Standard Companion Guide

Refers to the Implementation Guide

Based on X12 Version 005010X217

Request for Review and Response

(278)

Companion Guide Version Number 11.0

October 14, 2021

Reviewed 10/20/23

CHANGE LOG

Version	Release Date	Changes
1.0		Initial External Release
2.0	9/4/2011	Section 10.4 error codes and interpretations have been updated, please refer to the MSG segment for information on why the transaction has rejected. • New (loop, AAA03/AAA04) – 2000A 41/N – 2010A 42/Y – 2010B 44/C – 2010B 79/N – 2010C 67/N – 2010C 68/C – 2010C 72/C – 2010D 68/C – 2010D 95/N – 2010EA 44/C – 2010EA 33/N – 2010FA 15/C – 2010FA 33/C – 2010FA 33/N – 2010FA 43/C – 2010FA 44/C – 2010FA 46/C – 2010FA 47/C • Eliminated (loop, AAA03/AAA04) – ISA15 41/C (moved to 2010A 41/N) – BHT02 41/N (moved to 2010A 41/N) – 2010A 79/N (moved to 2010B 79/N) – 2010B 79/C – 2010D 78/N – 2010EA 97/C (moved to 33/C?) – 2000F 95/N – 2000F AA/N – 2010F 15/C (moved to 2010FA 15/C) – 2010F 43/C – 2010F 46/C (moved to 2010FA 46/C) – 2010F 47/C (moved to 2010FA 47/C) – 2010F 51/C – 2010F 79/C – 2010F 97/C • Modified – 2010A 42/N (changed to 42/Y)

2.1	2/17/2012	Section 6.1 and 6.5 – Payer Specific Rules and Limitations • Added new rule stating: Community & State plans in Connecticut, Rhode Island, Florida and Louisiana may not submit updates to add additional Procedure codes for a previously submitted 278. Please submit additional Procedure codes using a new 278 or contact the number on the back of the patient's Medical ID card for further assistance. Section 10.3 – Business and Transaction Examples • Case 1: Added a row for MSG01. • Case 3 split into 3a & 3b to show examples of different types of blocking scenarios. • Case 3: Removed HCR03 row. Section 10.4 – Error Codes and Interpretations • 2010C 78/N error description changed from "Subscriber Not in Group/Plan Identified" to "Subscriber not currently supported for 278 transactions" • 2010C 78/N trading partner action changed from "Please call the phone number on the back of the member's card" to "Review message in 2000E-MSG01 for instructions". • Removed 2010C 78/N "Message will be variable depending on policy." • Added 2000E 33/N Case/Service Block • Added 2000F 33/N Case/Service Block
2.2	8/29/2012	Section 6.1 – Payer Specific Rules and Limitations • Added: Please do not submit both ICD9 and ICD10 diagnosis codes on the same authorization. Section 10.4 – Error Codes and Interpretations • Added 2000E 33/C Mixed Diagnosis Code Type Not Supported
3.0	11/22/2013	Section 3.1 – Process flows • Added: It is also possible for another separate 278 AUTH response transaction to be returned if the initial request incurred a time out situation and the first 278 sent was identifying that we were unable to respond at the current time. • Added IMPORTANT NOTE: The time out response will be sent back in batch mode, therefore, anyone setting up a 278-authorization real-time transaction will need to set up a batch connection also. Section 6.1 – Payer Specific Business Rules – 278 Request • Added information to send radiology and cardiology codes to CareCore National Section 6.3 – 278 Response • Added IMPORTANT NOTE: The time out response will be sent back in batch mode, therefore, anyone setting up a 278-authorization real-time transaction will need to set up a batch connection also. Section 9.1 – Data Element Grid • Added HI03 through HI12 information in the 2000E loop Section 10.4 – Error Codes and Interpretations • Updated/added/deleted error codes.

4.0	3/21/2014	Section 6.1 – Payer Specific Business Rules – 278 Request • #12 - Added: Transactions received before the service date (prior to 10/1/2014) with ICD-10 code qualifiers will be rejected by UnitedHealthcare. Note: Mandate date for accepting the ICD -10 is set as 10/1/2014.
5.0	11/17/2014	Section 6.1 – Payer Specific Business Rules – 278 Request • #12 – Updated ICD-10 date from 1/2/2014 to 10/1/2015. Section 9.1 – Data Element Grid Request for Review Updated 2010C DMG. • Added 2010D – DMG03 • Removed 2000E DTP Segment • Removed 2000F DTP Segment Section 10.4 – Error Codes and Interpretations • Updated/added/deleted error codes and messages.
6.0	6/30/2015	Section 6.1 – Payer Specific Business Rules – 278 Request • #11 – Removed the words: Connecticut, Florida, Rhode Island and Louisiana from Community and State information. Section 6.3 – Payer Specific Business Rules – 278 Response • Added: Action codes and additional notes under Response tracking numbers. Section 6.4 – Duplicate Processing – Authorizations • If match found, updated to include HCR01 and REF02, deleted REF01. • If no match found, added 2000F and removed REF01. Section 6.5 – Update Processing – Authorizations • #4 – Updated verbiage for both outpatient and inpatient. Removed the word “notification” and added the word “number”. • #5 – Outpatient: Removed the word “notification” and added the word “number”. • Updated verbiage in paragraph following outpatient service note. • Removed Connecticut, Florida, Rhode Island and Louisiana from Community and State information. Section 9.1 – Data Element Grid • 2000F UM02 – Added the words: Prior and Reference. Section 10.3 – Business and Transmission Examples • Case 1 (278 Response Successful) – 2000E REF02 – Added the words (Event SRN) in comment field. – 2000F REF01 – Deleted “BB = Authorization Number” and added “NT = Admin Reference Number” in the comments field. – 2000F REF02 – Added (Service SRN) after reference number in the comments field. • Case 1a – Added: Auth successful in system certified in total • Case 1b – Added: Auth successful in system – delegated vendors • Case 2 (278 Response Error) – 2000E – Added REF01 and REF02 segment and information – 2000F – Added REF01 and REF02 segment and information

		• Case 4 (Request held for Manual Processing)
		  – 2000E – Added REF01 and REF02 segment and information
		  – 2000E – HCR03 changed OW to CT
		  – 2000E – Removed HCR03
		• Case 5 (Duplicate) – Example changed from Notification to Duplicate
		• Case 6 (Updated Authorization)
		  – 2000E – REF01 changed description and comments to "Prior Authorization Reference Number"
		  – 2000E – REF02 changed comment to "Prior Authorization Reference Number"
		Section 10.4 – Error Codes and Interpretations
		Added "Only HS is supported for Authorizations. (2000E UM01) in 2000E loop, AAA03 = 33 and AAA04 =C (internal error code 20379)
		• Removed Error code 20551 (covered under another message)
		• Removed Error code 20274 (covered under another message)
		• Removed Error code 20330 (covered under another message)
		• Removed Error code 20340 (covered under another message)
		• Removed Error code 20383 (covered under another message)
		• Removed the word "notification" from Error Code 20405
		• Added internal B2B error code of 300, 301
		• Added the word Prior to Authorization for 2010EA 41 N internal error code 390
		• Internal error code 509, 2010C 95 N: Changed the error description to Subscriber ID not found from "Patient not Eligible"
		• Internal error code 533, 2010C 58 C and 2010C 73 C: Changed the error description to "Subscriber Date of Birth and Subscriber Last Name Must be Provided on Request" from Invalid/Missing Date of Birth and Invalid/Missing Subscriber/Insured Name
		• Removed error code 20450 (covered under 20454 message)

7.0	10/1/2015	Section 1.2 – Overview • Updated links Section 2.1 – Connectivity with UnitedHealthcare • Removed "Direct Connection" and "Connectivity Director" Section 2.2 – Trading Partner Registration • Removed "Direct Connection to UnitedHealthcare and Connectivity Director" • Under Clearinghouse connections, added option 2 and website. Section 2.4 – Testing with UnitedHealthcare • Removed "Direct Connection" to UnitedHealthcare and Connectivity Director • Added phone number and website to clearinghouse section. Section 3.2 – Transmission Administrative Procedures • Removed Direct Connect and Connectivity Director information Section 3.4 – Communication Protocol Specifications • Removed Direct Connect and Connectivity Director information Section 3.5 – Passwords • Removed Direct Connect and Connectivity Director information

		Section 3.6 – Cost to Connect • Updated paragraph to Optum Insight Solution. Removed Connectivity Director Section 4.1 – EDI Customer Service • Updated links and removed Direct Connect and Connectivity Director information Section 4.2 – EDI Technical Assistance • Removed Direct Connect and Connectivity Director Information. Updated clearinghouse wording. Section 4.4 – Applicable Websites/email • Updated links, and removed Connectivity Director and EDI support information Section 6.1 – Payer Specific Business Rules – 278 Request • #11 – Changed the wording to UnitedHealthcare Community Plan from Community and State • #13 – Added the word oncology and the website for reference. Also changed CareCore National to eviCore Healthcare. Section 8 – Trading Partner Agreements • Removed Connectivity Director and Direct Connects Section 9.1 – Data Element Grid – Request for Review • Updated loop 2000E, HI to reflect ICD-10 requirement for date of service 10-1-15
8.0	12/1/2017	Section 1.2 – Overview • Updated information about where companion guides can be found. (Removed uhconline and added uhcprovider.com) Section 2.1 – Connectivity with UnitedHealthcare • Updated connectivity section Section 2.2 – Trading Partner Registration • Updated clearinghouse phone number Section 2.4 – Testing with UnitedHealthcare • Updated phone number Section 3.6 – Cost to Connect • Updated information to reflect IEDI Section 4.1 – EDI Customer Service • Added information about IEDI sales team • Removed UHCOnline and added UHCprovider.com/EDI Section 4.2 – Technical Assistance • Updated phone number under clearinghouse Section 4.4 – Applicable Websites/Email • Updated with UHCprovider.com • Added additional link for authorization and referral pdf Section 6.1 – 278 Request • #6 Removed UHCOnline wording • #12 Removed ICD9 wording • #13 Updated links to the new sites for UHC cardiology, radiology, and oncology

