Standard Companion Guide

Refers to the Implementation Guide Based on X12 Version

005010X217

Request for Review and Response (278)

Companion Guide Version Number: 7.0

October 1, 2015

Preface

This companion guide (CG) to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging 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 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

1.1. SCOPE

This UnitedHealthcare companion guide is designed to assist those who request reviews in advance to services being rendered (specialty care, treatment, admission) and those who respond to those requests using the 005010X217 – Health Care Services Review Information (278) format.

1.2. OVERVIEW

This companion guide will replace, in total, the previous UnitedHealth Group companion guide(s) for Health Care Services Request for Review and Response.

This UnitedHealthcare Companion Guide has been written to assist you in designing and implementing Referral and Authorization transactions to meet UnitedHealthcare's processing standards. This companion guide 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 companion guide 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 EDI transactions with UnitedHealthcare.

Updates to this companion guide will occur periodically and new documents will be posted on www.UnitedHealthcareOnline.com at Tools & Resources > EDI Education for Electronic Transactions > Companion Guide Documents

These updates should be available and distributed to all registered trading partners with reasonable notice, or a minimum of 30 days, prior to required implementation.

In addition, trading partners can also sign up for the Network Bulletin at: http://www.uhc-networkbulletin.com/registration/

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 these documents, consult the Washington Publishing Company web site at www.wpc-edi.com

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator and clearinghouse 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.

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 companion guide. We are not responsible for any changes and updates made to the IG.

2. GETTING STARTED

2.1. CONNECTIVITY WITH UNITEDHEALTHCARE

You may submit and receive EDI transactions to UnitedHealthcare by using our clearinghouse OptumInsight or your current clearinghouse.

2.2. TRADING PARTNER REGISTRATION

Clearinghouse Connections:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss their ability to support the 278 005010X217 Health Care Services Review-Request for Review and Response transaction, as well as associated timeframe, costs, etc. Physicians and Healthcare professionals also have an opportunity to submit and receive a suite of EDI transactions via the OptumInsight (formerly "Ingenix Health Information Network (HIN)") clearinghouse. For more information, please contact your OptumInsight Account Manager. If you do not have an Account Manager, please contact the OptumInsight Sales Team at (800) 341-6141, Option 2 for more information. You may also visit **Optum.com/connectivity**

2.3. CERTIFICATION AND TESTING OVERVIEW

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.

2.4. TESTING WITH UNITEDHEALTHCARE

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss testing or reach out to OptumInsight at 1-800-341-6141, option 2, or visit Optum.com/connectivity.

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOWS

Batched 278 5010 Inquiry and Response:

- Submitter submits a 278 batch request.
- B2B receives a 278 batch request.
- Validation Map is invoked
- 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.
- 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.
    - 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.
    - 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.
    - AK9 indicates the number of transaction sets received and accepted.
    - Any time there are IK3 and IK4 segments in a 999, there is a rejected batch.
    - If there are no IK5 or AK9 segments, there is a problem with the format of the file and file was rejected.
- Transactions that passed the format validation (good transactions) are then de-batched and processed individually
- 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.)
- The de-batch map WTX (Websphere Transformation Extender translation) will convert the 278 file submissions into individual XML request for our clinical area.
- 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.
- WTX converts the response to a 278 X12.
- WTX map generates the re-batch map.
- We will hold the individual 278B ACK Responses until the entire batch has finished processing and send the 278B ACK responses to the submitter. (All of the response transactions from each of the 278 requests are batched together and sent to the submitter.)
- Provider receives either a 278 response or a 278 response with an AAA error.

Real-time 278 5010 Inquiry and Response:

- Submitter submits a 278 real-time request in.
- B2B receives a 278 real time request via Secure HIPAA Services.
- 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.
- WTX Validation Map is invoked
- 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.
- A real-time (Implementation Guide Acknowledgement) is created and sent back to the submitter if the submitted 278 file failed format edits.

- 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.
- 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.
- If there are no IK5 or AK9 segments, there is a problem with the format of the file and file was rejected.

- 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.)
- The de-batch map (WTX) will convert the 278 file submissions into an XML request for our clinical area.
- A response is sent back from our clinical area, for each real time request.
- WTX converts the response to a 278 X12.
- Submitter receives either a 278 response or a 278 response with an AAA error.
- 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.
- **IMPORTANT NOTE; THE TIME OUT RESPONSE WILL BE SENT BACK IN BATCH MODE, THEREFORE, ANYONE SETTING UP A 278 AUTH REALTIME TRANSACTION WILL NEED TO SET UP A BATCH CONNECTION ALSO.**

3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

Physicians and Healthcare professionals should contact their current Clearinghouse Vendor to discuss transmission types and availability.

