Availity

Availity® Health Information Network

Batch Electronic Data Interchange (EDI) Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Where healthcare **connects.**

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Disclosure Statement

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Preface

Rules for format, content, and data element values are listed in the HIPAA Technical Reports Type 3 (TR3s) for submitting 5010 HIPAA transactions. These guides are available on the x12.org website.

This Availity EDI Companion Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the transactions specified in this guide as related to Availity. This guide also provides specific information for data elements and values required by Availity.

Important: As defined in the HIPAA TR3s, documents like this Availity EDI Companion Guide are intended to supplement, not replace, the standard HIPAA TR3 for each transaction set. Information in this guide is not intended to modify the definition, data condition, or use of any data element or segment in the standard TR3s. It is also not intended to add any additional data elements or segments to the defined data set. This guide does not utilize any code or data values that are not valid in the standard TR3s. It also does not change the meaning or intent of any implementation specifications in the standard TR3s.

Note:

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Table of contents

2 Introduction

2.1 Scope

The purpose of the Availity Health Information Network EDI Guide (Availity EDI Guide, for short) is to communicate Availity-specific requirements and other information that supplements requirements and information already provided in standard EDI and HIPAA communications.

2.2 Overview

Availity, LLC., a leader in EDI healthcare technology, offers a full suite of EDI health information exchange services through a single web connection to the Availity® Health Information Network. In addition to offering an extensive array of real-time EDI transactions, we also provide near real-time processing of batch EDI transactions. The Availity® Health Information Network is your one stop on the web for secure connectivity and electronic access to an extensive list of commercial insurance payers.

The Availity® Health Information Network is operationally HIPAA compliant, accepting and processing in a secure environment all American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standard transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA). Availity edits batches of transactions for X12N syntax compliance, and then splits the batches into the lowest transaction level possible before applying HIPAA-semantic validation rules. Depending on the payer, Availity might also apply payer-specific edits to transactions that pass HIPAA syntax validation before routing the transactions to the designated payer.

Using the Availity® Health Information Network file transfer features, users can send all files and retrieve responses through one interface.

2.3 Benefits

As an Availity user, you will realize the following benefits:

- Electronic access to commercial and government insurance payers
- The ability to submit transactions destined for multiple payers in a single batch
- Reduced administrative work and expense
- Reduced postage and material expense
- Ability to submit transactions twenty-four hours a day, seven days a week (except during scheduled maintenance times)
- Acknowledgement of receipt for each transmitted file
- Increased accuracy of data and reduced risk of duplication
- Increased productivity
- Improved payment cycle and reduced appeals
- Compliance with HIPAA mandates for electronic transactions

2.4 Supported EDI transactions

Availity is operationally HIPAA compliant, securely accepting and processing a number of X12N transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA). The table below provides information about the ANSI ASC X12N health care electronic transactions adopted for use by the HIPAA regulations, and supported by the Availity Health Information Network.

Table 1: Supported transaction formats

Format	Version supported	Transaction type	Optimal batch file
ASC X12N 837	005010X223A2	Institutional Claims	5,000 claims or 4 megabytes
ASC X12N 837	005010X222A1	Professional Claims	5,000 claims or 4 megabytes
ASC X12N 837	005010X224A2	Dental Claims	5,000 claims or 4 megabytes
ASC X12N 270/271	005010X279A1	Health Care Benefit Inquiry/Response (Eligibility and Benefits)	4 megabytes
ASC X12N 276/277	005010X212	Health Care Claim Status Request/ Response	4 megabytes
ASC X12N 278	005010X217	Health Care Services Request (Authorization and Referral) for Review/Response	4 megabytes
ASC X12N 278	005010X216	Health Care Services Review Notification and Acknowledgement	4 megabytes
ASC X12N 835	005010X221A1	Health Care Claim Payment/Advice (ERA)	4 megabytes
ASC X12N 275	005010X210	Additional Information to Support a Health Care Claim or Encounter (275)	40 megabytes max per attachment and 80 megabytes max per batch

Note: For the ASC X12N 835 format, files over 12 megabytes with large checks might not be validated.

The Availity HIPAA validation is based on the HIPAA-mandated implementation guides. For information about HIPAA edits, please refer to the appropriate *HIPAA Implementation Guide* for the transaction you are submitting.

- For a cost, you can obtain the appropriate *HIPAA Implementation Guide* from x12.org. Choose the implementation guide that best suits your business needs.
- You might want to validate or certify your transactions prior to submitting them to Availity. This service is offered over the internet by various vendors.

  Tip: Search on `free HIPAA validator`, in a search engine, for a list of sites that might be offering HIPAA validators.

2.4.1 Additional Availity EDI Companion Guides and resources

The following are additional companion guides or resources:

- For an introduction to submitting batch EDI transactions to Availity, see the EDI Connection Guide.
- For Availity-specific information about ASC X12N 275 (005010X210) transactions, refer to the Availity EDI 275 Companion Guide.
- For payer and partner connections, refer to the Availity Vendor Business-to-Business (B2B) Specifications Guide.
- For API implementation, refer to the Availity API Guide.

3 Getting started

3.1 Trading Partner Registration

To start submitting transactions to the Availity Health Information Network, the Availity administrator for your organization must first register the organization with Availity by following these steps:

1. Go to www.availity.com and select **REGISTER**.

   Note: The registration must be completed by someone from your business with the authority to authorize the Availity Organization Agreement.

2. Complete the online registration for your type of organization. The process involves providing demographic information about your organization and choosing a user ID for the administrator. At the end of the registration process, you will electronically agree to the Organization Access Agreement, which you can print for your records.

   Learn More: Learn about Availity Essentials registration

When we have processed the application, we send a confirmation by email to the administrator. The first time you log in to Availity Essentials, the system prompts you to agree to the disclaimer, set up your security questions, change your password, and verify your email.

Once the administrator is able to log in to Availity Essentials, they can set up authorized personnel in the office as Availity Essentials users. Each user must have a unique user ID and password. Availity does not allow users to share login credentials.

4 Connectivity with the payer/communications

4.1 EDI file submission methods

Availity provides the following modes for submitting batch files of EDI transactions:

Submit transaction files through EDI

If you work with a practice management system, health information system, or other automated system that supports an EDI connection, you can securely upload batch files of X12 EDI transactions to the Availity EDI site where they are automatically picked up by Availity and submitted to the appropriate health plans.

Important: Review New managed file transfer (MFT) site on page 12 for changes to FTP connections.

Submit transaction files through Availity Essentials

If you have batch files of X12 EDI transactions that you need to process and you don't have access to an EDI connection, you can manually upload the batch files through Availity Essentials.

