UnitedHealthcare Standard Encounter Companion Guide

UHC Payer ID 95958 & 98789

Refers to the Implementation Guide

Based on X12 Version 005010X222A1

Health Care Claim – Professional

(837p)

Companion Guide Version Number 7.0

January 30, 2023

CHANGE LOG

Version	Release Date	Changes
1.0	09/2011	Initial external release.
2.0	04/2012	Section 7.1: • Added note regarding Member cost Share/Revenue Section 10: • Removed AMT references from Loop 2300 in the table • Added Loop 2320 and CAS elements • Added Loop 2430 and CAS elements
2.1	11/2012	Section 10: • Added Loop 2000B and SBR elements • Loop 2010AA changed from Receiver Detail to Billing Provider Detail • Added Loop 2010BB NM1 and N3 and N4 elements • Loop 2300 CLM02 Notes/Comments changed from SV2 to SV1 • Added Loop 2320 SBR and AMT elements • Loop 2320 CAS 02 Added website to CARC • Added loop 2330A and 2330B and NM1 elements • Added loop 2430 and SVD elements • Loop 2430 CAS 02 • Added website to CARC
3.0	03/2014	ICD-10 effective date change to 10/01/2015.
4.0	04/2015	Section 7.1: • Updated requirements for submitting voids and replacements Section 10: • Added Loop 2010BB REF02 requirement (Submitter ID) • Added Loop 2320 AMT Payer Paid Amount requirement
5.0	11/08/2017	Updated UnitedHealthcare and Optum contact information, including hyperlinks to online resources.
6.0	10/22/2019	Changed title of CG to reflect Encounter only and Payer ID 95958. Removed any reference to fee for service claims and UHC Payer ID 87726.
6.1	11/05/2019	Added reference to Fee for Service Claim submission in section 6.1
6.2	09/03/2021	Section 2.1: Getting Started • Added Optum360
7.0	01/30/2023	Added Payer ID 98789. Provided additional guidance when submitting out-of-network data, Coordination of Benefits and void/replacements. • Updated Optum information

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 837 Health Care Claim: Professional ASC X12N (005010X222A1), are compliant with both ASC X12 syntax and those guides. There are separate transactions for Health Care Claims - professional (837P) and institutional (837I). 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 the TR3.

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

This section describes how Technical Report Type 3 (TR3), also called 837 Health Care Claim: Professional (837P) ASC X12N/005010X222A1, adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has included, in addition to the information contained in the TR3s. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite, and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

In addition to the row for each segment, one or more additional rows are used to describe UnitedHealthcare's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment. Please utilize Loop 2300 NTE or K3 for any additional claim notes or detail.

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

The following is an example (from Section 9 – Transaction Specific Information) of the type of information that may be included:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71	1000A	**NM1**	Submitter Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
114	2100C	NM109	Subscriber Primary Identifier			This type of row exists to limit the length of the specified data element.
114	2100C	NM108	Identification Code Qualifier			
				MI		This type of row exists when a note for a particular code value is required. For example, this note may say that value MI is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
184	**2300**	**HI**	Principal Diagnosis Code			
	2300	**HI01-2**	Code List Qualifier Code	**ABK**		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

1.1 SCOPE

This document is to be used for the implementation of the TR3 HIPAA 5010 837 Health Care Claim Encounter: Professional (sometimes referred to as Professional Claim or 837P Claim in this document) for the purpose of submitting an encounter claim electronically. 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 Professional Claim and must be used in conjunction with the TR3 instructions.

This CG is intended to provide guidance during the implementation of electronic Professional Encounter transactions that meet UnitedHealthcare processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library on the Companion Guides page: https://www.uhcprovider.com/en/resource-library/edi/edi-companion-guides.html

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837 Health Care Claim: Professional (005010X222A1) 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 837 Professional Claim transactions. After careful review of the existing IG for the Version 005010X222A1, 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. All transactions must 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 837 Health Care Claim: Professional transaction (837P), as well as

associated timeframes, costs, etc. This includes protocols for testing the exchange of encounter 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.

- If interested in using Optum's online solution, visit optum.com/contactus for more details.