		• #13 Added links for Oxford cardiology, radiology, radiation therapy and oncology • #13 Updated verbiage to include eviCore Oxford number • #13 Updated verbiage to include radiation therapy Section 9.1 – Data Element Grid • Updated to include Oxford payer id 06111 and 061118515 Section 10.4 – Error Codes and Interpretations • Updated, added, and removed error codes Section 10.5 – Frequently Asked Questions • Updated to include Oxford Payer ID 06111 and 061118515
9.0	9/28/2018	Section 2.2 – EDI Support • Updated hyperlink to Intelligent EDI (IEDI) Section 3.8 – Costs to Connect • Updated hyperlink to Intelligent EDI (IEDI) Section 4.1 – EDI Support • Updated hyperlink to EDI 278 page online
10.0	8/3/2020	Minor clarifying changes Section 9 – Data Element Grid • Added 2010C NM109 missing from grid Section 10.4 – Error Codes and Interpretations • Updated and removed error codes
11.0	5/25/2021	Section 6.1 – Payer Specific Business Rules and Limitations • Removed #12 for outdated information. (evicore)
12.0	10/14/2021	Section 6.3 – Genetic Testing Authorizations • Added to include instructions for submission Section 9 – Data Element Grid • Added 2000F MSG

PREFACE

This companion guide (CG) to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with UnitedHealthcare.

Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Services Review – Request for Review and Response (278) ASC X12N/005010X217, are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N 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.

The TR3, also known as X12N Implementation Guide (IG), adopted under HIPAA, here on in within this document will be known as IG or TR3.

Table of Contents

1. INTRODUCTION

1.1 SCOPE

This UnitedHealthcare Companion Guide (CG) is designed to assist those who request reviews for specialty care, treatment, and admission, in addition to those requesting authorizations or certifications using the 005010X217 – Health Care Services Review Information (278) format. This companion guide is not intended to replace the TR3.

1.2 OVERVIEW

This CG will replace, in total, the previous UnitedHealthcare CG versions for Health Care Services Request for Review and Response.

This UnitedHealthcare CG has been written to assist you in designing and implementing Referral and Authorization transactions to meet UnitedHealthcare's processing standards. This CG must be used in conjunction with the Health Care Services Review Request for Review and Response (278) instructions as set forth by the ASC X12 Standards for Electronic Data Interchange (Version 005010X217), May 2006. The UnitedHealthcare CG identifies key data elements from the transaction set that we request you provide to us. The recommendations made are to enable you to more effectively complete Electronic Data Interchange (EDI) transactions with UnitedHealthcare.

Updates to this CG occur periodically, available online and distributed to registered trading partners with reasonable notice, or a minimum of 30 days, prior to required implementation. CG documents are posted in the EDI section of our Resource Library on the Companion Guides page:
https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html
In addition, trading partners can sign up for the Network Bulletin and other online news:
https://uhg.csharmony.epsilon.com/Account/Register

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange (005010X217) Health Care Services Review Information (278) 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.

Please note that this is UnitedHealthcare's approach to the 278 authorization and referral transactions. After careful review of the existing IG for the Version 005010X217, we have compiled the UnitedHealthcare specific CG. We are not responsible for any changes and updates made to the IG.

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH UNITEDHEALTHCARE

UnitedHealthcare exchanges transactions with clearinghouses and direct submitters, also referred to as Trading Partners. Most transactions go through the Optum clearinghouse, OptumInsight, the managed gateway for UnitedHealthcare EDI transactions.

2.2 CLEARINGHOUSE CONNECTION

Physicians, facilities, and health care professionals should contact their current clearinghouse vendor to discuss their ability to support the 278 005010X217 Health Care Services Review Request and Response transaction, as well as associated timeframes, costs, etc. This includes protocols for testing the exchange of transactions with UnitedHealthcare through your clearinghouse.

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.

- Please contact Optum Support at 800-341-6141 to get set up.
- If interested in using Optum's online solution, Intelligent EDI (IEDI), contact the Optum sales team at 866-367-9778, option 3, send an email to IEDIsales@optum.com or visit https://www.optum.com/campaign/fp/free-edi.html.

2.3 CERTIFICATION AND TESTING

All trading partners who wish to submit 278 Authorizations and Referrals to UnitedHealthcare via the ASC X12 278 (Version 005010X217), and receive corresponding EDI responses, must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed.

For testing EDI transactions with UnitedHealthcare, care providers and health care professionals should contact their current clearinghouse vendor or Optum.

3. CONNECTIVITY AND COMMUNICATION PROTOCOLS

3.1 PROCESS FLOW: BATCH 278 HEALTH CARE SERVICE REVIEW ANDRESPONSE

The response to a batch of health care service review inquiry and response transactions will consist of:

1. Submitter submits a 278-batch request.
2. B2B receives a 278-batch request.
3. Validation Map is invoked
4. If there is not valid data in the ISA/IEA or GS/GE segments, then a TA1 is generated and sent back to the submitter.
5. When a batch of 278 transactions is received, the individual transaction within the batch is first checked for format compliance. A 999 Implementation Acknowledgement is created and sent back to the submitter. It will indicate the number of transactions that passed and failed the initial edits. This will be created whether there are format errors or not.
    a. The 999 is created the same business day (20 seconds for real-time, 1 hour for batch processing) the file is submitted, unless a TA1 rejection occurred.
    b. AK2/IK3/IK4 is used as error identification in a data segment and the location of the data segment.

c. IK5 identifies the transaction set response trailer.
d. AK9 indicates the number of transaction sets received and accepted.
e. Any time there are IK3 and IK4 segments in a 999, there is a rejected batch.
f. If there are no IK5 or AK9 segments, there is a problem with the format of the file and file was rejected.

2. Transactions that passed the format validation (good transactions) are then de-batched and processed individually.
3. Transactions that pass the validation edit but fail further on in the processing (for example, ineligible member) will generate a 278-response including an AAA segment indicating the nature of the error (see section 10.4 Error Codes and Interpretations).
4. The de-batch map WTX (Websphere Transformation Extender translation) will convert the 278 file submissions into individual XML request for our clinical area.
5. B2B will process each XML 278 request is separately, in sequential order. This process will continue until all single transaction requests in the batch request are processed. A response is sent back to our B2B area from our clinical area, for each request.
6. WTX converts the response to a 278 X12.
7. WTX map generates the re-batch map.
8. We will hold the individual 278BACK Responses until the entire batch has finished processing and send the 278BACK responses to the submitter (all the response transactions from each of the 278 requests are batched together and sent to the submitter).
9. Provider receives either a 278 response or a 278 response with an AAA error.

3.2 PROCESS FLOW: REAL-TIME 278 HEALTH CARE SERVICE REVIEW ANDRESPONSE

The response to real-time health care service review inquiry and response transactions will consist of:

1. B2B receives a 278-batch request.
2. Submitter submits a 278 real-time request in.
3. B2B receives a 278 real time request via Secure HIPAA Services.
4. Once B2B has identified the request as a 278, UHG will have a fixed amount of time to process the request. (20 seconds for real-time, 1 hour for batch) Otherwise, a time out situation will exist.
5. WTX Validation Map is invoked.
6. If there is not valid data in the ISA/IEA or GS/GE segments, then a TA1 is generated and sent back to the submitter.
7. A real-time (Implementation Guide Acknowledgement) is created and sent back to the submitter if the submitted 278 file failed format edits.
8. The 999 is created the same business day (20 seconds for real-time, 1 hour for batch processing) the file is submitted, unless a TA1 rejection occurred.
9. AK2/IK3/IK4 – Is used as error identification in a data segment and the location of the data segment. IK5 identifies the transaction set response trailer.
10. If there are no IK5 or AK9 segments, there is a problem with the format of the file and file was rejected.
11. Transactions that pass the validation edit but fail further on in the processing (for example, ineligible member) will generate a 278 real-time response including a AAA segment indicating the nature of the error. (See section 10.4 Error Codes and Interpretations.)
12. The de-batch map (WTX) will convert the 278 file submissions into an XML request for our clinical area.
13. A response is sent back from our clinical area, for each real-time request.
14. WTX converts the response to a 278 X12.
15. Submitter receives either a 278 response or a 278 response with an AAA error.

16. It is also possible for another separate 278 AUTH response transaction to be returned if the initial request incurred a time out situation and the first 278 sent was identifying that we were unable to respond at the current time.
17. IMPORTANT NOTE: THE TIME OUT RESPONSE WILL BE SENT BACK IN BATCH MODE, THEREFORE, ANYONE SETTING UP A 278 AUTHORIZATION REAL-TIME TRANSACTION WILL NEED TO SET UP A BATCH CONNECTION ALSO.

3.3 TRANSMISSION ADMINISTRATIVE PROCEDURES

UnitedHealthcare supports both batch and real-time 278 transmissions. Contact your current clearinghouse vendor discuss transmission types and availability.

3.4 RE-TRANSMISSION PROCEDURES

Please follow the instructions within the 278 AAA data segment for information on whether resubmission is allowed or what data corrections need to be made for a successful response.

3.5 COMMUNICATION PROTOCOL SPECIFICATIONS

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

3.6 PASSWORDS

1. Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss password policies.

3.7 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 systems may be down for general maintenance and upgrades. During these times, our ability to process incoming 278 EDI transactions may be impacted. The codes returned in the AAA segment of the 278 response will instruct the trading partner if any action is required. Please see Appendix section 10.4, Error Codes, and Interpretations, for more information.

In addition, unplanned system outages may also occur occasionally and impact our ability to accept or immediately process incoming 278 transactions. UnitedHealthcare will send an email communication for scheduled and unplanned outages.

3.8 COSTS TO CONNECT

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss costs.

