Standard Companion Guide

Refers to the Implementation Guide

Based on X12 Version 005010X212

Health Care Claim
Status Request and Response

(276/277)

Companion Guide Version Number 6.0

August 31, 2022

Change Log

Version	Release date	Changes
1.0	10/14/2010	Initial Creation
1.1	11/16/2010	Updated BK review comments
1.2	12/16/2010	Updated whole document (formatting per CORE)
2.0	01/05/2011	Updated section 6.
2.1	06/22/2011	Update to section 6 page 16 Dependent Loop clarification
3.0	11/06/2017	Updated applicable UnitedHealthcareOnline references to UHCprovider.com and updated Optum contact information.
4.0	6/12/2018	Updates to section 4.4 Applicable Websites and section 6 Payer Specific Business Rules and Limitations historical search criteria
5.0	09/09/2020	Update Table in section 1. Introduction Update 1.3 Reference Change Diagram in section 3.1 Update Table in section 9. Transaction Specific Information
6.0	08/31/2022	Updated Post N Track URLs Updated EDI 276/277 URL Updated Optum contact information and URLs Updated EDI Support Form URL Updated Loop for Reference ID in Table for Group number in sections 1 & 9 Added Payer ID 06111 to section 9.1

PREFACE

This companion guide (CG) to the Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare Oxford. Transactions based on this companion guide, used in tandem with the TR3, also called 276/277 Health Care Claim Status Request and Response ASC X12N (005010X212), are compliant with both X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in theTR3.

Table of Contents

1. INTRODUCTION

This section describes how Technical Report Type 3 (TR3), also called 276/277 Health Care Claim Status Request and Response ASC X12N (005010X212), adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has included, in addition to the information contained in the TR3s. That information can:
1.   Limit the repeat of loops, or segments
2.   Limit the length of a simple data element
3.   Specify a sub-set of the TR3's internal code listings
4.   Clarify the use of loops, segments, composite, and simple data elements
5.   Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe usage for composite and simple data elements and for any other information for UnitedHealthcare Oxford. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The table below specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare Oxford has included, in addition to the information contained in the TR3s.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides:

TR3 Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
56	2100D	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
57	2100D	NM103	Last Name or Organization Name		60	This type of row exists to limit the length of the specified data element.
62	2200D	REF	Group Number			
62	2200D	REF01	Reference Identification Qualifier	6P		This is the only code accepted by OHP as per the Implementation Guide
65	2200D	REF	Claim Identification Number For Clearinghouses And Other Transmission			This row illustrates how to indicate a component data element in the Reference column and also how to
			Intermediaries			specify that only one code value is applicable.
65	2200D	REF01	Reference Identification qualifier	D9		Claim Number

1.1. SCOPE

This document is to be used for the implementation of the Technical Report Type 3 (TR3) HIPAA 5010 276/277 Health Care Claim Status Request and Response for the purpose of submitting claims inquiries electronically. This companion guide (CG) is not intended to replace the TR3.

1.2. OVERVIEW

This CG will replace, in total, the previous UnitedHealthcare Oxford CG versions for 276/277 Health Care Claim Status Request and Response and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing claims inquiries transactions that meet OHP processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide occur periodically and available at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange (EDI) > Companion Guides: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html

In addition, all trading partners will receive an email with a summary of the updates and a link to the new documents posted online.

1.3. REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 276/277 Health Care Claim Status Request and Response(005010X212) and to purchase copies of the TR3 documents, consult the Washington Publishing Company website: http://www.wpc-edi.com

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

This companion guide complies to Council for Affordable Health Care (CAQH) is seeking to simplify healthcare administration. CAQH through CORE, (Committee on Operating Rules for Information Exchange) a voluntary organization comprised of providers, health plans, vendors, and clearinghouses, has developed industry rules. These rules seek to increase interoperability between health plans and providers to reduce administrative costs. The rules are being release in phases. CORE has defined methods for connecting to a health plan, details of the connectivity methods can be found on CAQH's website http://www.CAQH.org.

2. GETTING STARTED

2.1. EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE OXFORD

There are three methods to connect with UnitedHealthcare Oxford for submitting and receiving EDI transactions: through Post-n-Track, Optum or another clearinghouse.

Post-n-Track Connection

To register with Post-n-Track for UnitedHealthcare Oxford's UnitedHealthcare Oxford's Claim Status Request and Response transaction visit https://www.pntdata.com/ or call 860-257-2030.