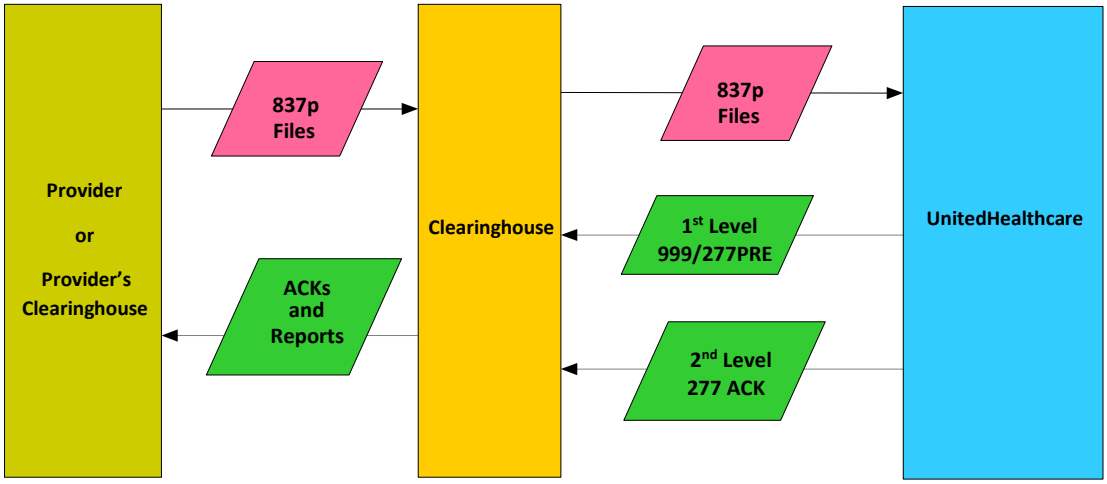
2.3 CERTIFICATION AND TESTING

All trading partners who are required to submit 837P Claim transactions to UnitedHealthcare via the ASC X12 837 (Version 005010X222A1), 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 837 PROFESSIONAL ENCOUNTERS



3.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

UnitedHealthcare supports both batch and real-time 837P Claim transmissions. Contact your current clearinghouse vendor to discuss transmission types and availability.

3.3 RE-TRANSMISSION PROCEDURES

Physicians, facilities, and health care professionals should contact their current clearinghouse vendor for information on whether resubmission is allowed or what data corrections need to be made for a successful response.

3.4 COMMUNICATION PROTOCOL SPECIFICATIONS

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

3.5 PASSWORDS

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

3.6 SYSTEM AVAILABILITY

UnitedHealthcare will accept 837 claim transaction submissions at any time, 24 hours per day, 7 days a week. Unplanned system outages may occur occasionally and impact our ability to accept or immediately process incoming transactions. UnitedHealthcare will send an email communication for scheduled and unplanned outages.

3.7 COSTS TO CONNECT

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

Optum:

- Optum EDI Clearinghouse Support –
  - Call 866-678-8646, Option #2
  - Submit a trouble ticket online at https://optumconnectivityportal.force.com/edisupport
- Optum's online solution
  - Visit Solving Challenges for Health Care Providers | Optum or Healthcare Claims Integrity (optum360.com)

4. CONTACT INFORMATION

4.1 EDI SUPPORT

Most questions can be answered by referring to the EDI section of our resource library at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange (EDI): https://www.uhcprovider.com/en/resource-library/edi.html. View the EDI 837: Electronic Claims page for information specific to 837 Claim and Encounter transactions.

If you need assistance with an EDI 837 transaction accepted by UnitedHealthcare, please contact EDI Support by:

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

Physicians, facilities and health care professionals should contact their current clearinghouse vendor or Optum for technical support. If using Optum, contact their technical support team at 866-678-8646, Option #2.

For encounter data transaction set up or issues, send an email to the Encounter Data Collection Team: encountercollection@uhc.com

4.3 PROVIDER SERVICES

Provider Services should be contacted at 877-842-3210 instead of EDI Support if you have questions regarding 837 Claim transactions that do not pertain to EDI. Provider Services is available Monday - Friday, 7 am - 7 pm in the provider's time zone.

