ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Claim Acknowledgment (277CA)

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Location	X330 | Health Care Claim Acknowledgment 1.4 Business Usage
Action	**Add Chapter 1** Section 1.4.3.1 STC Composite and Code Use Rules, bullets 2 and 3: An Entity Code must be identified when the Health Care Claim Status Code or the National Council for Prescription Drug Programs Reject/Payment Code message refers to an Entity. For example the Entity Code '85 - Billing Provider' could be used when Status Code '24 - Entity not approved as an electronic submitter' is used. 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 1397	Update front matter to clarify usage of the TR3.

Location	X330 | Health Care Claim Acknowledgment 1.4 Business Usage
Action	**Modify Chapter 1** 1.4.3.1 STC Composite and Code Use Rules, bulleted item 4.
CR 1153	To clarify intended use.

Location	X330 | Health Care Claim Acknowledgment 1.4 Business Usage
Action	**Add Chapter 1** Section 1.4.3.2 Status Messaging for Real Time Adjudication or Predetermination/Estimation
CR 1037	Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.

Location	X330 | Health Care Claim Acknowledgment 1.4 Business Usage
Action	**Modify Chapter 1** Added new Section 1.4.5. Balancing
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

Location	X330 | Health Care Claim Acknowledgment 1.5 Business Terminology
Action	**Add Chapter 1** Section 1.5 Business Terminology

	Real Time Adjudication - allows providers to submit an electronic claim that is adjudicated in real time and receive a response in real time detailing payment or denial of the rendered service. This capability allows providers to accurately identify and collect member responsibility based on the finalized claim adjudication results.
CR 1037	Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.

Location	X330 | Health Care Claim Acknowledgment 1.5 Business Terminology
Action	**Add Chapter 1** Section 1.5 Business Terminology Real Time Predetermination/Estimation - allows providers to submit an electronic claim for a proposed service and receive a response in real time detailing the anticipated payment or denial of the proposed service. The response estimates the payment and member responsibility based on the current point in time and the data submitted for the proposed service. This capability allows providers to identify potential member responsibility and set patient financial expectations prior to a service.
CR 1037	Incorporate Real Time instructions, based on the Real Time TR2) in the 835 and 277CA.

Location	X330 | Health Care Claim Acknowledgment 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	X330 | Health Care Claim Acknowledgment 1.7 Related Transactions
Action	**Modify Chapter 1** 1.7.1 The Claim (837), paragraph 1. Changed to:

	Submitting a claim using the 837 format may initiate the creation of the Health Care Claim Acknowledgment (277CA) transaction. The 277 Health Care Claim Acknowledgment (277CA) is sent after the 837 transaction was "Accepted" or "Accepted with Errors" by the 999 Implementation Acknowledgement. A 277CA will not be sent if the 837 transaction was rejected in the 999. The 277CA transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.
CR 372	Section 1.7.1 should not definitively state that the 837 initiates a 277, as this is not always the case.

Location	X330 | Health Care Claim Acknowledgment 1.10 Data Overview
Action	**Modify Chapter 1** 1.7.1 The Claim (837), paragraph 1. Changed to: Submitting a claim using the 837 format may initiate the creation of the Health Care Claim Acknowledgment (277CA) transaction. The 277 Health Care Claim Acknowledgment (277CA) is sent after the 837 transaction was "Accepted" or "Accepted with Errors" by the 999 Implementation Acknowledgement. A 277CA will not be sent if the 837 transaction was rejected in the 999. The 277CA transaction provides confirmation that the receiver has received the claim file and will process or forward the accepted claims on for adjudication. This transaction is instrumental in tracking claim submissions through to payer adjudication.
CR 372	Section 1.7.1 should not definitively state that the 837 initiates a 277, as this is not always the case.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0200 BHT - Beginning of Hierarchical Transaction
Action	**Add Data Element Note** 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	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000A HL - Information Source Level
Action	**Modify Segment Note** TR3 Note Change To: This entity is the decision maker in the business transaction.
CR 1153	To clarify intended use.

Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100A NM1 - Information Source Name
Action	**Add Data Element Code Value** TU - Third Party Repricing Organization (TPO).
CR 737	Add Repricer functionality.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100A NM1 - Information Source Name
Action	**Delete Data Element Code Note** Loop ID 2100A/NM108 Identification Code Qualifier 46 - Electronic Transmitter Identification Number (ETIN) "This number is used for entities identified in translation software typically called "Trading Partner Profiles". It is used for non-health plan entities."
CR 1563	Format code notes consistently.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000B HL - Information Receiver Level
Action	**Add Data Element Code Note** Loop ID 2000B/HL01 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Add Data Element Code Value** PTP - Pay to Plan Name.
CR 378	Add Pay to Plan at the Information Receiver level.
Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Modify Data Element Code Note** Loop ID 2200B/STC03 Action Code Code Value: WQ - Accept