CAQH CORE Connectivity or Clearinghouse Connection

Council for Affordable Health Care (CAQH) is seeking to simplify healthcare administration.
CAQH through CORE, (Committee on Operating Rules for Information Exchange) a voluntary organization comprised of providers, health plans, vendors and clearinghouses, has developed industry rules. These rules seek to increase interoperability between health plans and providers to reduce administrative costs. The rules are being release in phases. CORE has defined methods for connecting to a health plan, details of the connectivity methods can be found on CAQH's website http://www.CAQH.org.

Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct. Optum partners with providers to deliver the tools that help drive administrative simplification at minimal cost and realize the benefits originally intended by HIPAA — standard, low-cost claim transactions. For more information visit IEDI Market Brochure

If interested in using Optum's online solution, Intelligent EDI (IEDI), contact the IEDI Support Team at 866-678-8646, or visit Optum Business Support .

2.2. CERTIFICATION AND TESTING WITH UNITEDHEALTHCARE OXFORD

The Claim Status Request and Response transaction and does not result in any data changing upon completion therefore test transactions (ISA15 value of "P") with production data can be sent to our production environment without any negative impact. The ISA15 value must be "P" for production.

Post-n-Track:

Physicians and health care professionals should contact their current clearinghouse vendor to discuss testing.

Clearinghouse Connection:

Physicians and health care professionals should contact their current clearinghouse vendor to discuss testing or Optum.

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOWS

Real-Time Claim Status Request and Response:

The response to a real-time claim status transaction will consist of:
1. First level response - TA1 will be generated when errors occur within the envelope.
2. Second level response - 999 if the submitted 276 failed compliance checks.
3. Third level response - 277 response indicating the claims status OR STC segment indicating the nature of the error.
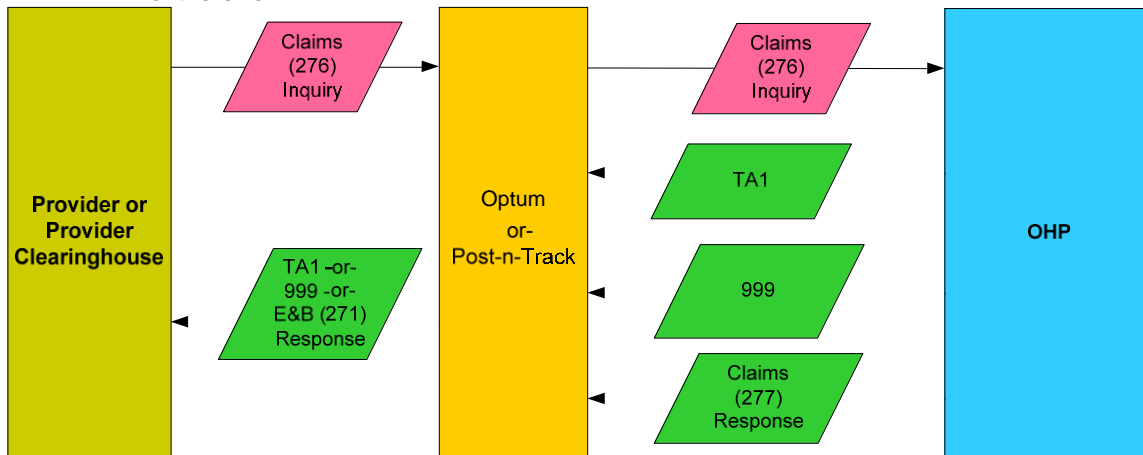
Each transaction is validated to ensure that the 276 complies with the 005010X212. Transactions which fail this compliance check will generate a real-time 999 message back to the sender with an error message indicating that there was a compliance error. Transactions that pass compliance checks, but failed to process (e.g. due to member / provider not being found) will generate a real-time 277 response transaction including an STC 01 (D0, E) segment indicating the nature of the error. Transactions that pass compliance checks and have do not generate STC 01 (D0, or E0, /508/Entity) segment indicating the nature of the error. See the list in section 10.5

3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

UnitedHealthcare Oxford supports both batch and real-time 276/277 transmissions. Contact your current clearinghouse vendor discuss transmission types and availability.

3.3. RE-TRANSMISSION PROCEDURE

Please follow the instructions within the 277 STC 01 (D0, E) data segment for information on whether resubmission is allowed or what data corrections need to be made in order for a successful response.

3.4. COMMUNICATION PROTOCOL SPECIFICATIONS

Post-n-Track:

Physicians and Healthcare professionals should contact Post-n-Track for more information on the supported communication protocols.

