D/E STC: Review business use to evaluate the need for line level payment information.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information

Action	**Add Data Element Code Value** O4 - Factor
CR 95	The Property & Casualty industry needs the ability to report external entities who purchase accounts receivable assets on behalf of a payer (i.e. Factoring Agent).
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Add Data Element Code Value** OOP - Other Operating Physician
CR 952	Replace the ZZ qualifier with an explicit qualifier that identifies Other Operating Physician.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Note** STC08 Remittance Date Changed to "This is the payment effective date from the remittance advice. In the 835, this is the value in BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Note** STC09 Remittance Trace Number Changed to "This is the unique identification number assigned to the payment in the remittance advice for tracking purposes. In the 835, this is the value from TRN02."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.
Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Add Data Element Situational Rule** STC06, STC08, STC09 Required when the remittance cycle is complete, this service is included on a payment that is reported in an 835 or paper remittance to the provider AND

	the payment information for this service is different from the claim level payment information. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Modify Data Element Note** STC06 Adjudication Finalized Date Changed to "This is the date of approval or denial for the service. This date may or may not be the same as the payment effective date from the remittance advice (STC08). In the 835, the payment effective date is BPR16."
CR 1265	Allow for card payments (p-card, debit card, and credit card) within the 835 and related X12 transactions so remittance information can be conveyed electronically in these scenarios.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Add Data Element Code Value** AY - Clearinghouse
CR 1120	Support reporting of a clearinghouse entity code in the claim status guides. Support reporting of a clearinghouse entity code in the claim status guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 1900 | 2220E STC - Service Line Status Information
Action	**Add Data Element** Loop ID 2220E / STC13 (Service Line Predetermination of Benefits Code)
CR 1192	Create a definitive method for identifying status requests and responses for pre-determination of benefit claims.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2000 | 2220E REF - Line Item Control Number
Action	**Modify Data Element Code Value** REF01 Replaced code value FJ with 6R - Provider Control Number.
CR 1562	For consistency across all guides

Location	X329 | Health Care Claim Status Request and Response | 277 | 2000 | 2220E REF - Line Item Control Number

Action	**Modify Segment Name** From: Service Line Item Identification Changed to: Line Item Control Number
CR 1539	Modify the 2000A REF segment situational rule and the segment name in 275, 276 and 277 guides.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2100 | 2220E DTP - Service Date
Action	**Add Segment Situational Rule** Required when a service level date was submitted on the claim for this service. If not required by this implementation guide, do not send.
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2100 | 2220E DTP - Service Date
Action	**Modify Segment Usage** Changed from Required to Situational
CR 395	The Service Line Date of Service is always required, however institutional lines can be reported without a date of service.

Location	X329 | Health Care Claim Status Request and Response | 277 | 2150 | 2220E TOO - Tooth Information
Action	**Add Segment** 277 Loop ID 2220E TOO - TOOTH INFORMATION
CR 1516	For consistency across guides.

Location	X267 | Health Care Claim Status Request and Response REF - Application or Location System Identifier
Action	**Delete Segment** LOOP 2200E REF - APPLICATION OR LOCATION SYSTEM IDENTIFIER
CR 412	HPID may make this obsolete. Unable to determine valid business needs for this proprietary routing data which causes provider reporting burdens.