Optum:

- Optum Support – 800-341-6141
- Optum's online solution, Intelligent EDI (IEDI) –
  - Call 866-367-9778, option 3
  - Email IEDIsales@optum.com
  - Visit https://www.optum.com/campaign/fp/free-edi.html.

4. CONTACT INFORMATION

4.1 EDI SUPPORT

Most questions can be answered by referring to the EDI section of our resource library: UHCprovider.com/EDI. View the EDI 278 page for information specific to Referral and Authorization requests: https://www.uhcprovider.com/en/resource-library/edi/edi-278i1.html

If you need assistance with an EDI transaction accepted by UnitedHealthcare, have questions on the format of the 278 or invalid data in the 278 response, please contact EDI Support by:

- Using our EDI Transaction Support Form,
- Sending an email to supportedi@uhc.com or
- Calling 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 SUPPORT

When receiving the 278 from a clearinghouse, please contact the clearinghouse. If using Optum, contact their technical support team at 800-225-8951, option 6.

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/EMAIL

For a copy of the TR3 [005010X217 Health Care Services Review-Request for Review and Response (278)], please visit the Washington Publishing Company: http://www.wpc-edi.com/reference
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
OptumInsight/Optum EDI Client Center - https://www.enshealth.com
UnitedHealthcare Administrative Guide:
https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/UnitedHealthcare_Administrative_Guide_2017.pdf
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 or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

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.

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 278 file can only contain 278 transactions. A 278 Authorization and Referral file can only contain 278 Authorization and Referral transactions.

5.4 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header
Segment First 278 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Second 278 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header
Segment Third 278 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 not populated with actual data must be filled with space.

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

5.6 FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 278 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 Element:** The first element separator following the ISA will define what Data Element Delimiter is used throughout the entire transaction. **The recommended data element delimiter is an asterisk (*)**.
2. **Data Segment:** The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **The recommended data segment delimiter is a tilde (~)**.
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(:)**.

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 278 REQUESTS

1. Use UM04-2 = A when UM01 = AR (Admissions Review) in loop 2000E. AR is for pre-authorization of scheduled inpatient admissions
2. Use UM04-2 = B when UM01 = HS (Health Services Review) in loop 2000E. HS is used for pre-authorization of outpatient services.
3. Use UM04-2 = B when UM01 = SC (Specialty Care Review) in loop 2000E.
4. It is preferred that you send NPI for authorizations and Tax ID for referrals to process the transaction correctly.
5. Not all services require a preauthorization. Providers should refer to the links below in #13 for a complete list of services requiring preauthorization.
6. You can submit a 2000F SV1 (Professional Service) and 2000F SV2 (Institutional Service), but they cannot be submitted on the same authorization. We do not accept SV3 (Dental Service).
7. If 2000E UM03 = 69 (Maternity) both 2000E DTP01 = 484 (Last Menstrual Period date) and DTP01 = ABC (Estimated Date of Birth) are required. If these values cannot be determined, UnitedHealthcare will accept a default value equal to the Admission Date, for both LMP and Estimated Date of Birth.
8. Please submit one Service Level loop (2000F) per referral request.
9. Please submit one Patient Event Provider Name (loop 2010EA) per referral request.
10. UnitedHealthcare Community Plan plans may not submit updates to add additional procedure codes for a previously submitted 278. Please submit additional procedure codes using a new 278 or contact the number on the back of the patient's medical ID card for further assistance.
11. Only ICD10 diagnosis codes will be accepted. All ICD9 codes will be rejected and only a 999 will be sent back. No AAA will be sent.

6.2 SERVICE TYPE (UM03) AND PLACE OF SERVICE (UM04) CODES

All service type codes (UM03) and place of service (UM04) are **allowed for Referrals**. The limited list below pertains to **Authorizations**.

The following UM03 codes are accepted by UHG for Authorizations when the **UM04-2 = A** (Uniform Billing Claim Form Bill Type).

PLACE OF SERVICE = INPATIENT HOSPITAL (11) including Medicare Part A

Service Type Code Description	UM03 Code
Medical Care	1
Surgical	2
Hospice	45
Long Term Care	54
Maternity	69
Transplants	70
Well Baby Care	68
Neonatal Intensive Care	NI

PLACE OF SERVICE = HOSPITAL OUTPATIENT FACILITY (13)

Service Type Code Description	UM03 Code
Surgical	2

PLACE OF SERVICE = SNF INPATIENT (21) including Medicare Part A

Service Type Code Description	UM03 Code
Hospice	45
Chemotherapy	78
Skilled Nursing Care	AG

The following UM03 codes are accepted by UHG for authorizations when the UM04-2=B (Place of Service Codes for Professional or Dental Services):

PLACE OF SERVICE = OFFICE (11)

Service Type Code Description	UM03 Code
Medical Care	1
Surgical	2
Diagnostic X-Ray	4
Diagnostic Lab	5
Chiropractic	33
Dental Accident	37

Medically Related Transportation	56
Diagnostic Medical	73
Chemotherapy	78
Pharmacy	88
Podiatry	93
Vision (Optometry)	AL

PLACE OF SERVICE = HOME (12)

Service Type Code Description	UM03 Code
Diagnostic Lab	5
Durable Medical Equipment Purchase	12
Renal Supplies in the Home	14
Durable Medical Equipment Rental	18
Hospice	45
Medically Related Transportation	56
Inhalation Therapy	72
Diagnostic Medical	73
Private Duty Nursing	74
Chemotherapy	78
Pharmacy	88
Occupational Therapy	AD
Speech Therapy	AF
Skilled Nursing Care	AG
Physical Therapy	PT

PLACE OF SERVICE = OUTPATIENT HOSPITAL (22)

Service Type Code Description	UM03 Code
Medical Care	1
Diagnostic X-Ray	4
Diagnostic Lab	5
Dental Accident	37
Medically Related Transportation	56
Inhalation Therapy	72
Diagnostic Medical	73
Prosthetic Device	75
Chemotherapy	78
Pharmacy	88

Occupational Therapy	AD
Speech Therapy	AF
Physical Therapy	PT

PLACE OF SERVICE = COMPREHENSIVE INPATIENT REHABILITATION FACILITY (61)

Service Type Code Description	UM03 Code
Rehabilitation	A9

PLACE OF SERVICE (UM04-1) – FOR AUTHORIZATIONS

The place of service codes below (UM04-1) are the only ones allowed when the UM04-2=A

Code	Location
11	Hospital Inpatient including Medicare Part A
13	Hospital Outpatient
21	Skilled Nursing Facility (SNF) Inpatient including Medicare Part A

The place of service codes below (UM04-1) are the only ones allowed when the UM04-2=B

Code	Location
11	Office
13	Home
21	Hospital Outpatient
61	Rehab Facility Comprehensive Inpatient

6.3 GENETIC TESTING AUTHORIZATIONS

When submitting authorizations for Genetic Tests please use the following:
Service Type = 5 (Lab)
Populate 2000F MSG with LabTestID=*registered test*;;LabDesc=*test description*
Date of service may be up to 90 days in the past based on the tissue collection date
If there are multiple CPT codes within a registered test, only the first occurrence of 2000F MSG should be populated.

6.4 278 RESPONSE

Disclaimer: Information provided in 278 responses is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols; date(s) of services rendered and benefit plan terms and conditions.

1. A referral/authorization request transaction which has been successfully processed will be indicated by the presence of a Review Identification Number in HCR02 in either the 2000E or 2000F loops. It does not imply that it follows policy requirements by UnitedHealthcare. If the referral/authorization request was not successfully processed, HCR02 will not be populated. The REF02 (Administrative Reference number) will also be present in the 2000E/2000F loops when the HCR01 = A4, A3 or CT.

2. For real-time, the response to an unsuccessful referral/authorization request will have BHT02 wrapped in a generic XML wrapper. It will contain an "AAA" segment with an indication of the reason for failure along with a message (refer to the Error Codes and Interpretations section in the appendix of this guide).
3. It is also possible for another separate 278 response transaction to be returned if the initial request incurred a time out situation and the first 278 sent was identifying that we were unable to respond at the current time.

   Important Note: The time out response will be sent back in batch mode. Therefore, a 278-authorization real-time transaction will also need to be set up as a batch connection.
4. Responses to all 278-initial request (UM02=I) will include an Authorization Request Receipt Number in a Ref segment in loop 2000E (REF01=NT). Responses may additionally include 2000E (REF01=BB) to reference a previously existing number of a number in loop 2000F (HCR02). In addition, responses for any authorization request transaction that is updating a previous request (UM02=S), the administrative reference number for that case will be included in a REF segment in loop 2000E (REF01=NT). Any authorization transaction that is updating a previously submitted service will also include the authorization request number in a REF segment in loops 2000E and 2000F (REF01=BB). Please refer to these numbers when calling for technical assistance regarding a 278-authorization request submission.

Response Tracking Numbers:
The following tracking numbers are available in the X12 specification and can be used for research and follow-up:

TR3 Term	Response Location	Action Code	Notes
Reference Identification	Loop 2000E **REF02** (where REF01=NT)	A3 = Not Certified CT = Contact payer	Also known in the IG as "Administrative Reference Number". When communicating with UnitedHealthcare EDI Support regarding a technical question about a submission, we recommend using this reference number. Administrative Reference Number = UHG's Clinical transaction ID (16 bytes) and is used on authorizations.
Reference Identification	Loop 2000E **REF02** (where REF01=NT)	A4 = Pended	Indicates transaction was applied to the database successfully. Also known in the TR3 as "Administrative Reference Number". Also referred to as Service Reference Number by the Health Plan. This number should be used when discussing referrals/authorizations with UnitedHealthcare Customer Service. Administrative Reference Number = UHG Service Reference Number which is only assigned for successfully processed authorization requests (10 bytes).
Reference Identification Number	Loop 2000E or 2000F **HCR02**	A1 = Certified in total A6 = Modified	Indicates transaction was applied to the database successfully. Also referred to as Reference Identification Number or Service Reference Number by the Health Plan. This number should be used when discussing referrals/authorizations with UnitedHealthcare Customer Service. Administrative Reference Number = UHG Service Reference Number which is only assigned for successfully processed authorization requests (10 bytes).
Reference Identification	Loop 2000E TRN02	All	Also known as the "Patient Even Trace Number". For UHC Authorizations, it indicates the UHG Clinical Transaction ID that is unique and assigned to every transaction.