Clearinghouse Connection:

Physicians, facilities, and health care professionals should contact their current clearinghouse for communication protocols with UnitedHealthcare Oxford.

3.5. PASSWORDS

Post-n-Track:

Physicians and Healthcare professionals should contact Post-n-Track for information regarding passwords.

Clearinghouse Connection:

Physicians, facilities, and health care professionals should contact their current clearinghouse vendor to discuss password policies

3.6. SYSTEM AVAILABILITY

Normal business hours: Monday - Friday, 5 am to 9 pm CST
Weekend hours: Saturday - Sunday, 5 am to 6 pm CST (exceptions may occur)

UnitedHealthcare Oxford systems may be down for general maintenance and upgrades. During these times, our ability to process incoming 276/277 EDI transactions may be impacted. The codes returned in the AAA segment of the 271 responses will instruct the trading partner if any action is required.

In addition, unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming 276 transactions. UnitedHealthcare will send an email communication for scheduled and unplanned outages.

3.7. COSTS TO CONNECT

Post-n-Track Connection:

Contact Post-n-Track for information on cost.

Clearinghouse Connection:

Physicians, facilities, and health care professionals should contact their current clearinghouse vendor or Optum to discuss costs.

Optum:
- Optum Support – 1-866-678-8646 (1-866-OPTUMGO)
- Optum's online solution, Intelligent EDI (IEDI),
- Optum's Claim Integrity Healthcare Claims Integrity (optum360.com) or,
- Visit Optum Business Support

4. CONTACT INFORMATION

4.1. EDI SUPPORT

Most questions can be answered by referring to the EDI section of our resource library at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange (EDI): https://www.uhcprovider.com/en/resource-library/edi.html. View the EDI 276/277 page for information specific to 276/277 Claim Status Request and Response transactions.

If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 277/277 or invalid data in the 277 responses, please contact EDI Support by:
- using our EDI Transaction Support Form,
- sending an email to supportedi@uhc.com or
- calling us at 800-842-1109

For questions related to submitting transactions through a clearinghouse, please contact your clearinghouse or software vendor directly.

4.2. EDI TECHNICAL ASSISTANCE

Clearinghouse
When receiving the 277 from a clearinghouse, please contact the clearinghouse for EDI technical assistance.

UnitedHealthcare EDI Issue Reporting
If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 270/271 or invalid data in the 271 response, please contact EDI Support by using our EDI Transaction Support Form, sending an email to supportedi@uhc.com or call us at 800-842-1109.

4.3. PROVIDER SERVICES

Provider Services should be contacted at 877-842-3210 instead of EDI Support if you have questions regarding the details of a member's benefits. Provider Services is available Monday - Friday, 7 am - 7 pm in the provider's time zone.

4.4. APPLICABLE WEBSITES / E-MAIL

CAQH CORE – http://www.caqh.org

Companion Guides: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html

Optum: https://www.optum.com/

Optum EDI Client Center - https://optumprovider.optum.com/

UnitedHealthcare Administrative Guide: https://www.uhcprovider.com/en/admin-guides.html

UnitedHealthcare EDI Support: supportedi@uhc.com or EDI Transaction Support Form

UnitedHealthcare EDI Education website: https://www.uhcprovider.com/en/resource-library/edi.html

Washington Publishing Company: http://www.wpc-edi.com

5. CONTROL SEGMENTS / ENVELOPES

5.1. ISA-IEA

Transactions transmitted during a session are identified by interchange header segment (ISA) and trailer segments (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission and provides sender and receiver identification.

The below table represents only those fields that UnitedHealthcare Oxford requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction the TR3 should be reviewed for that information.

TR3 Page#	Loop ID	Reference	NAME	Codes	Notes/Comments
C.3	None	ISA	ISA Interchange Control Header		
C.5		ISA08	Interchange Receiver ID	**061118515**	OHP Payer ID -Right pad as needed with spaces to 15 characters.
C.6		ISA15	Usage Identifier	**P**	Code indicating whether data enclosed is production or test.

5.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in a transmission may vary.

The below table represents only those fields that UnitedHealthcare Oxford requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

TR3 Page#	Loop ID	Reference	NAME	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		Required Header
C.7		GS03	Application Receiver's Code	**061118515**	UnitedHealthcare Oxford Payer ID Code
C.8		GS08	Version / Release / Industry Identifier Code	**005010X212**	Version expected to be received by UnitedHealthcare Oxford.