You can submit batch files through one mode or alternate between modes. Consult with your EDI transactions system/software vendor.

- Availity partners with many vendors. Refer to our Preferred Vendors list on the Availity website.
- If you work with a vendor, follow their instructions for building and submitting batch files.
- If you are a provider who has registered to send Medicare or Medicaid claims through Availity, you must configure your PMS, HIS, or other EDI system with the correct payer IDs and billing provider ID before you can send Medicare or Medicaid EDI claims through Availity. You might need to contact the vendor of your system for assistance with this process.
- Florida providers must register with Florida Medicaid prior to registering to send Medicaid claims through Availity.

Note: If you want to submit real-time (B2B) transactions through Availity's Simple Object Access Protocol (SOAP) Web service, you will need to contact Availity Client Services to request a B2B setup.

4.2 EDI transactions through FTP

4.2.1 New managed file transfer (MFT) site

Availity is implementing an MFT system. The system provides advanced functionality. To upload your batch files by connecting to Availity's new site through a web browser, you must follow these steps:

Availity has set migration windows for payers and submitters as an open development period where you can communicate with your Availity Account Management team or Availity Client Services.

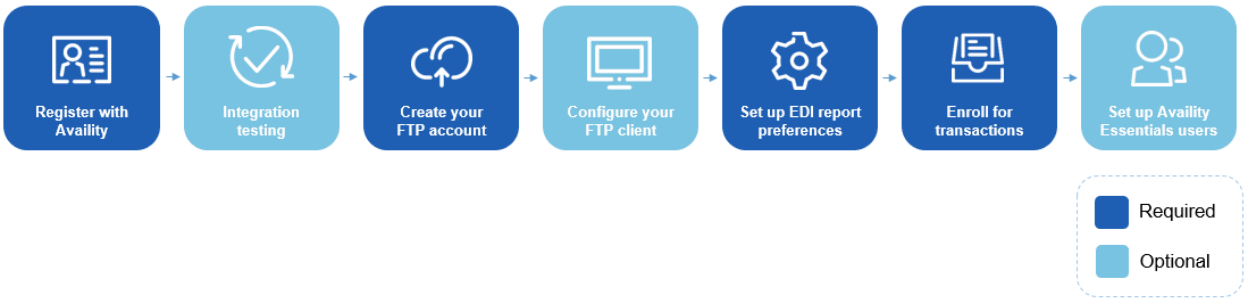
Data exchange process	What you need to know
Send and receive EDI files through Availity Essentials	• No action required.
Exchange files using external web client	• New URL: https://files.availity.com. • Availity will host both the old and new addresses for a time. • Availity will redirect the old URL to the new URL, and turn off the old system. • Usernames and passwords remain the same.
Exchange files with Availity using a third-party SFTP client or a custom SFTP script	• Availity has a new host name (files.availity.com). • This host has a different IP address and a different fingerprint. • You will need to update any connectivity rules that depend on IP addresses (for example, VPNs, firewall rules). • You will need to accept the new fingerprint. • Usernames and passwords remain the same.
Availity manages your connection	• Availity has a new host name (files.availity.com). • This host has a different IP address and a different fingerprint. • You will need to update any connectivity rules that depend on IP addresses (for example, VPNs, firewall rules). • You will need to accept the new fingerprint. • Usernames and passwords remain the same.

Refer to the following sub-sections.

- Please reference Updated connection information for new IP addresses, fingerprints, cyphers, and other connection updates.
- Configure your file transfer client software for QA on page 18

4.2.2 Setup steps for EDI through file transfer client software

Getting set up to submit batch files of EDI transactions to Availity through file transfer client software or web client involves the following steps, some of which you might have already completed. The lighter-colored tasks, such as integration testing, might not be required for your particular implementation.



1. **Register with Availity** - If you have not already registered your organization with Availity, go to www.availity.com and select **REGISTER**.

   Note: The registration must be completed by someone from your business with the authority to authorize the Availity Organization Agreement.

Availity's payer list

Check out the Availity payer list for participating payers and payer IDs. You can also access the payer list from within Availity Essentials by typing **payer list** in the keyword search option.

- Transactions that are listed as **Available** in the payer list are sponsored by the associated payer and are provided at no charge.
- Transactions that are listed as **Contract Required** in the payer list are fee-based. For information about submitting transactions that require a contract, see the information about Comprehensive plans in EDI Clearinghouse plans.

  Note: If your organization already has a contractual agreement with Availity for submitting transactions that require a contract, no other action is required.

2. **Integration testing** - Refer to Integration testing via EDI on page 22 for details.
3. **Create your Availity EDI account** - Refer to Create an Availity EDI production account on page 19 for details.
4. **Configure your FTP client** - Refer to Configure your file transfer client software for production on page 21 for details.
5. **Set up your EDI reporting preferences** - Availity's batch EDI processing generates response files for each batch file that you submit. The administrator for an organization can set reporting preferences that specify which response files are generated. See Configure EDI Reporting Preferences on page 40 for details.
6. **Enroll for transactions** - You might need to enroll for some transactions (such as claim submission) for particular health plans that you submit to. To determine if any of the health plans that you submit to require enrollments, see the Availity payer list. You can also enroll (if required) to have electronic remittance advice files (also known as ERAs and 835s) delivered to your Availity mailbox. Electronic remittance advice files display payment information from all claims, whether submitted electronically

or by paper. See the Availity payer list to determine if enrollment for ERAs is required for a particular health plan.

Note: If your ERAs are already delivered to Availity for the health plans that you submit claims to, you can skip the ERA transaction enrollment process.

7. **Set up your Availity Essentials users** - If other people in your organization need access to Availity Essentials, such as to view remittance advice information, you will need to create an Availity Essentials account for each such person. Log in to Availity Essentials at https://apps.availity.com, select your name or the avatar icon in the Availity Essentials menu, and then select **Add User**.

   Tip: Have a lot of users? On the Add Users page, select the option to upload users in a spreadsheet in CSV format.