6.5 DUPLICATE PROCESSING

Authorizations Duplicate Processing – Inpatient Cases:

UnitedHealthcare will consider a 278A a duplicate if the following conditions are ALL true:

1. The submission is an Initial submission (UM02=I).
2. The submission is an Admission Review (UM01=AR).
3. The case in our system is not cancelled.
4. There is a match between the submission and the case in our system on member, provider, diagnosis code(s), and all procedure code(s) if any.
5. The Expected Admission Date in the submission is between 7 days less than the Expected Admission Date and Expected Discharge Date in our system.
6. The Expected Discharge Date in the submission is between Expected Admission Date and 7 days greater than the Expected Discharge Date in our system.

Authorizations Duplicate Processing – Outpatient Cases:

UnitedHealthcare will consider a 278A a duplicate if the following conditions are ALL true:

1. The submission is an Initial submission (UM02=I).
2. The submission is a Health Services Review (UM01=HS).
3. The case in our system is not cancelled.
4. There is a match between the submission and the case in our system on member, provider, diagnosis code(s), all service code(s) and service quantity/frequency/length (HSD Segment).
5. The Service Start Date in the submission is between 7 days less than the Service Start Date and Service End Date in our system.
6. The Service End Date in the submission is between Service Start Date and 7 days greater than the Service End Date in our system.

If a match is found, we will send back HCR01 = A3 and the AAA03 error code of "33". We will also include the original Administrator's Reference Number in REF02 in the 2000E loopREF01 = NT). If no match is found, we will create a new case and return the current Administrator's Reference Number in the 2000E loop (REF01 = NT) and any applicable Prior Authorization Reference Numbers in the 2000E and 2000F loops. Location of the Prior Authorization Reference Number will vary based on the Action Code (see Examples in section 10.3).

Referral Duplicate Processing – Commercial:

There is no specific duplicate referral logic in our commercial platform except for vendor ID. This information is not communicated back to the provider.

Referral Duplicate Processing – Government:

There is no specific duplicate referral check logic in our government platform. The only checking that is performed is to verify whether a particular authorization audit number has been used already or not. When an audit number already exists, the transaction is processed as an update, instead of an add.

6.6 278 UPDATE PROCESSING

Authorizations Update Processing – Inpatient Cases:

UnitedHealthcare will update an existing case if the following conditions are ALL true:

1. The submission is a Revision submission (UM02=S).
2. The submission is an Admission Review (UM01=AR).
3. An Administrator's Reference Number is provided in the 2000E loop (REF01=NT).
4. Prior Authorization Reference Number (aka Previous Review Authorization Number) is included in the 2000E loop (REF01=BB) and the 2000F loop (REF01=BB). This is UHC's Clinical transaction ID. This is not required, although it is allowed. If sent, number 5 is true.

5. The submitted Authorization Numbers are related to the Administrator's Reference Number.
6. There is a match between the submission and the case in our system on member and provider.
7. No Actual Admission Date exists for the case.
8. The case in our system has not had a decision made.
9. At least one procedure is not denied or cancelled

If any of these conditions are not met, the update submission will be rejected. If all conditions are met, the case can be updated as shown below. Any other submitted changes will be ignored.

Updatable fields to an existing case:
1. Expected Admission Date
2. Expected Discharge Date

Additions to existing case:
1. Additional Procedures (only allowed if all current procedures are still pending on the case)
2. Additional Diagnoses
3. Additional Contacts

Changes to services where an approval has already been completed:
1. Expected Procedure Date

Changes allowed to services where an approval is pending:
1. Expected Procedure Date
2. Service Provider

Additions allowed where an approval is pending:
1. Service Note

UnitedHealthcare Community Plans in Connecticut, Rhode Island, Florida, and Louisiana may not submit updates to add additional procedure codes for a previously submitted 278. Please submit additional procedure codes using a new 278 or contact the number on the back of the patient's medical ID card for further assistance.

Authorizations Update Processing – Outpatient Cases:
UnitedHealthcare will update an existing case if the following conditions are ALL true:
1. The submission is a Revision submission (UM02=S).
2. The submission is an Admission Review (UM01=HS).
3. An Administrator's Reference Number is provided in the 2000E loop (REF01=NT).
4. Prior Authorization Reference Number is included in the 2000F loop (REF01=BB). This is not required, although it is allowed. If sent, number 5 is true.
5. The submitted Prior Authorization Reference Number is related to the Administrator's Reference number.
6. There is a match between the submission in our system on member and provider.
7. The case in our system has not had a decision made.
8. At least one service is not denied or cancelled.

If any of these conditions are not met, the Update submission will be rejected. If all conditions are met, the case can be updated as shown below. Any other submitted changes will be ignored.

Additions to existing case:
1. Additional Services (only allowed if all current procedures are still pending on the case)

2. Additional Diagnoses
3. Additional Contacts

Updatable fields to an existing case for service updates:
1. Service Start Date
2. Service End Date

Changes allowed to services where an approval is pending:
1. Service Start Date
2. Service End Date
3. Service Provider
4. Quantity, Frequency, Length (HSD in 2000F loop)

Additions allowed where an approval is pending:
1. Service Note

If all conditions are met and update is successful, we will include the original UHG Service Reference Number in REF02 of the 2000E loop (REF01 = NT). An additional UHG Clinical Transaction ID that is unique to the transaction will be included in the 2000E loop (TRN02). We will include the original UHG Clinical Transaction ID in REF02 of the 2000E loop (REF01 = BB). If a new procedure/service was added, its Prior Authorization Reference Number will be included in the 2000F loop (REF01 = NT).

UnitedHealthcare Community Plans may not submit updates to add additional procedure codes for a previously submitted 278. Please submit additional procedure codes using a new 278 or contact the number on the back of the patient's medical ID card for further assistance.

Referral Update Processing – Commercial:
There is update processing capability. The update processing will look for the employee information and the first 3 bytes of the CPT4 code. It will then compare them to the input file referral number against the existing referral number in the database. There is no update capability for our PPO-One product via the X12 transaction.

Referral Update Processing – Government:
When an authorization audit number already exists in our government platform, the transaction is processed as an update, instead of an add.

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 ACKNOWLEDGEMENTS

TA1 – Interchange Acknowledgement:
This file will be generated and sent to the submitter only when the data was not valid in the ISA/IEA or the GS/GE segments. This pertains to batch and real-time transactions.

999 – Functional Acknowledgement:
- Batch: For batch 278 transactions, a 999 (Implementation Guide Acknowledgement) will always be returned. It will contain errors or good responses.
- Real Time: For real-time 278 transactions, a 999 will be returned only when there are format errors in the inquiry file.

7.2 REPORT INVENTORY

There are no known applicable reports.

8. TRADING PARTNER AGREEMENTS

- **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 UHG.

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.

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

9. TRANSACTION SPECIFIC INFORMATION

UnitedHealthcare has put together the following grid to assist you in designing and programming the information needed in a 278 request. This CG is meant to illustrate the data needed by UnitedHealthcare for successful Referral and Authorization transactions. The 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 the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

- **DATA ELEMENT GRID – REQUEST FOR REVIEW**

Loop ID	Reference	Name	HIPAA Codes	Notes/Comments
Header	**ISA**	**Interchange Control Header**		
Header	ISA01	Authorization Information Qualifier	00	
Header	ISA03	Security Information Qualifier	00	
Header	ISA05	Interchange Information Qualifier	ZZ	
Header	ISA07	Interchange Information Qualifier	ZZ	
Header	ISA08	Interchange Receiver ID	87726 or 06111 061118515	Receiver ID. Left justify and pad with spaces to 15 characters.

Header	ISA11	Repetition Separator	^	The delimiter in ISA 11 must be ^ (caret)
Header	ISA16	Component Element Separator	:	The delimiter in ISA 16 must be : (colon)
Header	**ISA**	**Functional Group Header**		
Header	GS03	Application Receiver's Code	87726 or 06111 061118515	This is the same value as the Receiver's Interchange ID from ISA08 (do not pad with spaces).
Header	**BHT**	**Beginning of Hierarchical Transaction**		
Header	BHT02	Transaction Set Purpose Code	13	Accept only 13
Header	**NM1**	**UMO (Payer Name)**		
2010A	NM101	Entity Identifier Code	X3	
2010A	NM102	Entity Type Qualifier	2	
2010A	NM108	Identification Code Qualifier	PI	
2010A	NM109	Identification Code	87726 or 06111 061118515	UHC Payer ID Oxford Payer ID
2010B	**NM1**	**Requestor Name**		
2010B	NM101	Entity Identifier Code	FA 1P	
2010B	NM103	Name Last / Organization Name		The name of the provider or facility submitting the request is required.
2010B	NM108	Identification Code Qualifier	XX	NPI is required
2010B	**REF**	**Supplemental Identifier**		
2010B	REF01	Supplemental Identification Qualifier	EI ZH	Accept only EI = Facility Tax Identification Number (TIN). ZH = Unique provider identifier assigned by payer (MPIN).
2010B	REF02	Supplemental Identifier		Must be padded with leading zeros to equal 9 digits
2010B	**N4**	**Requester City/State/Zip**	**To assist in data matching, please provide the city, state, and zip code of the facility where the patient is being admitted or service is being provided when multiple locations exist.**	
2010B	**PER**	**Requester Contact**		
2010B	PER02	Name		Free form contact name. This should be the name of an individual at the submitting provider/facility that UnitedHealthcare can contact if there are questions or more information is needed about this admission notification. If an individual contact name cannot be provided, please populate this field with the facility or provider name from NM103.
2010B	PER03	Communication	TE	At least one contact phone number is required.