5.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. A 276 file can only contain 276 transactions.

The below table represents only those fields that UnitedHealthcare Oxford requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

TR3 Page #	Loop ID	Reference	NAME	Codes	Notes/Comment s
70	None	ST	Transaction Set Header		Required Header
		ST03	Implementation Convention Reference	**005010X212**	Version expected to be received by UnitedHealthcare Oxford

5.4. CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment GS - Functional Group Header segment

ST - Transaction Set Header segment

276 Transaction

SE - Transaction Set Trailer segment GE - Functional Group Trailer segment

IEA - Interchange Control Trailer segment

5.5. CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled with space.

- The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
- The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
- ISA16 defines the component element

5.6. FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 270 files. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Please contact UnitedHealthcare if there is a need to use a delimiter other than the following:

1. Data Segment: The recommended data segment delimiter is a tilde (~)
2. Data Element: The recommended data element delimiter is an asterisk (*)
3. Component Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a carrot (^)**.**

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1. 276 REQUEST

1. **Primary Search Criteria** (keys) that are required on the claims inquiry: Primary Keys[1] are:
   a. Provider ID (Loop 2000C)
   b. Patient ID (Loop 2000D)
   c. Patient/Member Last Name, First Name, DOB
   d. DOS (single or range, from Claim or Line level)
2. **Search Filters:**
   a. Use Payer Claim Control Number (ICN) to search for a **specific claim**
   b. Use Claim Total Charges to search for a **specific claim**
   c. Use Provider Org/Last Name, First Name to search for claims for a **specific provider.**
   d. Use a date range along with the Primary Keys to search for **multiple** claims
   e. Notes: All other situational criteria will be ignored. When ICN, Claim Total Charges and Provider Name information is used, an *exact match* against a claim is required.
3. Provider:
   Identification Code Qualifiers supported:
   a. **FI** = Federal Taxpayer's Identification Number (FTIN)
   b. **SV** = Service Provider Number (Oxford ID)
   c. **XX** = Centers for Medicare and Medicaid Services National Provider Identifier (NPI)
   d. The provider identified can be either the Billing/Group or Rendering provider. Provider Name (Org/Last Name and First Name) can be submitted as a filter.
4. Member/Patient:
   Identification Code Qualifiers supported
   a. **MI =** Member Identification Number
   b. UnitedHealthcare Oxford members have a unique ID. Therefore, the patient is considered to be the subscriber. When the patient is the subscriber, or a dependent with a unique
   c. Identification number, the claim status request information can be sent in Loop 2200D under the Subscriber HL, 2000D Loop (HL03 = 22).
   d. **The Dependent HL, 2000E Loop should not be submitted.**
5. **Dates of Service:**

a. Claims status requests will be checked for **claim level dates**. If present on the 276 inquiry the claim level dates will be used in searches for the claims being returned on the claims response.
b. If claim level dates are **not** present on the 276 inquiry, **service line dates** will be used to in the search for the claims being returned on the claims response. A date range will be derived based on the **earliest** and **latest** service line dates.
c. Both **single** date and date **range** (from & to) will be supported for the claims search transaction at claims or service line level.
d. A Maximum date range of **31 days** will be allowed for the claims inquiry 276 on the searches. Date ranges must have an end date no greater than 31 days from the start date.
e. A date range that **exceeds the maximum date 31 days** will be truncated to 31 days: Ex: From date = **Jan 1st**, add 31 days would make the Thru Date = **Feb 1st**.
f. A Maximum history of **18 months** will be supported for the claims inquiry 276 on the searches from the date the claims transaction is being inquired. Date range / single date inquiries must have a start date **no greater than 18 months in the past** and the end date must be no greater than the current date.
g. Any search that **exceeds the maximum date 31 days** or date range or history of 18 months from current date (date of inquiry) will be rejected.

6. When claims are not found (search = no claims, or error transaction) return the information submitted in the 276 Request when required. For error situations, this will depend on the level the error occurs in the transaction. See section **10.5** for details.

6.2. 277 RESPONSE

Disclaimer: Information provided in 277 responses is not a guarantee of payment for the claims that have not been finalized. Actual payments depend on various factors,
including compliance with applicable administrative protocols; date(s) of services rendered and benefit plan terms and conditions.