3.3. RE-TRANSMISSION PROCEDURE

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 in order for a successful response.

3.4. COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection: Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss protocol specifications.

3.5. PASSWORDS

Clearinghouse Connection: Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss passwords.

3.6. COST TO CONNECT

There is no cost to connect using an OptumInsight solution. However, for other clearinghouse solutions, please contact them for pricing.

3.7. SYSTEM AVAILABILITY & DOWNTIME

UnitedHealthcare's normal business hours for 278 Authorization and Referral EDI processing are as follows:

Monday through Friday: 7 am – 2 am (Eastern)
Saturday: 7 am – 6 pm (Eastern)
Sunday: 7 am – 6 pm (Eastern)

Outside these windows, UnitedHealthcare systems may be down for general maintenance and upgrades. During these times, our ability to process incoming 278 EDI transactions may be impacted. When system resources are unavailable UnitedHealthcare will make every effort to queue incoming transactions and process them as soon as required resources are available. There may be certain rare cases in which the transaction cannot be held and must be resubmitted. The codes returned in the AAA segment of the 278 acknowledgement 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. We will send an email communication for scheduled and unplanned outages.

4. CONTACT INFORMATION

4.1. EDI CUSTOMER SERVICE

Most business policy questions can be answered by referencing the materials posted on twww.UnitedHealthcareOnline.com at:
https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=12f8c7958f5fa010VgnVCM100000c520720a____

If you have questions related to UnitedHealthcare's Authorizations and Referrals, and you use a clearinghouse vendor, please contact them directly.

For questions on the format of the 278 or invalid data in the 278 response, use the Online EDI Issue Reporting at UnitedHealthcareOnline.com: under Contact Us > Service & Support > Electronic Data Interchange (EDI) or click
https://www.unitedhealthcareonline.com/b2c/CmaAction.do?txnType=ProblemReport&forwardToken=ProblemReport.

4.2. EDI TECHNICAL ASSISTANCE

Clearinghouse

- When receiving the 278 from a clearinghouse please contact the clearinghouse. If using OptumInsight, please contact them.

4.3. PROVIDER SUPPORT

If you have questions regarding the details of a member's benefits, or any other non EDI related issues please contact 877-842-3210. Provider Services is available Monday – Friday, 7 a.m. to 7 p.m. in provider's time zone.

4.4. APPLICABLE WEBSITES/E-MAIL

For a copy of the TR3 [*005010X217 Health Care Services Review-Request for Review and Response (278)*], please visit the Washington Publishing Company at www.wpc-edi.com .

Companion Guides – https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=73ef025adef0d410VgnVCM2000002a4ab10a

OptumInsight - www.optum.com

www.UnitedHealthcareOnline.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 the transmission. A 278 Auth and Referral file can only contain 278 Auth and referral transactions.

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, this will always be '1'. A 278 file can only contain 278 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 segment is a fixed length record and all fields must be supplied. Fields not populated with actual data must be space filled.

The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.

The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.

ISA16 defines the component element separator used throughout the entire interchange.

5.6. FILE DELIMITERS

UnitedHealthcare requests that you use the following delimiters on your 278 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:

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 (*).**

Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **The recommended Segment Terminator Delimiter is a tilde (~).**

Component-Element: Element ISA16 will define what Component-Element Separator is used throughout the entire transaction. **The recommended Component-Element Delimiter is a colon (:).**

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1. 278 REQUEST

1. Please use UM04-2 = A when UM01 = AR (Admissions Review) in loop 2000E. AR is for pre-auth of scheduled inpatient admissions.

2. Please use UM04-2 = B when UM01 = HS (Health Services Review) in loop 2000E. HS is used for pre-auth of outpatient services.

3. Please 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. Urgent/Emergency pre-auth requests (i.e. those that are requested on day of service), should be called into the number on the patient's member card.

6. Not all services require a pre authorization. Providers should refer to www.unitedhealthcareonline.com for a complete list of services requiring pre-auth.

7. 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)

8. 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.

9. Please submit one Service Level loop (2000F) per referral request.

10. Please submit one Patient Event Provider Name (loop 2010EA) per referral request.

11. 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.