4.2.2.1 Set up FTP for the QA environment

Create an Availity QA EDI account

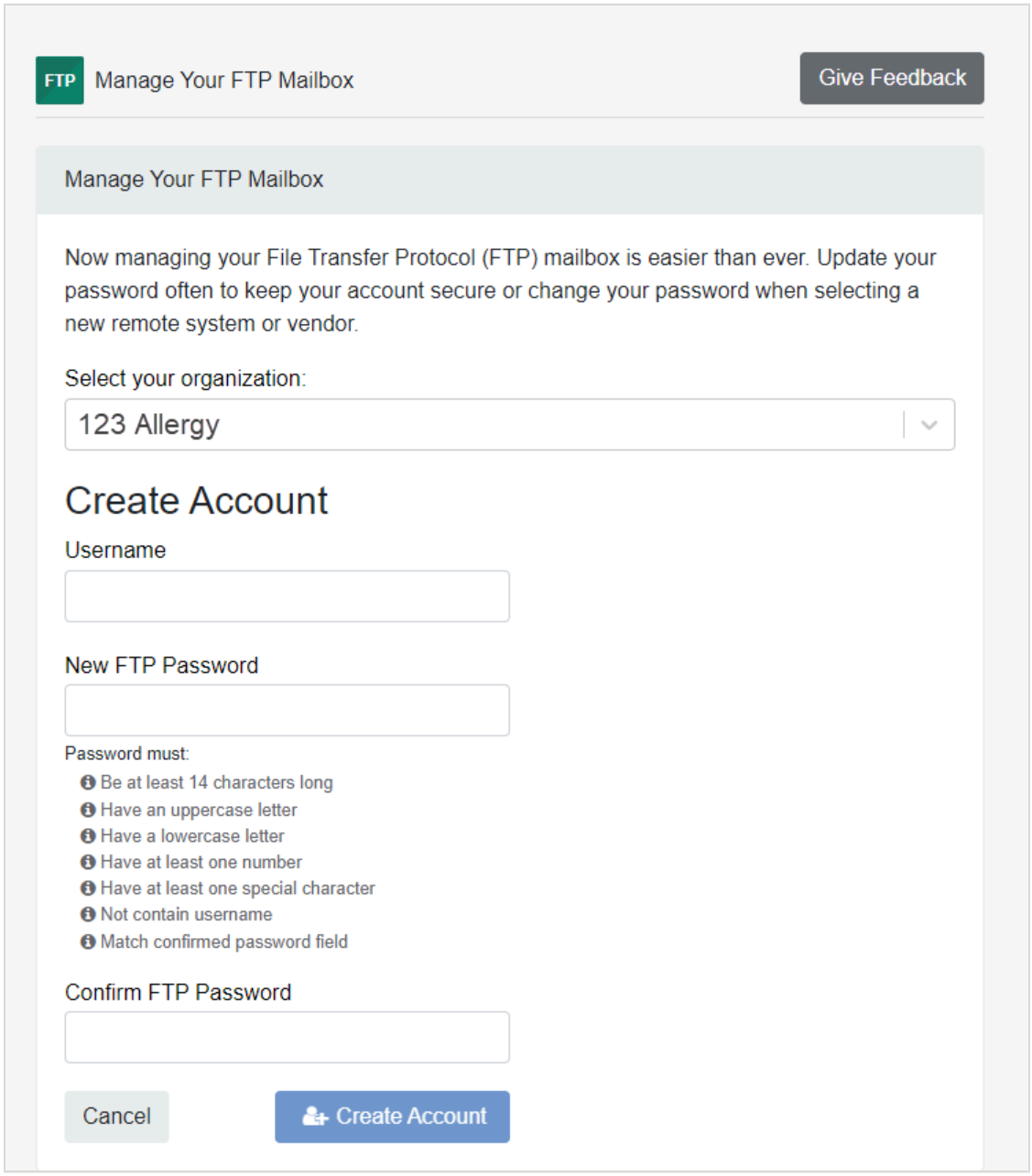
To do integration testing, create an Availity EDI account in the Availity QA environment. Once the account is created, access your organization's mailbox in the QA environment to submit test transactions and retrieve response files.

Important: Availity EDI account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, follow the steps below. If you do not have the appropriate permissions, select your name or the avatar icon in the Availity Essentials navigation bar, and then select **My Administrators** to identify your account administrator. Ask an administrator to follow the instructions below to create an Availity EDI account for your organization.

To create an EDI account in the QA environment, follow these steps:

1. Log in to the Availity QA environment at https://qa-apps.availity.com.
2. In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **FTP and EDI Connection Services**, and then select **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

   Note: You can also access the FTP and EDI Connection Services page from the **My Account Dashboard** tab on the Home page.
3. On the Manage Your FTP Mailbox page, **Select your organization**.
4. Enter a username and password for the new FTP account, confirm the password, and then select **Create Account**.



Configure your file transfer client software for QA

After creating your Availity EDI account in the QA environment, configure your file transfer client software to connect to the Availity QA EDI site.

1. Open your file transfer client software, and then create a new entry to access the Availity EDI site.
2. Use the table below to specify the fields for the new entry.

1. **Table 2: File transfer client software settings for QA**

Field	Value
Host	• (Set to retire) Non-MFT: Use qa-ftp.availity.com until you complete your MFT implementation with Availity. • MFT: Use qa-files.availity.com.
Port	• (Set to retire) Non-MFT: Use 9922 (typically used for SFTP) until you complete your MFT implementation with Availity. • MFT: Use 22 (standard SSH port).
Protocol or server type	Select the appropriate option in your file transfer client software for Secure File Transfer Protocol (SFTP). For example, **SFTP - SSH File Transfer Protocol**.
Login type	If there is an option for the login type, select normal.
User	The username for your Availity QA EDI account.
Password	The password for your Availity QA EDI account.

3. Select **Connect** or press **Enter** to connect to the server. If you're prompted to enter a username and password, enter the same Availity QA EDI account username and password that you entered in your file transfer client software.

Note: As an alternative to using a file transfer client software to connect to the Availity EDI site in the QA environment, you can access it by entering the appropriate URL into a browser and then entering your Availity QA EDI account username and password. If you have not yet implemented MFT, use https://qa-ftp.availity.com Once you have implemented MFT with Availity, use https://qa-files.availity.com.

4.2.2.2 Set up FTP for the production environment

Create an Availity EDI production account

To submit batch files of EDI transactions to Availity through FTP, you need to create an Availity EDI account (also referred to as your SFTP mailbox) in the production environment. Once you've created the Availity EDI account, you'll be able to access your organization's mailbox in the production environment, allowing you to submit transactions and retrieve response files.