	Changed to "Use when code value "U" is not used. At least one subordinate HL loop must be reported. Acceptance at this level does not mean all claims have been accepted for processing."
CR 1563	Format code notes consistently.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200B STC - Information Receiver 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	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200B STC - Information Receiver Status Information
Action	**Add Data Element Note** Loop ID 2200B / STC04 (Total Submitted Charges for Unit of Work) Monetary Amounts returned in this element may exceed 10 characters.
CR 1510	Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200B QTY - Total Accepted Quantity
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200B/QTY For QTY segment balancing, see Section 1.4.5 (Balancing)
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200B QTY - Total Rejected Quantity
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200B/QTY For QTY segment balancing, see Section 1.4.5 (Balancing)
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

Location	X269 | Health Care Claim Acknowldgement STC - Billing Provider Status Information
Action	**Delete Segment** Loop ID 2200C / STC (Billing Provider Status Information)
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Accepted Amount
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200B/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Accepted 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	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Accepted Amount
Action	**Add Data Element Note** Loop ID 2200B / AMT02 (Total Accepted Amount) Monetary Amounts returned in this element may exceed 10 characters.
CR 1510	Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Rejected Amount
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200B/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).

CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Rejected 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	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200B AMT - Total Rejected Amount
Action	**Add Data Element Note** Loop ID 2200B / AMT02 (Total Rejected Amount) Monetary Amounts returned in this element may exceed 10 characters.
CR 1510	Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.
Location	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000C HL - Billing Provider Level
Action	**Modify Segment Note** CHANGE TO: This loop may be used to provide totals and amounts by billing provider or when a secondary provider identifier needs to be reported in the Provider Secondary REF segment.
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.
Location	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000C HL - Billing Provider Level
Action	**Add Data Element Code Note** Loop ID 2000C/HL01 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	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100C NM1 - Billing 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	X330 | Health Care Claim Acknowledgment | 277 | 0900 | 2200C TRN - Provider of Service Trace Identifier
Action	**Modify Segment Situational Rule** Changed To: Required when 2200C Loop is used to provide totals and amounts by billing provider or a secondary provider identifier needs to be reported in the Provider Secondary REF segment. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200C QTY - Total Accepted Quantity
Action	**Modify Segment Note** Loop ID 2200C / QTY (Total Accepted Quantity) Changed to: The purpose of this segment is to report the total number of claims accepted to the adjudication process by the Information Source for the Billing Provider in this acknowledgment.
CR 1153	To clarify intended use.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200C QTY - Total Accepted Quantity
Action	**Modify Segment Situational Rule** Changed to "Required when reporting totals for a specific billing provider and

	at least one claim is accepted. If not required by this implementation guide, do not send."
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200C QTY - Total Accepted Quantity
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200C/QTY For QTY segment balancing, see Section 1.4.5 (Balancing)
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200C QTY - Total Rejected Quantity
Action	**Modify Segment Situational Rule** Changed to "Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send."
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1210 | 2200C QTY - Total Rejected Quantity
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200C/QTY For QTY segment balancing, see Section 1.4.5 (Balancing)
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Accepted Amount
Action	**Modify Segment Situational Rule** Changed to "Required when reporting totals for a specific billing provider and at least one claim is accepted. If not required by this implementation guide, do not send."
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Accepted Amount

Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200C/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Accepted 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	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Accepted Amount
Action	**Add Data Element Note** Loop ID 2200C / AMT02 (Total Accepted Amount) Monetary Amounts returned in this element may exceed 10 characters.
CR 1510	Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Rejected Amount
Action	**Modify Segment Situational Rule** Changed to "Required when reporting the number of claims rejected for a specific billing provider. If zero claims are rejected for the billing provider do not send."
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Rejected Amount
Action	**Add Segment Note** Shared TR3 Note added to Loop ID 2200C/AMT For AMT segment balancing, see Section 1.4.5 (Balancing).
CR 1497	Define balancing requirements for 2200B QTY and AMT to ensure the totals accurately reflect the 277CA data.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Rejected 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	X330 | Health Care Claim Acknowledgment | 277 | 1220 | 2200C AMT - Total Rejected Amount
Action	**Add Data Element Note** Loop ID 2200C / AMT02 (Total Rejected Amount) Monetary Amounts returned in this element may exceed 10 characters.
CR 1510	Expand the allowed length of DE 782, Monetary Amount, as the total claim or encounter charge amounts in an incoming 837 transaction set sometimes exceed the 10 characters allowed per B.1.1.3.1.2 in Appendix B for the data element.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000D HL - Patient Level
Action	**Modify Segment Usage** Change Segment Usage to Required.
CR 379	Support re association of a 'batch' of provider claims within an 837 to a specific Provider Level status (2200C STC) within the 277CA.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0100 | 2000D HL - Patient Level
Action	**Add Data Element Code Note** Loop ID 2000D/HL01 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	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100D NM1 - Patient 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	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100D NM1 - Patient Name
Action	**Modify Data Element Usage** Changed NM108 from Required to Situational.
CR 1386	Consistency across all guides.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100D NM1 - Patient Name
Action	**Modify Data Element Usage** Changed NM109 from Required to Situational.
CR 1386	Consistency across all guides.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0500 | 2100D NM1 - Patient Name
Action	**Modify Data Element Situational Rule** Loop ID 2100D NM108 Identification Code Qualifier Changed to "Required when NM109 is used. If not required by this implementation guide, do not send."
CR 1478	Remove duplication of situational rules between the element and the code qualifier across the TR3.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0900 | 2200D TRN - Claim Status Trace Number
Action	**Modify Data Element Industry Name** Replace the Industry Name 'Patient Control Number' with 'Provider's Assigned Claim Identifier.
CR 1154	For consistency across all TR3s.