12. Please do not submit both ICD9 and ICD10 diagnosis codes on the same authorization. Transactions received before the service date (prior to 10/1/2015) with ICD10 code qualifiers will be rejected by UnitedHealthcare. Note: Mandate date for accepting the ICD10 is set as of 10/1/2015.

13. Authorizations that contain radiology, cardiology and oncology codes need to be submitted to eviCore Healthcare. Please contact them at 1-800-918-8924. The radiology, cardiology and oncology codes that are impacted can be found at the following links:

Cardiology

Radiology

Oncology

6.2. SERVICE TYPE (UM03) & 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 (Including Medicare Part A) (11)

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 = HOSPITALOUTPATIENT FACILITY (13)

Service Type Code description	UM03 Code
Surgical	2

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

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) (Including Medicare Part A) – Inpatient

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

Code	Location
11	Office
12	Home

22 Hospital – outpatient
61 Rehab Facility Comprehensive Inpatient

6.3. 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 was in compliance with UnitedHealthcare's policy requirements. 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, ANYONE SETTING UP A 278 AUTH REALTIME TRANSACTION WILL NEED TO SET UP A BATCH CONNECTION ALSO

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's EDI Support desk regarding a technical question about a submission, we recommend using this reference number. Administrative Reference Number= UnitedHealthcare'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 United Healthcare's Customer Service. Administrative Reference Number=UnitedHealthcare's Service Reference Number which is only assigned for successfully processed authorization requests (10 bytes)
Review 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 United Healthcare's Customer Service. Administrative Reference Number=UnitedHealthcare's 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 UnitedHealthcare Auth's, it indicates the UnitedHealthcare Clinical Transaction ID that is unique and assigned to every transaction.

6.4. 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).
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 with the exception of vendor ID MAH. 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 auth audit number has been used already or not. When an audit number already exists, the transaction is processed as a change (Update) instead of add.

6.5. 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 Auth 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 field(s) 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:

3. Service Note

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.

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 is 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 services are still pending on the case).
2. Additional Diagnoses
3. Additional Contacts

Updatable field(s) 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).

Community & State 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.

Referrals 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.

Referrals Update Processing - Government

When an auth audit number already exist in our government platform, the transaction is processed as an update, instead of add.

7. ACKNOWLEDGEMENTS AND OR 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

An EDI Trading Partner is defined as any UnitedHealth Group customer (provider, billing service, software vendor, 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. The agreement is an entity or a part of a larger agreement, between each party to the agreement.

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

TRANSACTION SPECIFIC INFORMATION

UnitedHealthcare has put together the following grid to assist you in designing and programming the information we need in the 278 request. This Companion Guide 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 of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

8.1. DATA ELEMENT GRID – REQUEST FOR REVIEW

Loop ID	Reference	Name	Codes	Notes/Comments
Header	**ISA**	**Interchange Control Header**		
Header	ISA01	Authorization Information Qualifier	00	
Header	ISA03	Security Information Qualifier	00	
Header	ISA05	Interchange ID Qualifier	ZZ	
Header	ISA07	Interchange ID Qualifier	ZZ	
Header	ISA08	Interchange Receiver ID	87726	Receiver ID. Left justify and pad with spaces to 15 characters.
Header	ISA11	Repetition Separator	^	The delimiter in ISA 11 must be ^
Header	ISA16	Component Element Separator	:	The delimiter in ISA 16 must be : (colon)
Header	**GS**	**Functional Group Header**		
Header	GS03	Application Receiver's Code	87726	This is the same value as the Receiver's Interchange ID from ISA08 (do not pad with spaces).
Header	**BHT**	**Beginning of Hierarchical Transaction**		
BHT	BHT02	Transaction Set Purpose Code	13	Accept only 13
2010A	**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	UHC Payer ID
2010B	**NM1**	**Requestor Name**		
2010B	NM101	Entity Identifier Code	FA 1P	
2010B	NM103	Name Last / Organization Name		The name of the facility submitting the request is required
2010B	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

Loop ID	Reference	Name	Codes	Notes/Comments
				Identification Number (TIN), or both. If sending both, use the following REF segment for the TIN
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 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 name from NM103.
2010B	PER03	Communication Number Qualifier	TE	At least one contact phone number is required.
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	**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

Loop ID	Reference	Name	Codes	Notes/Comments
				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	Acceptable for A 11 13 21 Acceptable for B 11 12 22 61	All professional place of service codes (UM04**) are** 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	H101-1	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 – 1	Diagnosis Type Code	BF BJ BK	FOR DATE OF SERVICE PRIOR TO 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	HI01 – 2	Diagnosis Code		FOR DATE OF SERVICE PRIOR TO OCT 1, 2015 - ICD-9 code. Format RRR.SS
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 – 1	Diagnosis Type Code	BF BJ	DATE OF SERVICE PRIOR TO 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	HI02 – 2	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS

Loop ID	Reference	Name	Codes	Notes/Comments
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI03 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI04 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIO TO 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	HI05 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI06 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI07 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI08 - 3	Diagnosis Code		DATE OF SERVICE PROR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
2000E	HI09 - 1	Diagnosis Type	ABF	ICD-10 code to be used with DATE OF SERVICE AS OF OCT

Loop ID	Reference	Name	Codes	Notes/Comments
		Code		1, 2015. Additional diagnosis information may be provided if available.
2000E	HI09 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI09 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI10 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 - 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI11 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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 – 1	Diagnosis Type Code	BF	DATE OF SERVICE PRIOR TO 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	HI12 - 3	Diagnosis Code		DATE OF SERVICE PRIOR TO OCT 1, 2015 ICD-9 code. Format RRR.SS
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. For UM01=AR (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 For UM01=HS 1 Attending (71) per case -optional 1 Servicing Provider(SJ) per service - required
2010EA	NM103	Name Last or Organization		To assist in data matching, it is preferred that this value not contain title or suffix abbreviations such as Dr., MD, OB, etc.

Loop ID	Reference	Name	Codes	Notes/Comments
		Name		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	Acceptable for A 11 13 21 Acceptable 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

Loop ID	Reference	Name	Codes	Notes/Comments
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	
2010F	**NM1**	**Service Provider Name**		
2010F	NM101	Entity Identifier Code	FA SJ 1T	Please identify providers related to this submission 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 Cotact Information**		
2010F	PER03	Communication Number Qualifier	TE	At least one contact phone number is required

Loop ID	Reference	Name	Codes	Notes/Comments
2010F	PER04	Communication Number		Phone number - Format 10 digits with no punctuation or spaces
2010F	PER05	Communication Number Qualifier	EX	If applicable

9. APPENDIXES

9.1. IMPLEMENTATION CHECK LIST

The implementation check list will vary depending on your choice of connection; direct connect Connectivity Director, or clearinghouse. However, a basic check list would be to:

1. Register
2. Contract
3. Set up connections
4. Test
5. If testing results are good, a move to production is discussed/requested.

9.2. 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

A.) 999 Functional Acknowledgement (Batch Only):

Z or N_278999_<batch ID>_<submitter ID >_<datetimestamp>.RES.pgp

Example: Z_2780999_000000004_ABC123456789_01102010142034. **RES**.pgp

B.) 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.

C.) 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.

9.3. 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 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 With out 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

10.4 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. TA1 generated. Please correct and resend.
			Syntax errors or implementation guide non compliance	999 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	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 available.
2000A	42	Y	Acknowledgment for Real-time HIPAA Suite Processing	**Do Not Resubmit;** We Will Hold Your Request and Respond Again Shortly'
2000A	42	Y	See Implementation Guide	Check for number on www.unitedhealthcareonline.com The next day.
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	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	43	C	See Implementation Guide	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.
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	Please correct and resend

			Match DB	
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	Invalid/Missing Patient Name	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	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 submission are correct.
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.
2010D	15	C	Dependent Date Of Birth and Dependent Last Name Must be Provided on Request	Please correct and resend.
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 requet	Please correct and resend
2010D	64	C	Invalid Missing Subscriber/Insured ID	Subscriber ID is required. Please correct and resend.
2010D	64	C	Invalid/Missing Patient ID and Invalid/Missing Patient Name	Please correct and resend.
2010D	64	C	Invalid/Missing Patient Id and Invalid/Missing Patient Name and Patient DOB Does Not Match DB	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	65	C	Invalid/Missing Patient ID and Invalid/Missing Patient Name	Please correct and resend.