For a successfully processed 276 requests, the 277 responses will return: Provider information **as-submitted** in the 276 Request.
Patient information **as-validated** in Oxford's system. Patient information will always be returned in **LOOP ID - 2000D SUBSCRIBER LEVEL.** LOOP ID - 2000E DEPENDENT LEVEL is not returned.
Claim information as found on the claim record in the Oxford system (Patient Control Number, Bill Type, Service Line Information, etc.)
When the remittance cycle is complete for the claim(s), the Remittance Trace Number and Remittance Date. The remittance information allows the provider to
identify the check or EFT number, and the date of issuance. Loop 2200D and 2200E STC will contain this information.
Reporting of Service Line Units: For claims where decimal units are submitted, the 277 responses will contain rounded units when claims are found.
Claims response can include Entity Code Identifiers at both the Claim and Service Line levels.

1. ACKNOWLEDGEMENTS AND OR REPORTS

7.1. REPORT INVENTORY

None identified at this time.

2. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

An EDI Trading Partner is defined as any UnitedHealthcare customer (provider, billing service, software vendor, clearinghouse, employer group, financial institution, etc.) that transmits to, or receives electronic data from UnitedHealth Group.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party

to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

3. TRANSACTION SPECIFIC INFORMATION

This section describes how TR3's adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has something additional, over and above, the information in the TR3's. That information can:
1. Limit the repeat of loops or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the implementation guide's internal code listings
4. Clarify the use of loops, segments, composite, and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare Oxford's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that UnitedHealthcare has included, in addition to the information contained in the TR3s.

TR3 Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
56	2100D	NM1	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
57	2100D	NM103	Last Name or Organization Name		60	This type of row exists to limit the length of the specified data element.
62	2200D	REF	**Group Number**			
62	2200D	REF01	Reference Identification Qualifier	6P		This is the only code accepted by OHP as per the Implementation Guide
65	2200D	REF	**Claim Identification Number For Clearinghouses And Other Transmission Intermediaries**			This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.
65	2200D	REF01	Reference Identification qualifier	D9		Claim Number

9.1 CLAIM STATUS REQUEST AND RESPONSE: 276 (05010X212)

The below table represents only those fields that UnitedHealthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction the TR3 should be reviewed for that information.

TR3 Page #	Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
Payer Information -> NM1*PR*2*OHP*****PI*061118515~					

41	**2100A**	NM1	Information Source Name		
41		NM101	Entity Identifier Code	PR	Used to identify organizational entity. Ex. PR = Payer
41		NM102	Entity Type Qualifier	2	Used to indicate entity or individual person. Ex. 2 = Non-Person Entity
41		NM103	Name Last or Organization name		Used to specify subscribers last name or organization name. Ex. OHP
42		NM108	Identification Code Qualifier	PI	Used to qualify the identification number submitted. Ex. PI = Payor Identification
42		NM109	Identification Code		Used to specify primary source information identifier The changes will apply to commercial and government business for UnitedHealthcare Oxford: **061118515 or 06111** Ex. **061118515** *Interpretation:* Payer ID – **061118515**

Claims – Date Of Service Validation					
Claim level – Range of dates -> DTP*472*RD8*20090101-20090131!					
67	**2200D(E)**	DTP	Claim service Date		
67		DTP01	Date/Time Qualifier	472	Used to identify 472 Service
67		DTP02	Date Time Period Format Qualifier	RD8	Used to indicate Range of Dates "To and From" Expressed in Format CCYYMMDDCCYYMMDD
67		DTP03	Date Time Period	20090101-20090131	Used to specify Claim Service Period **OHP Rule:** Maximum date range of **31 days** will be allowed for the claims inquiry 276 on the searches. Date range must have an end date no greater than 31 days from the start date. A date range that **exceeds the maximum date 31 days** will be truncated to 31 days. **OHP Rule:** Maximum history of 18 months will be supported for the claims inquiry 276 on the searches from the date the claims transaction is being inquired. Date range / single date inquiries must have a start date **no greater than 18 months in the past** and the end

Service Line level – Date Of Service validation					
Line level - Range of dates -> DTP*472*RD8*20090101-20090131!					
74	**2210D(E)**	DTP	Service Line date		
74		DTP01	Date/Time Qualifier	472	Used to identify 472 Service
74		DTP02	Date Time Period Format Qualifier	RD8	Used to indicate Range of Dates "To and From" Expressed in Format CCYYMMDDCCYYMMDD

74		DTP03	Date Time Period	20090101-20090131	Used to specify Claim Service Period
					If claim level (2200D loop) dates are not present (logic: checks for dates at service level (2210D loop) and selects earliest and latest dates. **OHP Rule:** Maximum date range of **31 days** will be allowed for the claims inquiry 276 on the searches. Date range must have an end date no greater than 31 days from the start date. A date range that **exceeds the maximum date 31 days** will be truncated to 31 days. **OHP Rule:** Maximum history of **18 months** will be supported for the claims inquiry 276 on the searches from the date the claims transaction is being inquired. Date range / single date inquiries must have a start date **no greater than 18 months in the past** and the end date must be no greater than the current date.