Location	X330 | Health Care Claim Acknowledgment | 277 | 0900 | 2200D TRN - Claim Status Trace Number
Action	**Modify Segment Note** This segment is the Provider's Assigned Claim Identifier submitted in the 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	X330 | Health Care Claim Acknowledgment | 277 | 0900 | 2200D TRN - Claim Status Trace Number
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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200D STC - Claim Level Status Information
Action	**Modify Data Element Usage** Loop ID 2200D / STC12 (Free-form Message Text) Changed to NOT USED
CR 1229	Data element usage change is required to meet industry needs.

Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1000 | 2200D 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1100 | 2200D REF - Payer Claim Control Number
Action	**Modify Segment Situational Rule** Loop ID 2200D REF - Payer Claim Control Number TO: Required when Loop ID 2100A NM101 value is PR and the claim has been accepted for adjudication. If not required by this implementation guide, maybe provided at the sender's discretion but cannot be required by the receiver.
CR 1121	Requiring the payer claim number to be returned on the 277CA for accepted claims, would allow providers to improve front-end automation and would support downstream processes.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1100 | 2200D REF - Repriced Claim Number
Action	**Add Segment** Loop ID 2200D REF - Repriced Claim Number
CR 737	Add Repricer functionality.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1100 | 2200D REF - Property & Casualty Claim Number
Action	**Add Segment** Loop ID 2200D REF - Property & Casualty Claim Number
CR 385	Support the Property and Casualty industry need for a P&C Claim Number.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1100 | 2200D REF - EDI Control Number
Action	**Add Segment** Loop ID 2200D REF - EDI Control Number
CR 382	Some payers use EDI Control Number when a Payer Claim ID has not been assigned. Add support for this identifier to the 277.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1200 | 2200D DTP - Service Date
Action	**Modify Segment Usage** Change usage from Required to Situational.
CR 383	Change the usage requirement for the Claim Level Claim Date of Service DTP to situational to support predeterminations.

Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1200 | 2200D DTP - Date of Illness/Injury/Accident
Action	**Add Segment** Loop ID 2200D DTP - DATE OF ILLNESS/INJURY/ACCIDENT
CR 387	277 Response: Support the Property and Casualty industry need for Corrected Date of Illness and Date of Accident.
Location	X330 | Health Care Claim Acknowledgment | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Add Data Element Situational Rule** "Required if submitted on the original claim service line. If not required by this implementation guide, do not send."
CR 384	Revise the SVC01 as necessary to accommodate more than 4 modifiers.
Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1800 | 2220D SVC - Service Line Information
Action	**Add Data Element Note** SVC07 Original 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Usage** STC12 Changed to Not Used.
CR 1229	Data element usage change is required to meet industry needs.

Location	X330 | Health Care Claim Acknowledgment | 277 | 1900 | 2220D STC - Service Line Status Information
Action	**Modify Data Element Code Value** Loop ID 2220D / 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 2000 | 2220D REF - Line Item Control Number
Action	**Add Segment Situational Rule** Required when a Service Line Item Control Number was submitted on the claim. If not required by this implementation guide, do not send.

CR 394	Make a decision on the usage requirement for the Line Item Control Number (required or situational) and apply the decision consistently across the TR3s.
Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 2000 | 2220D REF - Pharmacy Prescription Number
Action	**Add Data Element Note** This is the Pharmacy Prescription Number submitted in the 2410 REF02 from the 837 claim.
CR 1153	To clarify intended use.
Location	X330 | Health Care Claim Acknowledgment | 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	X330 | Health Care Claim Acknowledgment | 277 | 2150 | 2220D TOO - Tooth Information
Action	**Add Segment** Loop ID 2220D TOO - TOOTH INFORMATION
CR 1516	For consistency across guides.