		Number Qualifier		
2010B	PER04	Communication Number		Phone number - Format 10 digits no punctuation or spaces
2010B	PER05		EX	If applicable
2010B	PER06	Communication Number		Extension (numeric only), if applicable
2010C	**NM1**	**Subscriber Detail**		
2010C	NM103	Name Last		Subscriber Last name (Required)
2010C	NM104	Name First		Subscriber First name. Required if member has a legal first name. If member has only 1 legal name, send member name in Last Name and do not populate first name.
2010C	NM108	Identification Code Qualifier	MI	
2010C	NM109	Identification Code		Member Identification preferably from UnitedHealth insurance card.
2010C	**REF**	**Supplemental Identifier**		
2010C	REF01	Reference Identification Qualifier	1L 6P IG	6P (preferred)
2010C	REF01	Reference Identification Qualifier	HJ N6	Referral only
2010C	**DMG**	**Subscriber Demographic Information**		
2010C	DMG03	Gender Code		Gender Code is required.
2010D	**NM1**	**Dependent Name**		
2010D	NM103	Name Last		Dependent's Last Name
2010D	NM104	Name First		Dependent's First Name - Required if dependent has a legal first name. If dependent has only 1 legal name, send dependent name in Last Name and do not populate first name.
2010D	**DMG**	**Dependent Demographic Information**		
2010D	DMG03	Gender Code	Gender Code is required	
2000E	**UM**	**Healthcare Services Review**		
2000E	UM01	Request Category Code	AR HS SC	Accepted codes
2000E	UM02	Certification Type Code	I, S	If submitting a change to a previously submitted and approved authorization, please provide the administrative Reference Number from the original authorization request in the following REF segment. This is required when submitting a revision or update.)
2000E	UM03	Service Type Code		All service type codes (UM03) are allowed for Referrals. Please see section 6.2 for the limited service type codes accepted for Authorizations with the place of service to be used.
2000E	UM04 - 1	Facility Type Code	Accept	All professional place of service codes (UM04**)** are

			for A 11 13 21 Accept for B 11 12 22 61	allowed for Referrals. **Uniform Billing Claim Form Bill Type (when UM04-2 = A)** 11 - Hospital – Inpatient (Including Medicare Part A) 13 - Hospital - outpatient 21 - Skilled Nursing Facility (SNF) (Including Medicare Part A) – Inpatient **The limited list below pertains to Authorizations** **Professional Services (when UM04-2 = B)** 11 - Office 12 - Home 22 - Hospital – outpatient 61 - Comprehensive Inpatient Rehab Facility
2000E	UM06	Level of Service Code	E	All non-urgent, non-emergent admissions. This is the only value accepted
2000E	**HI**	**Patient Diagnosis**		
2000E	HI01 – 1	Diagnosis Type Code	ABF ABJ ABK	ICD-10 is to be used with DATE OF SERVICE AS OF OCT 1, 2015 - In order to assign appropriate resources to the case; UnitedHealthcare needs to understand why the patient is being treated. A Principal or Admitting diagnosis code is required. Please send it in this HI segment.
2000E	HI01 – 2	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI02 – 1	Diagnosis Type Code	ABF ABJ	ICD-10 to be used with DATE OF SERVICE AS OF OCT 1, 2015 Additional diagnosis information may be provided if available.
2000E	HI02 – 2	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI03 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Additional diagnosis information may be provided if available.
2000E	HI03 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI04 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Additional diagnosis information may be provided if available.
2000E	HI04 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI05 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS of OCT 1, 2015 Additional diagnosis information may be provided if available.

2000E	HI05 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI06 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI06 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI07 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI07 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI08 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI08 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI09 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI09 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI10 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI10 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI11 - 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI11 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	HI12 – 1	Diagnosis Type Code	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015. Additional diagnosis information may be provided if available.
2000E	HI12 - 3	Diagnosis Code		ICD-10 code to be used with DATE OF SERVICE AS OF OCT 1, 2015 Format ANX.XXXX
2000E	**HSD**	**Healthcare Services Delivery**		
2000E	HSD01	Quantity Qualifier	DY	DY is only accepted for Admission Review (AR).
2000E	**CL1**	**Institutional Claim Code**		
2000E	CL101	Admission Type Code	3	Required for Admission Review (AR); Accept Admission Type Code = 3
2010EA	**NM1**	**Patient Event Provider Name**		
2010EA	NM101	Entity Identifier Code	FA 71 AAJ SJ	Please identify providers related to this submission that are not identified in a 2010F loop. <u>For UM01=AR</u> (Admission Review) 1 Facility (FA) per case - required

				1 Attending (71) per case -optional 1 Admitting (AAJ) per case -optional 1 Servicing Provider (SJ) per service – required <u>For UM01=HS</u> 1 Attending (71) per case -optional 1 Servicing Provider(SJ) per service - required
2010EA	NM103	Name Last or Organization Name		To assist in data matching, it is preferred that this value not contain title or suffix abbreviations such as Dr., MD, OB, etc. either before or after the provider's last name
2010EA	NM104	Name First		To assist in data matching, it is preferred that this value not contain title or suffix abbreviations such as Dr., MD, OB, etc. either before or after the provider's last name
2010EA	NM108	Identification Code Qualifier	XX 24	XX = NPI (Preferably for Authorizations) 24 = Tax Identification Number (TIN) (Preferably for Referrals) In order to accurately identify the submitting facility, UnitedHealthcare must receive either the NPI or Tax Identification Number (TIN), or both. If sending both, use the following REF segment for the TIN
2010EA	**REF**	**Patient Event Provider Supplemental Identifier**		
2010EA	REF01	Supplemental Identification Qualifier	EI ZH	Accept only EI = Facility Tax Identification Number (TIN). ZH = Unique provider identifier assigned by payer (MPIN).
2010EA	REF02	Supplemental Identifier		Must be padded with leading zeros to equal 9 digits.
2010EA	**N4**	**Patient Event Provider City/State/Zip**	**To assist in data matching, please provide the city, state, and zip code of the provider where the patient is being admitted or service is being provided when multiple locations exist.**	
2010EA	**PER**	**Patient Event Provider Contact Information**		
2010EA	PER02	Name		Please send the name of the contact if it is different or not sent in NM1
2010EA	PER03	Communication Number Qualifier	TE	At least one contact phone number is required
2010EA	PER04	Communication Number		Phone number - Format 10 digits with no punctuation or spaces
2010EA	PER05	Communication Number Qualifier	EX	If applicable
2010EA	PER06	Communication Number		Extension Number, if applicable
2000F	**UM**	**Healthcare Services Review**		
2000F	UM02	Certification Type Code	I or S	If submitting a change to a previously submitted and approved authorization, please provide the Prior Authorization Reference Number from the original notification in the following REF segment

2000F	UM03	Service Type Code		All service type codes (UM03) are allowed for referrals. Please see section 6.2 for the limited service type codes accepted for authorizations with the place of service to be used.
2000F	UM04 - 1	Facility Type Code	Accept for A 11 13 21 Accept for B 11 12 22	Uniform Billing Claim Form Bill Type **(when UM04-2 = A)** 11 - Hospital – Inpatient (Including Medicare Part A) 13 - Hospital - outpatient 21- Skilled Nursing Facility (SNF) (Including Medicare Part A) – Inpatient All professional services are available for Referrals. The list below refers to Authorizations only. Professional Services **(when UM04-2 = B)** 11 - Office 12 - Home 22 - Hospital - outpatient
2000F	**SV1**	**Professional Service**		
2000F	SV101 – 1	Product/Service ID Qualifier	HC	
2000F	SV101 – 8	Product/Service ID		Procedure code ranges are not allowed.
2000F	SV103	Unit or basis for measurement code	UN	
2000F	**SV2**	**Institutional Service**		
2000F	SV202 – 1	Product/Service ID Qualifier	HC	
2000F	SV202 – 8	Product/Service ID		Procedure code ranges are not allowed.
2000F	SV204	Unit or basis for measurement code	UN	
2000F	**HSD**	**Healthcare Services Delivery**		
2000F	HSD01	Quantity Qualifier	DY FL HS VS	Required when requesting services that have a specific pattern of delivery or usage.
2000F	HSD05	Time Period Qualifier	7 34 35	
2000F	**MSG**	**Free Form Text**		
2000F	MSG01	Message Text		Required for Genetic Testing Example: "LabTestID=PPP;;LabDesc=Panorama Prenatal Panel"

2010F	NM1	Service Provider Name		
2010F	NM101	Entity Identifier Code	FA	Please identify providers related to this submission
			SJ 1T	that are not identified in a 2010EA loop. FA = Facility – **Use for Auths only**. SJ = Service Provider – **Use for Auths and Referrals** 1T = Physician, Clinic, Group Practice – **Use for Referrals only.**
2010F	NM103	Name Last or Organization Name		To assist in data matching, it is preferred this value not contain title or suffix abbreviations such as Dr., MD, OB, etc. either before or after the provider's last name.
2010F	NM104	Name First		To assist in data matching, it is preferred this value not contain title or suffix abbreviations such as Dr., MD, OB, etc. either before or after the provider's last name.
2010F	NM108	Identification Code Qualifier	XX 24	XX = NPI (Preferably for authorizations) 24 = Tax Identification Number (TIN) (preferably for referrals) In order to accurately identify the submitting facility, UnitedHealthcare must receive either the NPI or Tax Identification Number (TIN), or both. If sending both, use the following REF segment for the TIN
2010F	**REF**	**Service Provider Supplemental Identifier**		
2010F	REF01	Supplemental Identification Qualifier	EI ZH	Accept only EI = Facility Tax Identification Number (TIN). ZH = Unique provider identifier assigned by payer (MPIN)
2010F	REF02	Supplemental Identifier		Must be padded with leading zeros to equal 9 digits.
2010F	**N4**	**Service Provider City/State/Zip**	**To assist in data matching, please provide the city, state, and zip code of the provider where the patient is being admitted or service is being provided when multiple locations exist.**	
2010F	**PER**	**Service Provider Contact Information**		
2010F	PER03	Communication Number Qualifier	TE	At least one contact phone number is required
2010F	PER04	Communication Number		Phone number - Format 10 digits with no punctuation or spaces
2010F	PER05	Communication Number Qualifier	EX	If applicable

10. APPENDECIES

- **IMPLEMENTATION CHECKLIST**

The implementation check list will vary depending on your choice of connection, e.g. clearinghouse. 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

- **FILE NAMING CONVENTIONS**

All response files, other than the response file related to a time out situation, will be sent as either zipped or unzipped. If the 278 request was sent zipped, the response file will be sent zipped. If the 278 request was sent unzipped, the response file will be sent unzipped. Time out situation response files will always be sent unzipped. If a batch is received with an invalid file name according to the specifications in the File Naming Conventions section, the file will not be processed.