10. APPENDICES

10.1. IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection. However, a basic check list would be to:

1. Register with Trading Partner
2. Create and sign contract with trading partner
3. Establish connectivity
4. Send test transactions
5. If testing succeeds, proceed to send production transactions

10.2. FREQUENTLY ASKED QUESTIONS

1. **Does this Companion Guide apply to all UnitedHealthcare payers?**
   No. It's applicable to UnitedHealthcare Commercial, UnitedHealthcare Community Plan and UnitedHealthcare Medicare and Retirement.

2. **How does UnitedHealthcare Oxford support, monitor and communicate expected and unexpected connectivity outages?**
   Our systems do have planned outages. We will send an email communication for scheduled and unplanned outages.

3. **If a 276 is successfully transmitted to UnitedHealthcare Oxford, are there any situations that would result in no response being sent back?**
   No. UnitedHealthcare Oxford will always send a response. Even if UnitedHealthcare Oxford's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.3. FILE NAMING CONVENTIONS

Error scenarios with STC values from Washington Publishing Company:

#	Scenario	277 Loop STC	STC01-1 (DO or E - 507)	STC01-2 508 codes	Entity STC01-3		STC10-1 (DO or E - 507)	STC10-2 508 codes	Entity STC 10-3	
1	Provider Not Found (No match - Commercial ID)	LOOP ID - 2200C	DO	135	1P					
2	Provider Not Found (No match - Commercial ID) No subscriber/DOS errors	LOOP ID - 2200D	DO	135	1P					
3	Provider Not Found (No match - Tax ID)	LOOP ID - 2200C	DO	128	1P					
4	Provider Not Found (No match - Tax ID) No subscriber/DOS errors	LOOP ID - 2200D	DO	128	1P					
5	Provider Not Found (No match - NPI ID)	LOOP ID - 2200C	DO	562	1P					
6	Provider Not Found (No match - NPI ID) No subscriber/DOS errors	LOOP ID - 2200D	DO	562	1P					
7	Provider Not Found (No match -L Name)	LOOP ID - 2200C	DO	125	1P					
8	Provider Not Found (No match -L Name) No subscriber/DOS errors	LOOP ID - 2200D	DO	125	1P					
9	Provider Not Found (No match -F Name)	LOOP ID - 2200C	DO	125	1P					
10	Provider Not Found (No match -F Name) No subscriber/DOS errors	LOOP ID - 2200D	DO	125	1P					
11	Subscriber Not Found (No match Sub ID)	LOOP ID - 2200D	DO	33						
12	Subscriber Not Found (Member ID Code Qualifier of 24 entered)	LOOP ID - 2200D	DO	33						
13	Subscriber Not Found (No match Sub ID) Claim not found (Claim DOS - From date is greater than 18 months from system date. (History))	LOOP ID - 2200D	DO	33			DO	187		
14	Subscriber Not Found (Member ID Code Qualifier of 24 entered) Claim not found (Claim DOS - From date is greater than 18 months from system date. (History))	LOOP ID - 2200D	DO	33			DO	187		
15	Claim not found (Claim DOS - From date is greater than 18 months from system date. (History))	LOOP ID - 2200D	DO	187						

16	Claim not found (Claim DOS - No match)	LOOP ID - 2200D	DO	187						
17	Claim not found (Total Billed Amount (Original Claim Total Charges) does not match)	LOOP ID - 2200D	DO	178						
18	Claim not found (Payer Assigned Control Number does not match)	LOOP ID - 2200D	DO	464						
19	Level 5 Code Set Errors: Invalid Bill Type	LOOP ID - 2200D	DO	228						
23	Level 5 Code Set Errors: Invalid Modifier	LOOP ID - 2200D	DO	453						
24	Level 5 Code Set Errors: Invalid Procedure Code	LOOP ID - 2200D	DO	454						
25	Level 5 Code Set Errors: Invalid Revenue Code	LOOP ID - 2200D	DO	455						