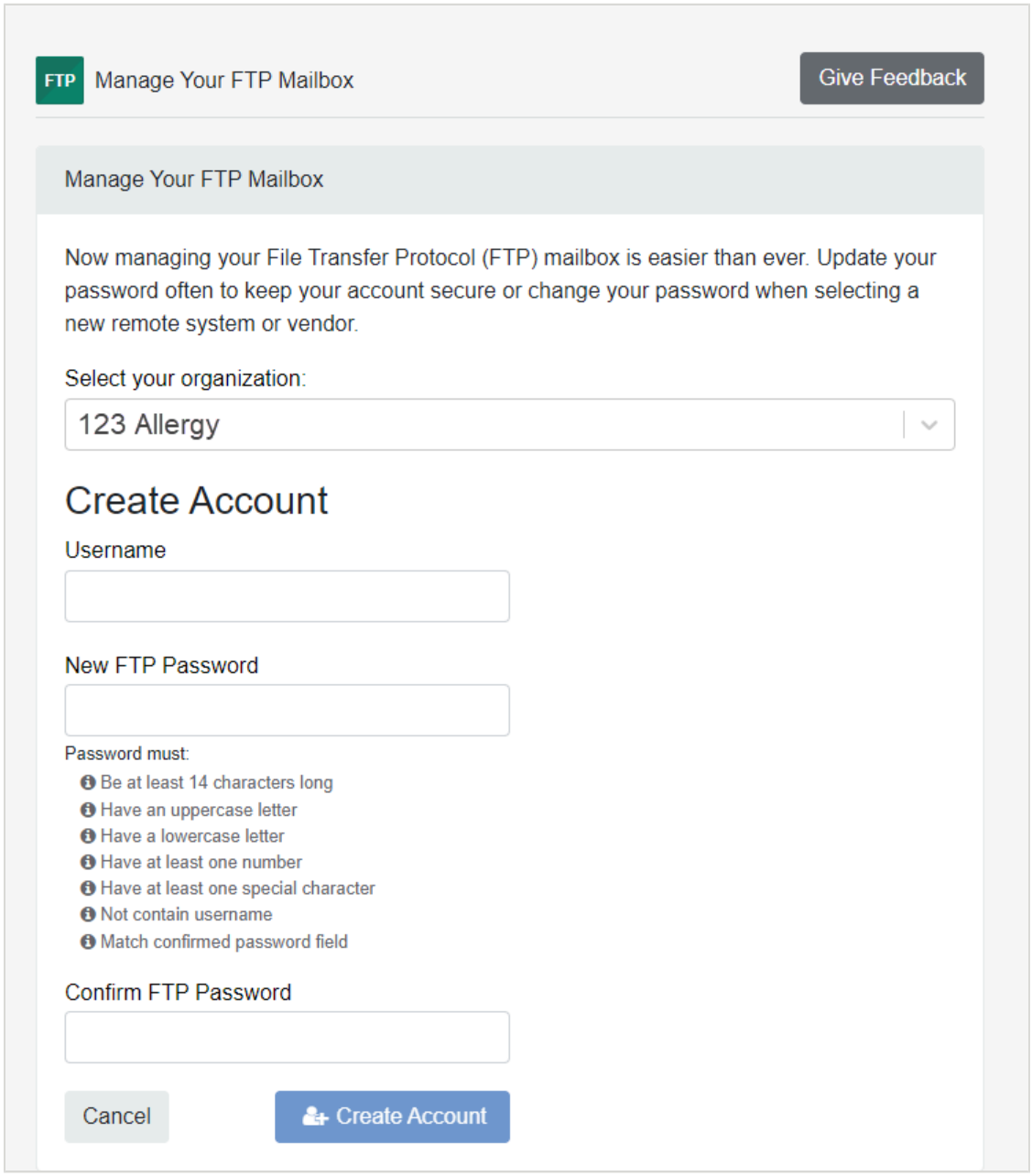
- If you requested an Availity SFTP mailbox during registration and completed the associated activation, then skip this task since you have already created your Availity EDI account. If you want to change the password you were given for your Availity EDI account, log in to Availity Essentials and navigate to **Claims & Payments** | **FTP and EDI Connection Services** | **Manage Your FTP Mailbox**.
- **Important:** Availity EDI account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, follow the steps below. If you do not have the appropriate permissions, select your name or the avatar icon in the Availity Essentials navigation bar, and then select **My Administrators** to identify your account administrator. Ask an administrator to follow the instructions below to create an Availity EDI account for your organization.

To create an Availity EDI account in the production environment, follow these steps:

1. Log in to Availity Essentials at https://apps.availity.com.
2. In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **FTP and EDI Connection Services**, and then select **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

   Tip: You can also access the FTP and EDI Connection Services page from the **My Account Dashboard** tab on the Home page.
3. On the Manage Your FTP Mailbox page, **Select your organization**.
4. Enter a username and password for the new FTP account, confirm the password, and then select **Create Account**.

   Important: Make a note of these account credentials.



Once you've created your Availity EDI account FTP account, you'll want to configure your FTP client with your new account credentials.

Configure your file transfer client software for production

Once you've created your Availity EDI account in the production environment, you'll need to configure your file transfer client software to connect to the Availity EDI site.

Note: As an alternative to using file transfer client software to connect to the Availity EDI site, you can access it by entering the appropriate URL into a browser and then entering your Availity EDI account username and password. If you have not yet implemented MFT, use https://ftp.availity.com. Once you have implemented MFT with Availity, use https://files.availity.com.

1. Open your file transfer client software, and then create a new entry for accessing the Availity EDI site.
2. Use the table below to specify the fields for the new entry.

Table 3: File transfer client software settings

Field	Value
Host	• (Set to retire) Non-MFT: Use ftp.availity.com until you complete your MFT implementation with Availity. • MFT: Use files.availity.com.
Port	• (Set to retire) Non-MFT: Use 9922 (typically used for SFTP) until you complete your MFT implementation with Availity. • MFT: Use 22 (standard SSH port).
Protocol or server type	Select the appropriate option in your file transfer client software for Secure File Transfer Protocol (SFTP). For example, **SFTP - SSH File Transfer Protocol**.
Login type	If there is an option for the login type, select normal.
User	The username for your Availity EDI account.
Password	The password for your Availity EDI account.

3. Select **Connect** or press **Enter** to connect to the server. If you're prompted to enter a username and password, enter the same Availity EDI account username and password that you entered in your file transfer client software.

4.2.3 Integration testing via EDI

Integration testing is coordinated through Availity Client Services at no charge to the submitter. Testing can be completed in the QA environment or production environment. It is recommended that new submitters test in the QA environment. If you test in the production environment, ensure ISA15 in your files contains the `T` indicator (test). Test files automatically receive a rejection message and are not sent to the payer for processing. The test is to verify that the file can go through the Availity system.

CAUTION: If you submit a file for test in the production environment with a `P` indicator in ISA15, the file will route to the payer.

Complete the following steps after Availity Client Services provides login credentials:

1. Create an Availity QA EDI account on page 16
2. Configure your file transfer client software for QA on page 18
3. Create an Availity EDI production account on page 19
4. Configure your file transfer client software for production on page 21

The process for uploading batches of transaction files to the Availity EDI site, viewing response files, and setting up which response files you receive is exactly the same in both the QA and production environments.

4.2.4 Submit transaction files via EDI

You can upload your batch files via file transfer client software, or by connecting to the Availity EDI site through a web browser.