4.4 APPLICABLE WEBSITES/EMAIL

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

Optum: https://www.optum.com

OptumInsight/Optum EDI Client Center: Healthcare Claims Integrity (optum360.com)

UnitedHealthcare Administrative Guide: Healthcare Provider Administrative Guides and Manuals | UHCprovider.com

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.

The table below 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.

LOOP ID	Reference	NAME	Values	Notes/Comments
None	**ISA**	**ISA Interchange Control Header**		
	ISA05	Interchange ID Qualifier	**ZZ**	ZZ = Mutually defined
	ISA06	Interchange Sender ID	[Submitter ID]	This is the Submitter ID assigned by UnitedHealthcare.

	ISA08	Interchange Receiver ID	**95958 & 98789** (encounters)	UnitedHealthcare Payer ID -Right pad as needed with spaces to 15 characters.

5.2 GS-GE

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

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

LOOP ID	Reference	NAME	Values	Notes/Comments
None	**GS**	**Functional Group Header**		**Required Header**
	GS03	Application Receiver's Code	**95958 & 98789** (encounters)	UnitedHealthcare Payer ID Code
	GS08	Version/Release/Industry Identifier Code	**005010X222A1**	Version expected to be received by UnitedHealthcare

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. An 837 file can only contain 837 transactions.

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

LOOP ID	Reference	NAME	Codes	Notes/Comments
None	**ST**	**Transaction Set Header**		**Required Header**
	ST03	Implementation Convention Reference	**005010X222A1**	Version expected to be received by UnitedHealthcare

5.4 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment GS
- Functional Group Header segment
  - ST - Transaction Set Header segment First
    - 837 Transaction
  - SE - Transaction Set Trailer segment
  - ST - Transaction Set Header segment Second
    - 837 Transaction
  - SE - Transaction Set Trailer segment
  - ST - Transaction Set Header segment Third
    - 837 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 270 file. 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 recommended data element delimiter is an asterisk (*)
2. Data Segment: 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 (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^)

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 ELECTRONIC ENCOUNTER SUBMISSION GUIDELINES

Following these guidelines will help you submit most of your claims electronically, without paper forms or attachments.

Services	Guidelines
Non-Encounter Fee for Service Claims	UHC West Fee for Service claims should be submitted under UHC Payer ID 87726, the UHC Standard 837 Companion Guide will apply.
Delegated Encounters	Delegated Encounters should be submitted under UHC Payer ID 95958 or 98789. Please contact encountercollection@uhc.com to confirm Payer ID.
Allergy Procedure Codes	Instead of submitting medical notes, use utilize **Loop 2300 NTE01** to indicate number of doses, vials or injections as well as the dose schedule.
Corrected Claims	Corrected claims can be submitted electronically using the Claims Reconsideration tool in claimsLink. Learn more online: https://www.uhcprovider.com/en/claims-payments-billing/claimslink-self-service-tool.html
Interest Payments	Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in its entirety that contains interest payments must display these payments using a claim adjustment reason code (CARC) 225 – Payment or Interest Paid by Payer. This code should only be used for plan-to-plan encounter reporting. According to Section 1.1.1.1 of the 005010X222A1, balancing to the claim payment involves the subtraction of adjustments from the service line payment total. A positive dollar amount for interest would reduce the payment of the claim. A negative dollar amount would increase the payment on the claim. As a result, reporting the payment of interest by a prior payer in the 837 would require a "negative dollar" amount to balance. CARC 225 payments should not be equal to zero.
Laboratory Services	When performed in the office on an urgent basis, use modifier **"ST"** in the modifier field.
Lifetime Events	A lifetime event is described as a medical procedure that can only occur once in a lifetime. Such events include but are not limited to Hysterectomy, Prostatectomy, Appendectomy, and Amputations, etc. Lifetime events must be reported with a unit value of only 1.
Participating Physician Covering Primary Care Physician (PCP)	When a UnitedHealthcare participating physician is covering for a PCP, use the EDI Notes Field* to indicate "Covering for Dr. X" instead of submitting an attachment.
Rejected Claims and Encounters	Claim and encounter rejections that appear on clearinghouse reports have not been accepted by UnitedHealthcare and should be corrected and resubmitted electronically.
Required Member Cost Share / Revenue Reporting	For Commercial and Medicare Advantage plans, UnitedHealthcare requires[1] contracted providers to submit current, complete and accurate encounter data including member cost share/revenue weekly in order to effectively track member cost share. UnitedHealthcare welcomes and encourages your encounter submissions more frequently than weekly (e.g., twice a week, daily). Greater encounter submission frequency allows us to more effectively administer products where member cost share administration is essential. [1] *Centers for Medicare & Medicaid Services mandate for Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B Services 75 FR 19709, effective Jan. 1, 2011*