2010D	65	C	Invalid/Missing Patient Name and Patient DOB Does Not Match DB	Please correct and resend.
2010D	65	C	Invalid/Missing Patient Name	Please correct and resend.
2010D	65	C	Invalid/Missing Patient Id and Invalid/Missing Patient Name and Patient DOB Does Not Match DB	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	C	Invalid/Missing Patient Name and Patient DOB Does Not Match DB	Please correct and resend.
2010D	71	C	Invalid/Missing Patient Id and Invalid/Missing Patient Name and Patient DOB Does Not Match DB	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	Only Service Status A1, A3, A4, A5 are supported. (2000E MSG01)	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.
2000E	33	C	Submitting Provider is not authorized to update the case. (UM02=S)	Please correct and resend
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 can not be submitted together. Please correct and resend.
2000E	33	C	Mixed Diagnosis Code Type not supported for multiple service lines (2000E	ICD9 and ICD10 can not be submitted together. Please correct and resend.
2000E	33	C	Mixed - ICD9 Diagnosis Code on case, ICD10 submitted	ICD9 and ICD10 can not be submitted together. Please correct and resend.
2000E	33	C	Mixed - ICD10 Diagnosis Code on case, ICD9 submitted	ICD9 and ICD10 can not 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	Clinical Information Complete Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 InfoCpDte)	Please correct and resend.
2000E	33	C	Decision Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 DeciDte)	Please correct and resend.
2000E	33	C	Member Notice Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 MemNotDte)	Please correct and resend.
2000E	33	C	Member Letter Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 MemLDte)	Please correct and resend.
2000E	33	C	Provider Notice Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 ProvNotDte)	Please correct and resend.
2000E	33	C	Provider Letter Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 ProvLDte)	Please correct and resend.
2000E	33	C	Member Extension Letter Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 MemExtLetDte)	Please correct and resend.
2000E	33	C	Provider Extension Letter Date must be valid format YYYYMMDDHHMMSS. (2000E MSG01 ProvExtLetDte)	Please correct and resend.
2000E	33	C	Clinical Information	Please correct and resend.

			Complete Date is missing. (2000E MSG01 InfoCpDte)	
2000E	33	C	Decision not allowed on 278A transaction. (2000E event:note	Please correct and resend.
2000E	33	C	Decision Date is missing. (2000E MSG01 DeciDte)	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	Unable to Save Authorization due to internal CareOne validation errors.	Unable to save authorization request 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.
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 instructions
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	Update is not allowed. You may call the number on the back of the member's card for further information.

			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	Multiple non-cancelled preauthorizations found for CareCore ID. Case cannot be updated. (UM02=S).	Update is not allowed
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	ICD10 is not supported for this case. (2000E)	All ICD10 Diagnosis Type Codes received on request before the ICD10 Cutover Date. Please resubmit with valid ICD9 codes.
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. Call 1-800-708-4414 if you cannot submit --- Authorizations electronically - Provider state is in the

				request. The provider state is: X restricted state. CALL NUMBER ON ENROLLEE CARD
2010EA	43	C	See Implementation Guide	Please correct and resend.
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	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. (2000F)	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	Please correct and resend.

			authorizations. (2000F)	
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.
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 "MO". (2000F)	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "7" is supported when Unit of Measure is "DA". (2000F HSD)	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "34" is supported when Unit of Measure is "MO". (2000F HSD)	Please correct and resend.
2000F	33	C	Only Time Period Qualifier "35" is supported when Unit of Measure is "WK". (2000F HSD)	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 Companion Guide for valid patterns	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	Clinical Information Complete Date must be valid format YYYYMMDDHHMMSS. (2000F MSG01 InfoCpDte)	Please correct and resend.
2000F	33	C	Decision Date must be valid format YYYYMMDDHHMMSS. (2000FMSG01 DeciDte)	Please correct and resend.
2000F	33	C	Member Notice Date must be valid format YYYYMMDDHHMMSS.	Please correct and resend.

			(2000FMSG01 MemNotDte)	
2000F	33	C	Member Letter Date must be valid format YYYYMMDDHHMMSS. 2000F(MSG01 MemLDte)	Please correct and resend.
2000F	33	C	Provider Notice Date must be valid format YYYYMMDDHHMMSS. (2000FMSG01 ProvNotDte)	Please correct and resend.
2000F	33	C	Provider Letter Date must be valid format YYYYMMDDHHMMSS. (2000F MSG01 ProvLDte)	Please correct and resend.
2000F	33	C	Member Extension Letter Date must be valid format YYYYMMDDHHMMSS. (2000F MSG01 MemExtLetDte)	Please correct and resend.
2000F	33	C	Provider Extension Letter Date must be valid format YYYYMMDDHHMMSS. (2000FMSG01 ProvExtLetDte)	Please correct and resend.
2000F	33	C	Clinical Information Complete Date is missing. (2000F MSG01 InfoCpDte)	Please correct and resend.
2000F	33	C	Decision Date is missing. (2000F MSG01 DeciDte)	Please correct and resend.
2000F	33	C	Decision not allowed on 278A transaction. (2000F service:note)	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	33	N	Service Status from Approved to Denied must be Handled Manually.	Submit the change on the UHG daily manual error file.
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
2010FA	33	C	Only one Admitting Provider supported.	Please correct and resend.
2010FA	33	C	Admitting Provider not supported for Outpatient Service.	Please correct and resend.
2010FA	33	C	Only one Facility Provider supported.	Please correct and resend.