Submit batch files via file transfer client software

1. Connect to the Availity EDI site through your file transfer client software.
2. Once you're connected, select the **SendFiles** folder on the remote site (i.e., the Availity EDI site.
3. Add the files that you want to submit to the **SendFiles** folder, or the folder provided to you for file submission.Availity processes the files you add.

Submit batch files via web client (before MFT is implemented)

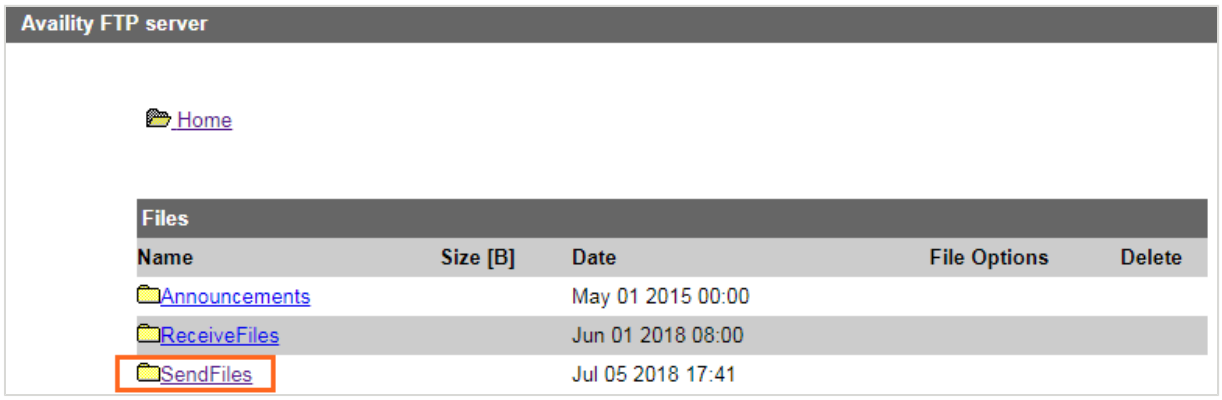
Attention: The steps in this section are valid if you have not yet implemented Availity's MFT process. After you have MFT implemented, refer to the next section.

1. Enter https://ftp.availity.com in a browser, and then enter your Availity EDI account username and password when prompted.

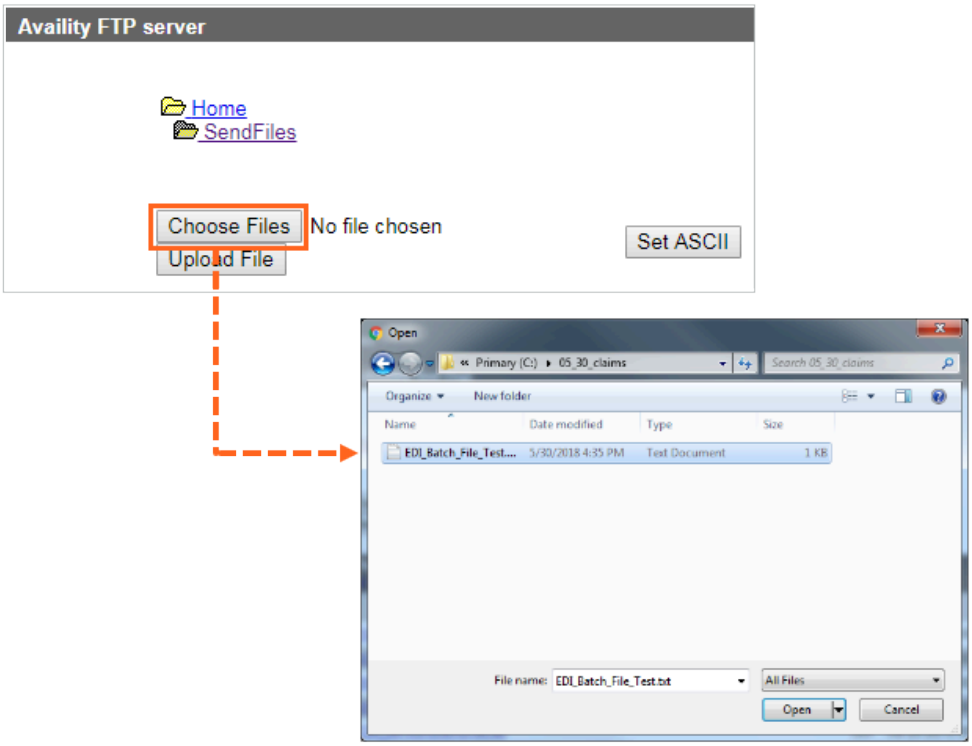
   Note: If you are connecting to the Availity EDI site in the QA environment through a browser, use https://qa-ftp.availity.com, and then enter your Availity QA EDI account username and password.

2. On the Availity EDI site, select **SendFiles**.

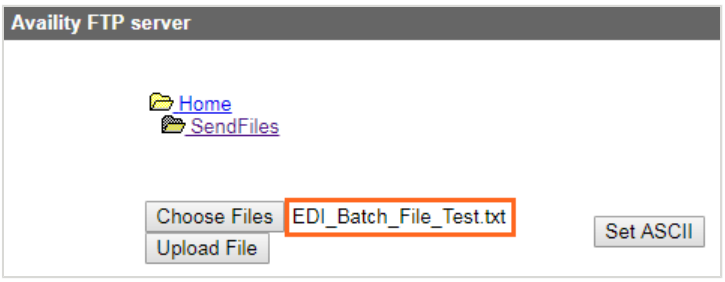
   Note: File submission via **SendFiles** folder is the standard. If you have been provided an alternate folder, which can be based on specialty type, please select that folder and follow the remaining steps.



3. Select **Choose Files** to open a File Explorer window,
4. Locate and select the file that you want to submit, and then select **Open**.



5. The file names display to right of the **Choose Files** button. Select **Upload File** to upload the files to the Availity server.



Submit batch files via web client (after MFT is implemented)

Attention: The steps in this section are valid once you have implemented MFT with Availity. If you have not yet implemented MFT, use the steps in the previous section.