Sequestration	As required by federal law under a sequestration order dated March 1, 2013, Medicare Fee-For-Service claims with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. [Source: Center for Medicare and Medicaid Services]. Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in entirety that contains a reduction in payment due to "sequestration" should be reported to UnitedHealthcare using claim adjustment reason code (CARC) 253 – Sequestration. Sequestration reduction should be presented at the service line level.
"Tracers" or Re-Bills	It isn't necessary to send a paper claim backup for a claim sent electronically: • Please allow 20-30 business days for your claim(s) to be processed. • To avoid duplicate claim denials, check the status of your claim as a 276/277 EDI transaction or using Link instead of submitting a tracer.
Unspecified CPT and HCPCS codes	Unlisted and Unspecified Service or Procedure Codes can be submitted an electronic claim, however, UnitedHealthcare will need to review medical notes in order to process these claims. Attachments requested can be uploaded using the claimsLink app. More information on submitting unspecified codes on an electronic claim is online: https://www.uhcprovider.com/en/resource-library/edi/edi-quick-tips-claims.html
Duplicate Encounter Submissions	UHC recommends the use of Group Code 'OA' in combination with CARC Code '18' [Exact duplicate claim/service] to flag service lines that are an exact duplicate of a previous encounter submission. Currently, all encounter submissions that are a complete match to a previous submission will be rejected back to the delegated medical group. Please reach out to encountercollection@uhc.com for further guidance.
Submission of CARC Code B11	UHC recommends the use of CARC code B11 to identify encounters that have been denied due to claim/service has been transferred to the proper payer/processor for processing. Any claim adjudicated using CARC code B11 on all service lines should not be submitted to UHC. Please reach out to encountercollection@uhc.com for further guidance.
In Network / Out of Network	Under the capitated delegated agreement with UnitedHealthcare to support Medicare Advantage EOB for Part C, all encounter submissions must reflect whether the services provided to the member is "in network" or "out of network." Any finalized claim or encounter that contains a service that is out of network should be reported using claim adjustment reason code (CARC) 242 – Services Not Provided by Network/Primary Care Provider, at the service line level (Loop 2430 CAS) OR at the claim header level (Loop 2320 CAS).

FORMATS	LOOP	SEG-FLD	FIELD Description	CARC Code
837p	2320	CAS02	• Use this segment to report OON at the claim header level	242
	2430	CAS02	• Use this segment to report OON at the service line level	242

Medicare Primary claims	When Medicare is primary, check your Medicare Explanation of Benefits (EOB) for Code MA-18 to indicate the claim has been forwarded to the secondary carrier. If it hasn't been forwarded or has been sent to the wrong carrier, then submit the claim and the EOB/Coordination of Benefits (COB) information electronically. More information on Medicare Crossover is online in the Secondary/COB or Tertiary Claims section: https://www.uhcprovider.com/en/resource-library/edi/edi-quick-tips-claims.html

Secondary Claims	When another commercial insurance plan is primary and UnitedHealthcare is secondary, the secondary claim can be submitted electronically. Information from the primary payer's EOB/COB can be included in the electronic claim. UHC recommends the use of CARC code 23 (The impact of prior payer adjudication including payments and/or adjustments) to flag the service lines paid for by the other commercial insurance plan. Please reach out to encountercollection@uhc.com for further guidance. More information on submitting electronic Secondary/COB or Tertiary Claims, including COB Electronic Claim Requirements and Specifications, is online: https://www.uhcprovider.com/en/resource-library/edi/edi-quick-tips-claims.html