2010FA	33	C	Only one Servicing Provider is supported per Service.	Please correct and resend
2010FA	33	C	The referred to provider selected is not a valid physician	Please correct and resend.
2010FA	41	C	Facility Provider not supported for Professional Service (UM01 = HS).	Please correct and resend if applicable.
2010FA	43	C	See Implementation Guide	Please correct and resend.
2010FA	43	C	Tax ID OR NPI is missing	Please correct and resend
2010FA	43	C	Referred to Provider information is missing.	Please correct and resend
2010FA	43	C	Invalid Provider NPI: Must be 10 digits	Please correct and resend
2010FA	43	C	Invalid Provider Tax ID: Must be 9 digits	Please correct and resend
2010FA	44	C	See Implementation Guide	Please correct and resend.
2010FA	47	C	See Implementation Guide	Please correct and resend.
2010FA	51	C	No providers found	Please correct and resend.
2010FA	51	C	Referred to provider NPI not found	Please correct and resend.
2010FA	51	C	The Referred to Provider selected is not a participating provider for your product	Please correct and resend if applicable.
2010FA	79	C	Supplemental referred to provider identification is required	Please correct and resend.
2010FA	97	C	See Implementation Guide	Please correct and resend.

10.5 FREQUENTLY ASKED QUESTIONS

1. Does this Companion Guide apply to all UnitedHealthcare payers?

No. The changes will apply to commercial and government business for UnitedHealthcare using payer ID 87726

10.6 CHANGE SUMMARY

This section describes the differences between the current Companion Guide and previous guide(s).

Version	Release date	Changes
1.0		Initial External Release
2.0	9/14/11	Section 10.4 error codes and interpretations have been updated, please refer to the MSG segment for information on why the transaction has rejected. o 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 o 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 o Modified ▪ 2010A 42/N (changed to 42/Y)
2.1	2/17/2012	Section 6.1 and 6.5 of Payer Specific Rules and Limitations o 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 o Case 1: Added a row for MSG01. o Case 3 split into 3a & 3b to show examples of different types of blocking scenarios. o Case 3: Removed HCR03 row. Section 10.4 – Error Codes and Interpretations o 2010C 78/N error description changed from "Subscriber Not in Group/Plan

Version	Release date	Changes
		Identified" to "Subscriber not currently supported for 278 transactions" o 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". o Removed 2010C 78/N "Message will be variable depending on policy." o Added 2000E 33/N Case/Service Block o Added 2000F 33/N Case/Service Block
2.2	8/29/12	Section 6.1 - Payer Specific Rules and Limitations o Added: Please do not submit both ICD9 and ICD10 diagnosis codes on the same authorization. Section 10.4 – Error Codes and Interpretations o Added 2000E 33/C Mixed Diagnosis Code Type Not Supported
3.0	11/22/13	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 auth real-time transaction will need to set up a batch connection also". Section 6..1 – Payer Specific Buisiness Rules - 278 Requst • Added information to send radiology and cardiology codes to CareCore Natiional 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 auth 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	3/21/14	Section 6..1 – Payer Specific Buisiness Rules - 278 Requst • #12 - Added sentence "Transactions received before the service date (prior to 10/1/2014) with ICD-10 codes qualifiers will be rejected by UnitedHealthcare. Note: Mandate date for accepting the ICD -10 is set as 10/1/2014.
5.0	11/17/14	Section 6..1 – Payer Specific Buisiness Rules - 278 Requst • #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	6-30-15	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 Ruels – 278 Response • Added action codes and addional notes under Response tracking numbers.

Version	Release date	Changes
		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 outpaitient 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 Auth Reference Number" ○ 2000E – REF02 changed comment to "Prior Authorizaton Reference Number Section 10.4 – Error Codes and Interpretations • Added "Only HS is supported for Authroizations. (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)

Version	Release date	Changes
7.0	10/01/15	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 8 – Trading Partner Agreements • Removed Connectivity Director and Direct Connects 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 9.1 – Data Element Grid – Request for Review • Updated loop 2000E, HI to reflect ICD-10 requirement for date of service 10-1-15