Inbound 278 Batch Request to UnitedHealthcare:
For batch transactions, we will receive the following file name. The extension '.BTC' is an abbreviation for batch. The 278 request will be included in the file. We will validate that the submitter id and batch id in the file name match the data in the ISA segment.

N or Z_278B_<*Submitter ID*>_<Batch ID>_<datetimestamp>.BTC.pgp
Example: N_278B_ABC123456789_000000004_01102010142034.BTC.pgp

N or Z Identifies if the file is unzipped (N) or zipped (Z)
278B Identifies the file represents a 278-batch request.
<Submitter ID> Corresponds to the ISA06 in the 278
<Batch ID> Corresponds to the ISA13 (Interchange Control Number in the 278.
<Datetimestamp> Expressed in CDT/CST as MMDDYYYYHHMMSS. This is an optional field

Outbound Responses from UnitedHealthcare:

1. 999 Functional Acknowledgement (Batch Only):
   Z or N_278999_<batch ID>_<submitter ID >_<datetimestamp>.RES.pgp
   Example: Z_2780999_000000004_ABC123456789_01102010142034. RES.pgp
2. For batch transactions, the naming convention for the 278-acknowledgment file is listed below. The extension '.RES' is an abbreviation for response.
   N or Z_278BACK_<batch ID>_<Submitter ID>_<datetimestamp>.RES.pgp
   Example: N_278BACK_000000004_ABC123456789_01102010142034.RES.pgp
   N or Z Identifies if the file is unzipped (N) or zipped (Z)
   278BACK Identifies the file represents a 278 the 278 Acknowledgment.
   <Batch ID> This value is in the ISA13 (position 86) in the acknowledgement file.
   <Submitter ID> The value in the ISA08 (position 50) in the acknowledgement file.
   <Datetimestamp> Expressed in CDT/CST as MMDDYYYYHHMMSS. Represents the date and time the response file was created.

3. A 278 acknowledgement can be sent after a time out has occurred. Each file will contain one single transaction. The extension '.RES' is an abbreviation for response.
   N_278ACK_<batch ID>_<Submitter ID>_<control number>_ <datetimestamp>.RES.pgp
   N Represents that file will not be zipped. This will always be valued with N for this scenario.
   278ACK Valued with this value as a default since it is not known if the original request was a real time request or a transaction from a batch request.
   <Batch ID> This value is in the ISA13 (position 87) in the 278-acknowledgement file.

<Submitter ID> The value in the ISA08 (position 51) in the 278-acknowledgement file.
<Control number> This field is a counter that is set in the FTP process. The counter starts with 1 and increments to 999 and then is reset. The counter can be a maximum of the bytes and a minimum of 1 byte. The counter is added during the FTP process. The only place the counter will show up is in the file name when the client picks up the file.
<Datetimestamp> Expressed in CDT/CST as MMDDYYYYHHMMSS. Represents the date and time the response file was created.

- **BUSINESS AND TRANSMISSION EXAMPLES**

2000E/HSD Health Care Service Delivery
Use this only to specify an expected length of stay. Please do not use when specifying an expected or actual discharge date. HSD01 must be "DY".

Example: "3 Days"
HSD01 = DY
HSD02 = 3

2000F/HSD Health Care Service Delivery
UnitedHealthcare does not process every possible service delivery pattern that can be expressed using a HSD segment. The following rules will allow you to construct HSD segments that we can process.

Pattern 1: Basic Professional Services
Use SV Use SV103 and SV104. SV103 must be "UN". Use SV102 for DME Cost. Do not use a HSD segment. Specifying nothing is equivalent to "1 Unit".

Example: "7 Units"
SV103 = UN
SV104 = 7

Example: "2 Units at a total cost of $500"
SV102 = 500.0
SV103 = UN
SV104 = 2

Pattern 2: Basic Institutional Services
Use SV204 and SV205. SV204 must be "UN". Use SV203 for DME Cost. Do not use a HSD segment. Specifying nothing is equivalent to "1 Unit".

Example: "2 Units at a total cost of $500"
SV203 = 500.0
SV204 = UN
SV205 = 2

Pattern 3: Units Without Repetition
HSD02 HSD01s
Professional services only- Do not use SV103.
HSD01 must be one of the following DY=Days, FL=Units, HS=Hours, VS=Visits

Example: "7 Units"

HSD01 = FL
HSD02 = 7

Example: "3 Visits"
HSD01 = VS
HSD02 = 3

Example: "12 Days"
HSD01 = DY
HSD02 = 12

Example: "1 Hour"
HSD01 = HS
HSD02 = 1

Pattern 2: Units with repetition
HDS02 HSD01s every HSD04 HSD03s for HSD06 HSD05s
Professional services only. Do not use SV103.
HSD01 must be one of the following DY=Days, FL=Units, HS=Hours, VS=Visits

The units specified in HSD03 must match those in HSD05:
Days: HSD03 = DA, HSD05 = 7, HSD04 must be 1 or 2
Weeks: HSD03 = WK, HSD05 = 35, HSD04 must be 1 or 2
Months: HSD03 = MO, HSD05 = 34, HSD04 must be 1

Example: "1 Visit every Week for 10 Weeks"
HSD01 = VS
HSD02 = 1
HSD03 = WK
HSD04 = 1
HSD05 = 35
HSD06 = 10
(The calculated total = 10)

Example: "3 Units every other Day for 14 Days"
HSD01 = FL
HSD02 = 3
HSD03 = DA
HSD04 = 2
HSD05 = 7
HSD06 = 14
(The calculated total = 21)

Example: "1 Day every 2 Weeks for 8 Weeks"
HSD01 = DY
HSD02 = 1
HSD03 = WK
HSD04 = 2
HSD05 = 35
HSD06 = 8

(The calculated total = 4)

Example Response Scenarios for Authorization Requests

Case 1: Authorization request successfully entered into the system				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	HCR		Health Care Services Review	
		HCR01	Action code	A4 = Pending
		HCR03	Industry Code	0W - Disposition pending review
	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number (Event SRN)
	MSG	MSG01	Message	Upon a successful submission we may send the following message: *"Refer to Medical Policy or Coverage Determination Guideline for specific clinical information required for review of the requested service or procedure*."
2000F	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number (Service SRN)

Case 1a: Authorization Request Successfully Entered into the System & Certified in Total				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	HCR		Health Care Services Review	
		HCR01	Action code	A1 = Certified in Total
		HCR02	Reference Identification	**Review Identification Number** (Event SRN)
2000F		HCR01	Action code	A1 = Certified in Total
		HCR02	Reference Identification	**Review Identification Number** (Service SRN)

Case 1b: Authorization Request Successfully Entered into the System (Delegated Vendors)				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	HCR		Health Care Services Review	
		HCR01	Action code	A6 = Modified
		HCR02	Reference Identification	**Review Identification Number** (Event SRN)
2000F		HCR01	Action code	A6 = Modified
		HCR02	Reference Identification	**Review Identification Number** (Service SRN)
Case 2: Authorization Request Error				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	HCR		Health Care Services Review	
		HCR01	Action code	A3 = Not Certified
		HCR03	Industry Code	Services were not considered due to other errors in the request
	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number (Transaction ID)

2000F	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number (Transaction ID
Any	AAA	AAA01	Valid Request Indicator	N
		AAA03	Reject Reason Code	See IG for loop
		AAA04	Follow-up action code	C = Correct and Resubmit, N = Resubmission not allowed.

Case 3a: Member Blocked				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2010C	AAA	AAA01	Valid Request Indicator	N
		AAA03	Reject Reason Code	78 = Subscriber/Insured not in Group/Plan identified.
		AAA04	Follow-up action code	N = Resubmission not allowed.
2000E	HCR	HCR01	Action Code	A3 = Not Certified
	MSG01	MSG01	Free Form Message	Informational Message from UHG may be sent.

Case 3b: Case or Service Blocked				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	AAA	AAA01	Valid Request Indicator	N
		AAA03	Reject Reason Code	33 = Input Errors
		AAA04	Follow-up action code	N = Resubmission not allowed.
2000E	HCR	HCR01	Action Code	A3 = Not Certified
	MSG01	MSG01	Free Form Message	Informational Message from UHG will be sent.

Case 4: Authorization Request held for Manual Processing				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2010A	AAA	AAA01	Valid Request Indicator	N
		AAA03	Reject Reason Code	42 = Unable to respond at the current time
		AAA04	Follow-up action code	Y = Do not Resubmit; check Unitedheathcareonline.com the next day.
2000E	HCR	HCR01	Action Code	CT = Contact Payer
	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number (Transaction ID)
	MSG	MSG01	Free Form Message	Case sent to manual processing.

Note: If you receive a "CT" response, you will need to go to UnitedHealthcareOnline.com > Notifications > Notification Status the following day to obtain the Service Reference Number (SRN), it will not be sent to you via a 278ACK response.