FORMATS	LOOP	SEG-FLD	FIELD Description	CODE
837p	2000B	SBR01	• This is the destination payer	P = Primary S = Secondary T = Tertiary
	2320	SBR01	• This is the non-destination payer	
	2320	CAS02	• Please use CARC 23 for service lines with other payers	23
	2430	CAS02	• Please use CARC 23 for service lines with other payers	23

EXAMPLE	Destination vs. Non-Destination	CODE
One Payer (fee for service claim)	2000B *(destination)*	P = Primary
Two Payers (delegated encounter)	2000B *(destination)*	S = Secondary
	2320 *(non-destination)*	P = Primary
Three Payers (delegated encounter with dual coverage member)	2000B *(destination)*	T = Tertiary
	2320 *(non-destination)*	S = Secondary
	2320 *(non-destination)*	P = Primary

Voids and Replacements	A "replacement' encounter should be sent to UnitedHealthcare when an element of data on the encounter was either not previously reported or when there is an element of data that needs to be corrected. A replacement encounter should contain a claim frequency code of [7] in Loop 2300 CLM05-3 segment. A "void" encounter should be sent to UnitedHealthcare when the previously submitted encounter should be eliminated. A void encounter must match the original encounter with the exception of the claim frequency type code and the payer assigned claim number. A void encounter should not contain "negative" values within the encounter. It should contain a claim frequency code of [8] in Loop 2300 CLM05-3 segment. The replacement or void encounter is required to be submitted with the "Original Reference Number" (Payer Claim Control Number) in Loop 2300 REF segment. REF01 must be [F8] and REF 02 must be the "Original Reference Number". If the required information in Loop 2300 REF01 and REF02 is not submitted, the encounter will reject back to the submitter.

FORMATS	LOOP	SEG-FLD	FIELD Description	CODE
837p	2300	CLM05-3	Claim Frequency Type Code	7 or 8
	2300	REF02 (F8)	Original Claim Number	Claim Number from Initial Submission

6.2 VALIDATION OF ENCOUNTERS

UnitedHealthcare applies two levels of editing to inbound HIPAA 837 files and claims:

1. Level 1 HIPAA Compliance:

   Claims passing Level 1 Compliance are assigned a UnitedHealthcare Payer Claim Control Number and are "accepted" for front end processing.

2. Level 2 Front End Validation:
   - Member match
   - Provider match
   - WEDI SNIP Level 1-5 validation
   - Level 1 HIPAA Compliance:
3. Encounters passing front end validation are accepted into the UnitedHealthcare adjudication system for processing.
4. Encounters that do not pass front end validation will be rejected and returned to the submitter.

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 ACKNOWLEDGEMENTS

TA1 – Transaction Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Envelope of the submitted X12 file. UnitedHealthcare real-time will only respond with a TA1 when the X12 contains Envelope errors. The submitted 837 will need to be corrected and resubmitted.

999 – Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a submitted X12 file. UnitedHealthcare will respond with a 999 when the X12 contains Functional errors. The submitted 837 will need to be corrected and resubmitted.

277PRE

This file informs the submitter with more detail about why the claim failed validation. The 277PRE is generated when claims in the batch file failed Level 1 validation. If no claims failed Level 1 validation, then the 277PRE is not created.

277ACK

This file informs the submitter of the disposition of their claims through Level 2 Front End Validation, it reports both accepted and rejected claims.

7.2 REPORT INVENTORY

There are no known applicable reports.

8. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

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

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

9. TRANSACTION SPECIFIC INFORMATION

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

Loop	Reference	Name	Values	Notes/Comments
None	**BHT**	**Beginning of Hierarchical Transaction**		
	BHT06	Transaction Type Code	**RP**	**RP** = Capitated Encounters Use RP when submitting Encounters
1000A	**Submitter Detail**			
	PER	**Submitter Contact**		
	PER02	Contact name	*[Submitter Contact Name]*	UHC requires contact name even if 1000A NM1 submitter name is the same.
1000B	**Receiver Detail**			
	NM1	**Receiver Name**		
	NM103	Name Last or Organization Name	**UNITEDHEALTHCARE WEST** **(BHT06 = RP)**	Receiver Name

Loop	Reference	Name	Values	Notes/Comments
	NM109	Identification Code	**95958 & 98789** [for Encounters]	
2010AA	**Billing Provider Name**			
	NM1	**Billing Provider Name**		
	NM108	Billing Provider ID Qualifier	**XX**	NPI Identifier
	NM109	Billing Provider Identifier		Must be populated with a ten-digit number, begin with 1, 2, 3, or 4 and have the correct check digit in the 10th position.
	N4	**Billing Provider City, State, Zip Code**		
	N403	Zip Code		The full nine (9) digits of the ZIP Code are required.
	REF	**Billing Provider Tax Identification**		
	REF01	Reference ID Qualifier	**EI**	EI = Employer's Identification Number
	REF02	Reference ID		Billing Provider Tax ID. 9 digits with no separators.
2000B	**Subscriber Information**			
	SBR	**Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	**S**	S = Secondary
2010BA	**Subscriber Name**		If a UnitedHealthcare patient is a Dependent, then the dependent information must be supplied in Loop 2000C and 2010CA. If the claim is for the Subscriber only then Loop 2000C and 2010CA are not required. If the 2010CA Loop is sent it may cause a rejection	
	NM1	**Subscriber Name**		
	NM108	Subscriber Id Qualifier	**MI**	MI is the only valid value at this time. Claims received with value II will be rejected.
	NM109	Subscriber Primary Identifier		The Member ID of the Subscriber is required for NM109; however, if the patient is a Dependent, their unique Member ID must be entered here regardless of the Name in NM103/NM104.
2010BB	**Payer Name**			
	NM1	**Payer Name**		

Loop	Reference	Name	Values	Notes/Comments
	NM103	Last Name or Organization Name	**UNITEDHEALTHCARE (BHT06 = RP)**	Payer Name
	NM108	Identification Code Qualifier	**PI**	PI = Payer Identifier
	NM109	Identification Code	**UNITED HEALTHCARE (BHT06 = RP)**	When BHT06 = RP Please check with your clearinghouse for specific identification code that must be used
	REF	**Billing Provider Secondary Identification**		
	REF01	Reference ID Qualifier	**G2**	G2 = Provider Commercial Number
	REF02	Reference ID		The full 12 digit UHC Submitter ID is required
2300	**Claim Loop**			
	CLM	**Claim Information**		
	CLM01	Patient Control Number		The delegates own internal claim number
	CLM02	Total Claim Charge Amount		Must balance to the sum of the SV1 service lines in Loop 2400.
	CLM05-3	Claim Frequency Type Code	**1**, **7**, **8**	1=Original claim submission 7=Replacement 8=Deletion
	PWK	**Claim Supplemental Information**		
	PWK01	Report Type Code	**9**	Populated for chart review submissions only
	PWK02	Attachment Transmission Code	**AA**	Populated for chart review submissions only. Available upon request at provider site.
	DTP	**Date-Initial Treatment**		
		Submit Initial Treatment Date for End Stage Renal Disease (ESRD). Submit Initial Treatment Date for dental services required as the result of an accident.		
	DTP	**Date-Admission**		
		Submit Admission Date on all ambulance claims or when patient was known to be admitted to the hospital.		
	K3	**File Information**		
		Optional segment utilized to submit additional information such as provider claim ID's.		
	HI	**Health Care Information Codes**		