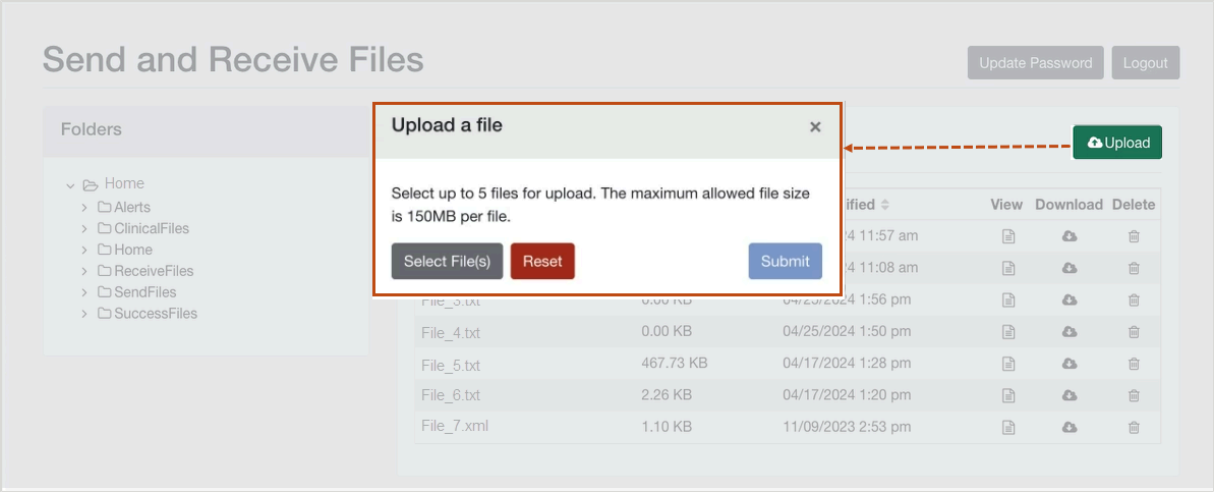
1. Enter https://files.availity.com in a browser, and then enter your Availity EDI account username and password when prompted.

   Note: If you are connecting to the Availity EDI site in the QA environment through a browser, use https://qa-files.availity.com, and then enter your Availity QA EDI account username and password.

2. On the Availity EDI site, select the **SendFiles** folder in the left panel of the Send and Receive Files page.

   Note: File submission via **SendFiles** folder is the standard. If you have been provided an alternate folder, please select that folder and follow the remaining steps.

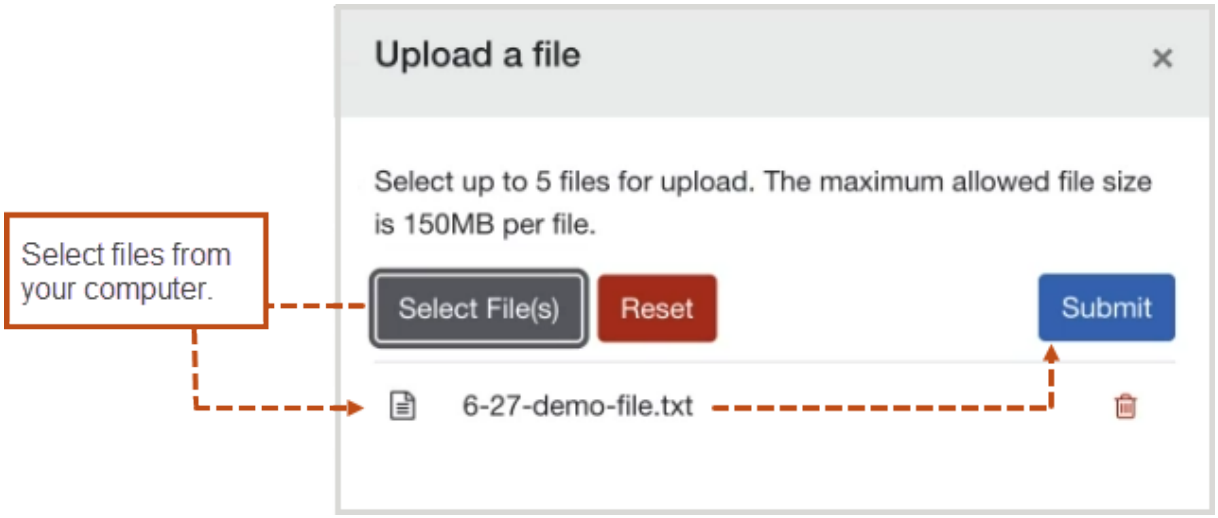
3. Select the **Upload** button in the upper-right corner of the page.



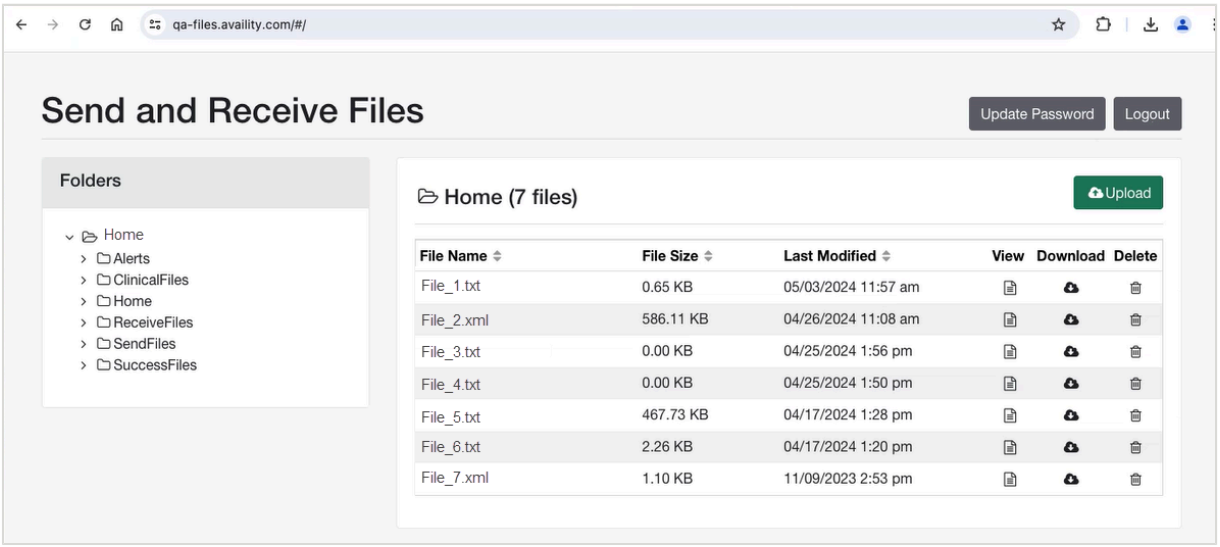
4. Select the **Select File(s)** button to open a File Explorer window.
5. Select the file(s) that you want to submit (upload).

   The file names display at the bottom of the Upload a file window.

   Note: Select up to five files with a maximum file size of 150 MB per file.
6. Once you have added your files, select **Submit** to upload the files to the Availity server.