Case 5: Authorization Request Duplicate				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response

2000E	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number – Administrative Reference Number = UHG Event SRN
	HCR		Health Care Services Review	
		HCR01	Action code	A3 = Not Certified
		HCR03	Industry Code	Duplicate Request
2000F	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	**Reference ID**	**Reference Number (Service SRN in case of partial dupe)**
Any	AAA	AAA01	Valid Request Indicator	N
		AAA03	Reject Reason Code	33 = Duplicate request with Administrative Reference Number xxxxxxxxxxxxxxx
		AAA04	Follow-up action code	N = Resubmission not allowed.

Case 6: Updated Authorization				
278 Response Transaction				
Loop	**Segment**	**Element**	**Description**	**Comments**
	BHT	BHT02	Transaction Set Purpose Code	11 = Response
2000E	REF	REF01	Reference Identification Qualifier	NT = Administrator's Reference Number
		REF02	Reference ID	Reference Number
	REF	REF01	Prior Authorization Reference Number	BB = Previous Review Prior Authorization Reference Number
		REF02	Reference ID	Previous Prior Authorization Reference Number

- **ERROR CODES AND INTERPRETATIONS**

Loop	AAA03	AAA04	Error Description	Trading Partner Action Required
			Invalid Envelope	This is used when the 278A request has envelope errors and the WTX compliance check map creates a TA1 transaction. The TA1 returned to the submitter, not a 278A with an AAA segment.
			Syntax errors or implementation guide noncompliance	999/TA1 created. Please correct and resend
2000A	41	C	Missing or invalid case number format. (BHT03)	Please correct and resend
2000A	41	N	Production transaction submitted to test environment. (ISA15)	Resubmit with ISA 15 = T
2000A	41	N	Previous Review BHT03 must be submitted for a revised submission	Please correct and resend as a new submission
2000A	41	N	Test transaction submitted to production environment. (ISA15)	Resubmit with ISA 15 = P
2000A	41	N	BHT02 (Purpose Code) is not supported.	Please correct and resend if applicable.
2000A	41	N	BHT03 must be present on an initial submission	Please correct and resend.
2000A	41	N	Previous Review BHT03 must be submitted for a revised submission	Update is not allowed. You may call the number on the back of the member's card for further information.
2000A	42	C	See Implementation Guide	Please correct and resend.
2000A	42	N	Outbound response has syntax or implementation guide errors	The 278A response failed in the compliance check map for interchange envelope, syntax, or IG errors, resulting in a TA1 or 999 being created.
2000A	42	P	The system is not available at this time. Please try again later.	Please resubmit later

Loop	AAA03	AAA04	Error Description	Trading Partner Action
2000A	42	P	See Implementation Guide.	Please resubmit later.
2000A	42	Y	Unidentifiable Message Received from Backend	Some system component(s) is/are unavailable at the current time**. Do not resubmit.** We will hold your request and respond again shortly
2000A	42	Y	An Unexpected Timeout Has Occurred	**Do not resubmit**. Some system components(s) are unavailable at the current time. The transaction will be processed as soon as resources are
2000A	42	Y	Acknowledgment for Real- time HIPAA Suite Processing	**Do Not Resubmit;** We Will Hold Your Request and Respond Again Shortly'
2000A	AA	N	See Implementation Guide	You may call the number on the back of the member's card for further information.
2010A	42	P	The system is not available at this time. Please try again later.	Please resubmit later.
2010A	79	N	Invalid Payer Id (message in 2000E loop)	Please call the number listed on the back of the member's card
2010B	41	C	Facility Provider not supported for Professional Service (UM01 = HS).	Please correct and resend if applicable.
2010B	42	P	The system is not available at this time. Please try again later.	Please resubmit later.
2010B	43	C	See Implementation Guide	Please correct and resend.
2010B	43	C	Primary Provider Information is required	Please correct and resend if applicable
2010B	43	C	Invalid Provider NPI: Must be 10 digits	Please correct and resend.
2010B	43	C	Tax ID or NPI is missing	Please correct and resend
2010B	43	C	Invalid Provider Tax ID: Must be 9 digits	Please correct and resend.
2010B	43	C	Provider is not authorized to submit Referral. Please check Referral Submission guidelines	Please correct and resend.
2010B	44	C	See Implementation guide	Please correct and resend.
2010B	46	C	See Implementation Guide	Please correct and resend.
2010B	47	C	See Implementation Guide	Please correct and resend.
2010B	49	C	Provider is not primary care physician.	Please correct and resend
2010B	51	C	No providers found	Please correct and resend
2010B	51	C	Primary provider NPI not found	Please correct and resend.
2010B	79	C	Supplemental primary provider identification is required	Please correct and resend.
2010B	97	C	See Implementation Guide	Please correct zip code and resend.
2010C	58	C	Subscriber Date of Birth and Subscriber Last Name Must be Provided on Request.	Please correct and resend
2010C	58	C	Date-of-Birth is missing	Subscriber date of birth is missing or invalid. Please correct and resend.
2010C	58	C	Subscriber Date of Birth missing/invalid.)	Please correct and resend subscriber date of birth.
2010C	58	C	Please see implementation guide	Please correct and resend.
2010C	64	C	Member Identification Number is Required to Process Request	Please correct and resend.

Loop	AAA03	AAA04	Error Description	Trading Partner Action Required
2010C	65	C	Subscriber Last Name Missing/Invalid	Subscriber last name is missing or invalid. Please correct and resend.
2010C	68	C	See Implementation Guide	Please correct and resend.
2010C	71	C	Patient DOB does not match data base	Please correct and resend.
2010C	71	C	Invalid/Missing Subscriber/Insured Name and Patient DOB Does Not Match Data Base	Please correct and resend.
2010C	71	C	Invalid/Missing Subscriber/Insured ID and Invalid/Missing Subscriber/Insured Name and Pt DOB Does Not Match DB	Please correct and resend
2010C	71	N	See Implementation Guide	
2010C	72	C	Please see implementation guide	Please correct and resend.
2010C	72	C	Invalid Missing Subscriber/Insured ID	Please correct and resend
2010C	72	C	Invalid/Missing Subscriber/Insured ID and Invalid/Missing Subscriber/Insured Name	Please correct and resend
2010C	72	C	Invalid/Missing Subscriber/Insured ID and Invalid/Missing Subscriber/Insured Name and Pt DOB Does Not Match DB	Please correct and resend
2010C	73	C	See Implementation Guide	Please correct and resend
2010C	73	C	Subscriber Date of Birth and Subscriber Last Name Must be Provided on Request	Please correct and resend
2010C	73	C	Invalid Missing Subscriber/Insured Name	Subscriber first and last names are required.
2010C	73	C	Invalid/Missing Subscriber/Insured Name and Patient DOB Does Not Match Data Base	Please correct and resend.
2010C	73	C	Please see implementation guide	Please correct and resend
2010C	73	C	Invalid/Missing Subscriber/Insured ID and Invalid/Missing Subscriber/Insured Name	Please correct and resend
2010C	73	C	Invalid/Missing Subscriber/Insured ID and Invalid/Missing Subscriber/Insured Name and Pt DOB Does Not Match DB	Please correct and resend
2010C	75	N	Subscriber ID not found	Resubmission not allowed
2010C	76	C	Multiple matches found. Please try another search option	Please resubmit with the subscriber group number in order to resolve ambiguity.
2010C	78	N	Subscriber not eligible	Verify correct information was submitted.
2010C	78	N	See Implementation Guide	See ID card
2010C	95	N	No subscriber found with this search criteria	Member not eligible for either beginning service date or end service date. Please verify dates of
2010C	95	N	See Implementation Guide	Please correct and resend.
2010C	95	N	Subscriber ID not found.	The subscriber was not found. Please correct and resend if applicable.

Loop	AAA03	AAA04	Error Description	Trading Partner Action Required
2010D	58	C	See Implementation guide	Please correct and resend.
2010D	58	C	Dependent Date of Birth is missing.	Please correct and resend.
2010D	58	C	Dependent Date of Birth must be provided on request	Please correct and resend
2010D	64	C	Invalid Missing Subscriber/Insured ID	Subscriber ID is required. Please correct and resend.
2010D	65	C	Dependent Last Name Must be Provided on Request	Please correct and resend.
2010D	65	C	See Implementation guide	Please correct and resend.
2010D	68	C	Multiple matches found. Please try another search option	Please resubmit with the subscriber group number in order to resolve ambiguity.
2010D	71	C	Patient DOB does not match Data Base	Please correct and resend.
2010D	71	N	See Implementation Guide	
2000E	15	C	2000E UM04 is required for an Admission Review. (UM01=AR)	Please correct and resend.
2000E	15	C	2000E UM03 value is not supported. See Companion guide for supported values.	Please correct and resend. Refer to Section 9.1 for supported values.
2000E	15	C	2000E UM04-1 value is not supported	Please correct and resend
2000E	15	C	2000E UM03 value is not supported.	Please correct and resend.
2000E	33	C	2000E HSD01 of DY requires an HSD02 Quantity of zero or greater	Please correct and resend.
2000E	33	C	Only "AR" or "HS" are supported. (2000E UM01)	Please correct and resend.
2000E	33	C	Only HS is supported for Authorizations. (2000E UM01)	Please correct and resend
2000E	33	C	2000E UM06 value of "E" only is supported	Please correct and resend.
2000E	33	C	2000E UM04-1 is not supported. See Companion Guide for supported values.	Please correct and resend.
2000E	33	C	2000E UM06 value is not supported. Only valid values are U or 03.	Please correct and resend.
2000E	33	C	ICD9 is not supported for this case	Please correct and resend using ICD10
2000E	33	C	ICD10 is not supported for this case	Please correct and resend using ICD9.
2000E	33	C	Only I or S are supported (2000E UM02)	Please correct and send.
2000E	33	C	For Admission Review (UM01="AR") if HSD segment sent only supported HSD01 = DY. (2000E)	Please correct and resend.
2000E	33	C	2000E UM04-2 is not supported for an Admission Review.	Please correct and resend.