Loop	Reference	Name	Values	Notes/Comments
		Submit only **ICD10** codes. Claims or Encounters received with value ICD9 codes will be rejected.		
2320	**Other Subscriber Information**			
	SBR	**Other Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	**P**	P = Primary
	AMT	**Coordination of Benefits (COB) Payer Amount Paid**		
	AMT01	Monetary Amount	**D**	D = Payer Amount Paid
	AMT02	Payer Paid Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment
2330A	**Other Subscriber Name**			
	NM1	**Other Subscriber Name**		
	NM108	Identification Code Qualifier	**MI**	MI is the only valid value at this time. Claims received with value II will be rejected.
	NM109			Member ID / Subscriber ID
2330B	**Other Payer Name**			
	NM1	**Other Payer Name**		
	NM103	Name Last or Organization Name		Name of Delegated Medical Group
	NM108	Identification Code Qualifier	**PI**	
	NM109	Identification Code		BHT06 = RP Please check with your clearinghouse for specific identification code that must be used.
2400	**Service Line Information**			
	SV1	**Professional Service**		
	SV103	Unit or Basis for measurement code	**MJ**	Submit code MJ when reporting anesthesia minutes in Loop 2400SV104

Loop	Reference	Name	Values	Notes/Comments
	SV104	Quantity		Units Submit a maximum unit quantity of 999 per occurrence of Loop 2400 SV1. When unit quantity is greater than 999, submit multiple occurrences with up to 999 units per occurrence. Minutes Submit quantity as minutes for time based anesthesia services, using MJ qualifier in Loop 2400 SV103.
	MEA	**Test Result**		
	MEA01	Measurement reference ID code	**TR**	TR = Hematocrit Hematocrit (HCT) test level is requested on all claims with services for erythropoietin (EPO).
	MEA02	Measurement qualifier	**R2**	R2 = Hematocrit To indicate test results being reported for Hematocrit
	MEA03	Measurement value		Submit Hematocrit test result value
	HCP	**Line Pricing/Repricing Information**		
		Submit line pricing for repriced claims. Providers do not submit this data. This data is to be submitted by re-pricers only.		
2410	**Drug Identification**			
	LIN	**Drug Identification**		
		Submit NDC for all unlisted injectable drugs and for other injectable drugs when required per the contract between UHG and the provider		
2430	**Line Adjudication Information**		Member Cost Share amounts made at the Line Level must be submitted in Loop 2430 (Line Level).	
	SVD	**Line Adjudication Information**		
	SVD01	Identification Code		Value reported here must match value utilized in Loop 2330B NM109.
	SVD02	Monetary Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment as identified below
	CAS	**Line Level Adjustments**		
	CAS01	Claim Adjustment Group Code		All of the Claim Adjustment Group Codes are allowed. Note: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below.

Loop	Reference	Name	Values	Notes/Comments
	CAS02	Claim Adjustment Reason Code		When submitting Member Cost Share using the PR qualifier, specify the appropriate reason code: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount View Code Source 139 Claim Adjustment Reason Codes: http://www.x12.org/codes/claim-adjustment-reason-codes/
	DTP	**Remittance Date**		
	DTP03	Adjudication or Payment Date		All delegated encounters are required to report the date where the claim was finalized under the delegates internal system.

10. APPENDECIES

10.1 IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your clearinghouse connection. A basic check list would be to:

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

10.2 FREQUENTLY ASKED QUESTIONS

1. **Does this Companion Guide apply to all UnitedHealthcare payers and payer IDs?**
   No. It's applicable to commercial and government business for UnitedHealthcare using Payer 95958 and 98789 for encounters.
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.
3. **If an 837 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?**
   No. UnitedHealthcare will always send a response. Even if UnitedHealthcare systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.3 FILE NAMING CONVENTIONS

Node	Description	Value
ZipUnzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES		
ZipUnzip	Responses will be sent as either zipped or unzipped depending on how UnitedHealthcare received the inbound batch file	**N - Unzipped Z - Zipped**

Node	Description	Value
ResponseType	Identifies the file response type	**999 – Implementation Acknowledgement**
Batch ID	Response file will include the batch number from the inbound batch file specified in ISA13	**ISA13 Value from Inbound File**
Submitter ID	The submitter ID on the inbound transaction must be equal to ISA06 value in the Interchange Control Header within the file	**ISA08 Value from Inbound File**
DateTimeStamp	Date and time format is in the next column (time is expressed in military format as CDT/CST)	**MMDDYYYYHHMMSS**