7. Verify that the file(s) display in the center panel table.



Results

Availity returns a notification file to your **SendFiles** folder indicating whether a batch file was accepted for processing. For details, refer to Notification file on page 84.

Important: Availity removes and archives the notification files from the **SendFiles** folder each night, regardless if they have been downloaded.

4.2.5 Download EDI response files through FTP

Availity's batch EDI processing generates response files for each batch file that you submit. When you're submitting batch files through the Availity EDI site, you'll want to download all response files on a regular basis to track the transactions that you submitted. Your administrator can specify which responses you receive.

- Acknowledgements (file-level issues)
- Immediate Batch Reports (claim-level issues)
- Immediate Batch Reports Plus (claim-level issues)
- Electronic Batch Reports (claim-level issues)
- Delayed Payer Reports (claim-level issues)
- Electronic Remittance Advice (ERA) (835 files)

Note:

- Availity removes and archives response files remaining in the **ReceiveFiles** folder after 30 days, whether or not they have been downloaded. You can self-serve and restore archived response files for up to six months after the creation date. You can also request a copy of any archived response file from Availity Client Services regardless of the creation date.
- Availity removes and archives the notification files from the **SendFiles** folder each night, whether or not they have been downloaded.
- The **ReceiveFiles** folder includes response files received for the entire organization. If you send transmission files to a clearinghouse or payer representative other than Availity, the response files are sent to that clearinghouse or payer representative and you cannot access them. It is their responsibility to notify you of any issues identified in the response files. Contact the clearinghouse or payer representative directly for assistance.
- For certain payers, such as Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are a direct pass through without any mapping or editing by Availity.
- If an organization submits claims using Availity online claim forms and the payer processes claims in batches, the payer's response also displays in the **ReceiveFiles** folder in an Electronic Batch Report (EBR) file. If the EDI reporting preferences are set up to receive EBRs together in a single file, the payer's responses for Web claims are mingled with payer responses for transmission files that were uploaded.

Download instructions (before MFT is implemented)

Attention: The steps in this section are only valid if you have not yet implemented Availity's MFT process. After you have MFT implemented, refer to the next section.

1. Enter https://ftp.availity.com in a browser, and then enter your Availity EDI account username and password when prompted.
2. On the Availity FTP site, select the **ReceiveFiles** folder in the left panel of the Send and Receive Files page.
3. Use the functions in your file transfer client software or browser to download files from the folder. For descriptions of the types of response files, see Acknowledgements and/or reports on page 72.

Tip: To download a response file from a browser, select the tools icon  in the **File Options** column of the file you want, and then select a download option such as **text/plain**, under **Download and Delete Files**. You can also download the file directly through your browser.

Download instructions (after MFT is implemented)

Attention: The steps in this section are only valid once you have implemented MFT with Availity. If you have not yet implemented MFT, use the steps in the previous section.

1. Enter https://files.availity.com in a browser, and then enter your Availity EDI account username and password when prompted.
2. On the Availity EDI site, select the **ReceiveFiles** folder in the left panel of the Send and Receive Files page.
3. In the center panel table, locate the application file, and then select the download button  . For descriptions of the types of response files, refer to Acknowledgements and/or reports on page 72

4.2.6 Change EDI password

You can update your Availity EDI account passwords either via the web client or within Availity Essentials.

Change password within Essentials

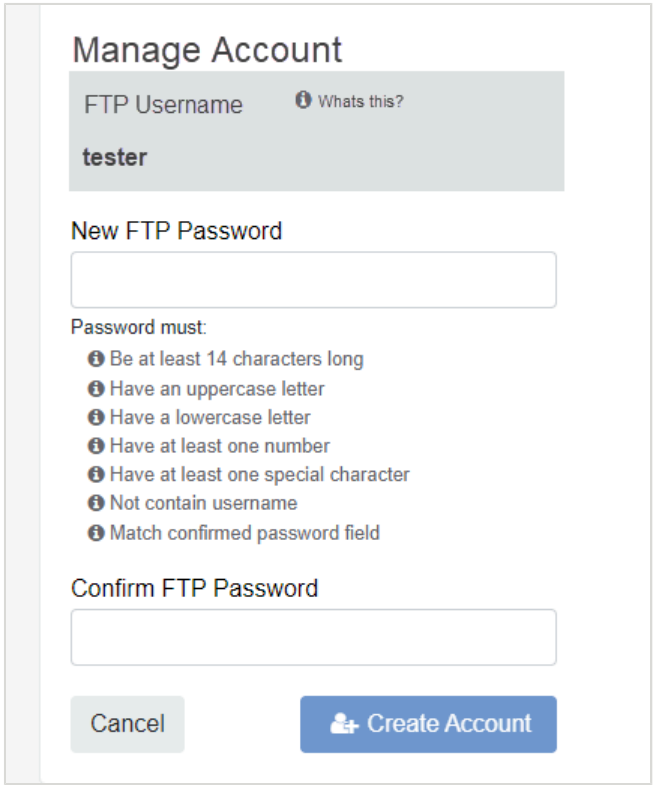
Important: Availity EDI account administration is limited to certain roles within Availity Essentials. If you have the appropriate permissions, follow the steps below. If you do not have the appropriate permissions, select your name or the avatar icon in the Availity Essentials navigation bar, and then select **My Administrators** to identify your account administrator. Ask an administrator to follow the instructions below to create an Availity EDI account for your organization.

1. Log in to Availity Essentials at https://apps.availity.com.

   Note: If you're changing the password for an EDI account in the QA environment, then log in to the QA environment at https://qa-apps.availity.com and complete the following steps.

2. In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **FTP and EDI Connection Services**, and then select **Manage Your FTP Mailbox** on the FTP and EDI Connection Services page.