Loop	AAA03	AAA04	Error Description	Trading Partner Action
2000E	33	C	UM04-2 value is not supported for a Professional Service.(2000E)	Please correct and resend.
2000E	33	C	Mixed Diagnosis Code Type not supported (2000E)	ICD9 and ICD10 cannot be submitted together. Please correct and resend.
2000E	33	C	Mixed Diagnosis Code Type not supported for multiple service lines (2000E	ICD9 and ICD10 cannot be submitted together. Please correct and resend.
2000E	33	C	Mixed - ICD9 Diagnosis Code on case, ICD10 submitted	ICD9 and ICD10 cannot be submitted together. Please correct and resend.
2000E	33	C	Mixed - ICD10 Diagnosis Code on case, ICD9 submitted	ICD9 and ICD10 cannot be submitted together. Please correct and resend.
2000E	33	C	Update to case is not supported. Date change(s) caused invalid Dx Code Type	Please correct and resend.
2000E	33	C	Transaction Set Create Date and Time (BHT04, BHT05) must be sent for Authorizations.	Please correct and resend.
2000E	33	C	Invalid Certification Type Code	Please correct and resend
2000E	33	C	When Certification Type is I, do not include Administrative Reference Number. (2000E)	Please correct and resend.
2000E	33	C	Previous Review Administrative Reference Number not found. Case cannot be updated. (UM02=S)	Please correct and resend.
2000E	33	C	Previous Review Administrative Reference Number and Authorization Number are not associated. Case cannot be updated. (UM02=S)	No action needed.
2000E	33	N	Case/Service Block	Review message in 2000E-MSG01 for instructions.
2000E	33	N	Update not allowed due to a completed appeal.	You cannot update.
2000E	33	N	Update not allowed due to an appeal	You cannot update
2000E	33	N	Update not allowed due to Post Service Claim Received.	You cannot update.
2000E	33	N	Service is cancelled or denied. Update is not supported. You may call the number on the back of the member id card for further information.	Update is not supported. You may call the number on the back of the member id card for further information.
2000E	33	N	Case is not Open. Updates are not supported. You may call the number on the back of the member's card for further information. (IP Only)	Update is not allowed. You may call the number on the back of the member's card for further information.

Loop	AAA03	AAA04	Error Description	Trading Partner Action
2000E	33	N	Duplicate request with Administrative Reference Number xxxxxxxxxxxxxxx.	No action needed.
2000E	33	N	Case is Cancelled. Update is not supported.	No action needed.
2000E	33	N	Certification Not required	Review message in 2000E-MSG01 for
2000E	33	N	Case is Cancelled or Denied. Update is not supported. You may call the number on the back of the member's card for further information.	Update is not allowed. You may call the number on the back of the member's card for further information.
2000E	33	N	Member does not match previously submitted Member for the event. Case cannot be updated. (UM02=S)	Please verify and resend if applicable.
2000E	33	N	Actual Admission Date exists for the event. Updates to case are not supported. (UM02=S)	Update is not allowed. You may call the number on the back of the member's card for further information.
2000E	57	C	Event Date is required to Process the Request	Please correct and resend
2000E	57	C	See Implementation Guide	Please correct and resend.
2000E	60	C	See Implementation Guide	Please correct and resend.
2000E	AA	N	See Implementation Guide	You may call the number on the back of the member's card for further information.
2000E	AF	C	ICD9 is not supported for this case. (2000E)	All ICD9 Diagnosis Type Codes received on request on or after the ICD10 Cutover Date. Please resubmit with valid ICD10 codes.
2000E	AF	C	See Implementation guide	Please correct and resend
2000E	AF	C	See Implementation guide	Please correct and resend
2000E	AF	C	See implementation guide	Please correct and resend.
2000E	AM	C	Admission Date is Required to Process Request	Please correct and resend.
2000E	AM	C	See Implementation Guide	Please correct and resend.
2000E	AM	C	See Implementation guide	Please correct and resend.
2000E	AN	C	See Implementation Guide	Please correct and resend.
2000E	T5	C	Administrative Reference Number is required for a Revision. (2000E REF02)	Please correct and resend
2000E	T5	C	Administrative Reference Number must be 16 digits. (2000E REF02)	Please correct and resend.
2010EA	15	C	Facility Provider required for Admission Review. (UM01=AR)	Please correct and resend if applicable.
2010EA	33	C	NM101 is not supported. See Companion Guide for supported values.	Please correct and resend.
2010EA	33	C	Admitting Provider not supported for Outpatient Service.	Please correct and resend
2010EA	33	C	Only one Admitting Provider supported.	Please correct and resend.
2010EA	33	C	Only one Attending Provider supported.	Please correct and resend.
2010EA	41	C	Facility Provider not supported for Professional Service (UM01 = HS).	Please correct and resend if applicable.
2010EA	41	N	Call number on enrollee card (message in 2000E)	The Notification/Prior Authorization request for this member must be submitted to Harvard Pilgrim Health Care electronically through HPHConnect or NEHEN.

Loop	AAA03	AAA04	Error Description	Trading Partner Action
2010EA	43	C	See Implementation Guide	Please correct and resend.
2010EA	44	C	See Implementation Guide.	Please correct and resend.
2010EA	46	C	See Implementation Guide	Please correct and resend.
2010EA	47	C	See Implementation Guide	Please correct and resend.
2010EA	51	C	Referred to provider NPI not found	Please correct and resend.
2010EA	97	C	See Implementation Guide	Please correct zip code and resend.
2000F	15	C	2000F UM04-1 value is not supported	Please correct and resend.
2000F	15	C	Authorization submission is only supported if Service Level (2000F) is provided when UM02 = I.	Please correct and resend.
2000F	15	C	SV1-(Professional Service) is required when requesting a Professional Service.	Please correct and resend.
2000F	15	C	Institutional Service (SV2) is required for Admission Review (UM01="AR"). (2000F)	Please correct and resend.
2000F	15	C	2000F UM03 value is not supported.	Please correct and resend if applicable.
2000F	33	C	Multiple service providers or services not accepted in a single request	Please correct and resend
2000F	33	C	The referred to provider selected is not a valid physician	Please correct and resend
2000F	33	C	HSD is not supported for services on an Admission Review. (2000F)	Please correct and resend if applicable.
2000F	33	C	Only "HS" is supported. (2000F UM01)	Please correct and resend if applicable.
2000F	33	C	Only "I" or "S" are supported (2000F UM02)	Please correct and resend if applicable.
2000F	33	C	Only Service Status A1, A3, A4, A5 are supported. (2000F MSG01)	Please correct and resend if applicable.
2000F	33	C	When Certification Type is "I", do not include Authorization Number. (2000F)	Please correct and resend.
2000F	33	C	2000F UM03 value is not supported. See Companion Guide for supported values.	Please correct and resend.
2000F	33	C	UM04-2 value is not supported for a Professional Service.	Please correct and resend.
2000F	33	C	2000F UM04-1 value is not supported. See Companion Guide for supported values.	Please correct and resend. .
2000F	33	C	Institutional Service (SV2) for Health Service Review (UM01="HS") is not supported. (2000F)	Please correct and resend.
2000F	33	C	Professional Service (SV1) for Admission Review (UM01="AR") is not supported for authorizations. (2000F)	Please correct and resend.
2000F	33	C	Dental Service (SV3) is not currently supported. (2000F)	No further action is needed.
2000F	33	C	Unit of Measure Code and quantity must both be sent. (2000F SV1)	Please correct and resend.
2000F	33	C	Unsupported Unit of Measure submitted. Only "UN" is supported. (2000F SV1)	Please correct and resubmit.
2000F	33	C	Provide a Quantity value in either HSD or SV1 but not both. (2000F)	Please correct and resend.
2000F	33	C	Quantity must be greater than zero (2000F SV104)	Please correct and resend.

Loop	AAA03	AAA04	Error Description	Trading Partner Action
2000F	33	C	Quantity Qualifier is not supported. See Companion Guide for values. (2000F HSD01)	Please correct and resend.
2000F	33	C	Only Sample Selection Modulus "1" or "2" are supported when Unit of Measure Code is “DA” or “WK”. (2000F)	Please correct and resend.
2000F	33	C	Only Sample Selection Modulus "1" is supported when Unit of Measure Code is	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "7" is supported when Unit of Measure is "DA".	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "34" is supported when Unit of Measure is "MO".	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "35" is supported when Unit of Measure is "WK".	Please correct and resend.
2000F	33	C	Quantity must be greater than zero (2000F HSD02)	Please correct and resend.
2000F	33	C	HSD segment does not conform to supported service delivery patterns. See	Please correct and resend. Refer to Section 9.1 for supported values.
2000F	33	C	Number of Periods must be greater than zero (2000F HSD06)	Please correct and resend.
2000F	33	C	Facility and Service certification type does not match.	Please correct and resend.
2000F	33	N	Case/Service Block	Review message in 2000E-MSG01 for instructions.
2000F	57	C	Missing Dates of service	Please correct and resend
2000F	57	C	See Implementation Guide	Please correct and resend
2000F	60	C	See Implementation Guide	Please correct and resend.
2000F	AG	C	See Implementation Guide	Please correct and resend.
2000F	T5	C	Prior Authorization Reference Number is required for a Revision. (2000F)	Please correct and resend.
2000F	T5	C	Prior Authorization Reference Number must be 10 digits. (2000F)	Please correct and resend.
2010FA	15	C	One Service Provider is required for an OP submission.	Please correct and resend
2010FA	33	C	Only one Attending Provider supported.	Please correct and resend

- **FREQUENTLY ASKED QUESTIONS**

1. **Does this Companion Guide apply to all UnitedHealthcare payers?**
   No. It applies to commercial and government business for UnitedHealthcare using Payer ID 87726 and UnitedHealthcare Oxford Payer id 06111 and 061118515.
2. **How does UnitedHealthcare 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.