3. Enter and confirm the new password, and then select **Change Password**.

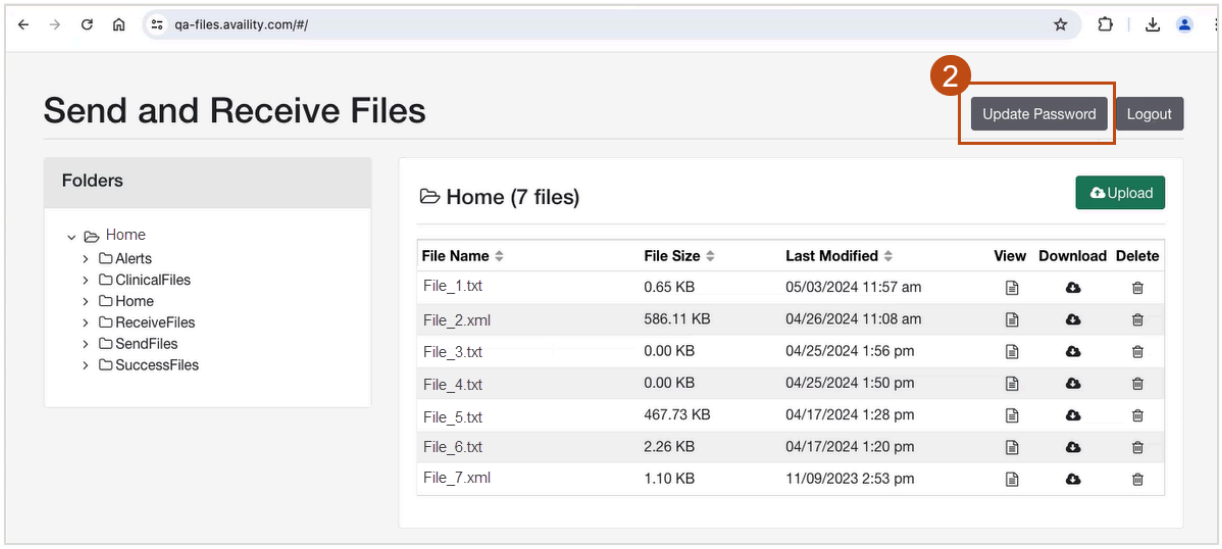


4. Update your FTP client with the new password.

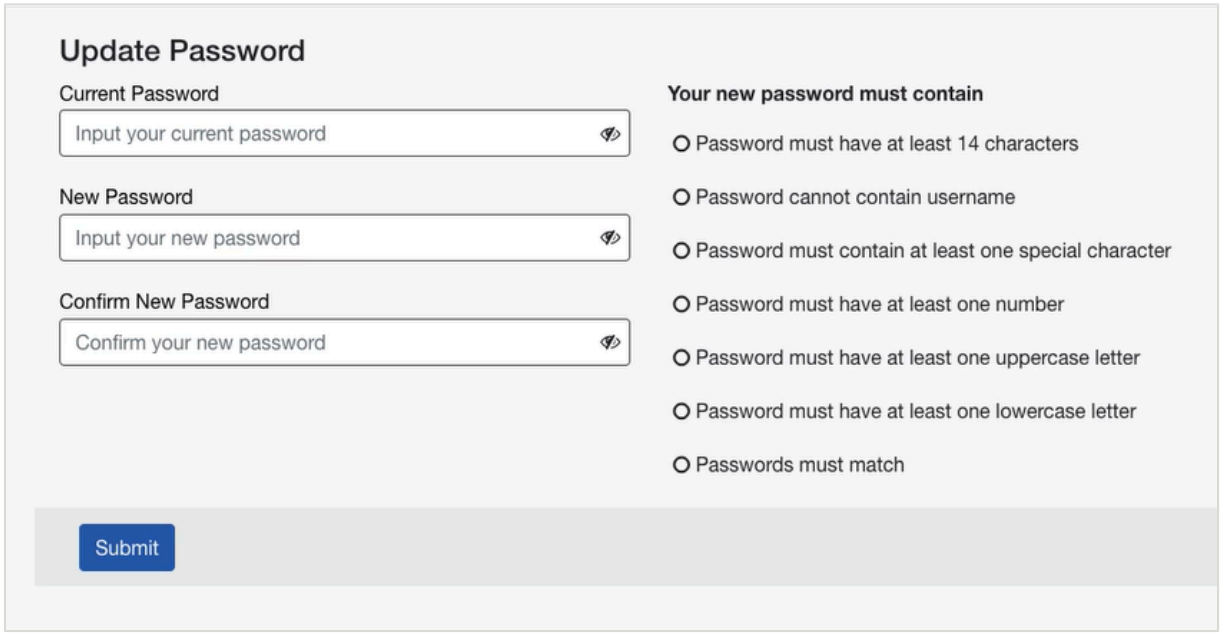
Change password via web client (after MFT is implemented)

Once MFT is implemented Availity EDI account passwords can be updated via web client site. If you need to update your password in both the QA and Production environments, please complete these steps on each site.

1. Connect to the applicable Availity EDI site through your FTP client.
   - **QA environment**: qa-files.availity.com
   - **Production environment**: files.availity.com
2. Once the Send and Receive page displays, select the **Update Password** button in the upper-right corner.



3. On the Update Password page, review the password complexity requirements.

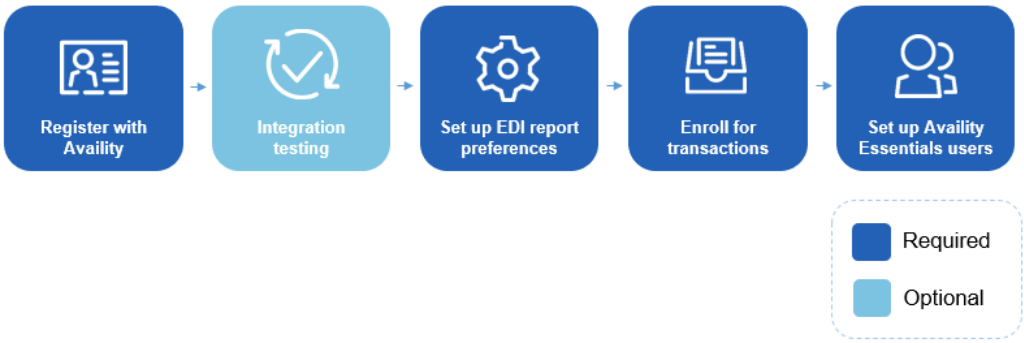


4. Enter your existing Availity EDI account password in the **Current Password** field, and your new EDI password in both the **New Password** and **Confirm New Password** fields, and then select **Submit**.

4.3 EDI transactions through Availity Essentials

4.3.1 Setup steps for EDI through Availity Essentials

Getting set up to submit batch files of EDI transactions to Availity through Availity Essentials involves the following steps, some of which you might have already completed. The integration testing step is optional.



1. **Register with Availity** - If you have not already registered your organization with Availity, go to www.availity.com and select **REGISTER**.

   Note: The registration must be completed by someone from your business with the authority to authorize the Availity Organization Agreement.

Availity's payer list

Check out the Availity payer list for participating payers and payer IDs. You can also access the payer list from within Availity Essentials by typing **payer list** in the keyword search option.

- Transactions that are listed as **Available** in the payer list are sponsored by the associated payer and are provided at no charge.
- Transactions that are listed as **Contract Required** in the payer list are fee-based. For information about submitting transactions that require a contract, see the information about Comprehensive plans in EDI Clearinghouse plans.

  Note: If your organization already has a contractual agreement with Availity for submitting transactions that require a contract, no other action is required.

2. **Integration testing** - Availity gives you the option of doing integration testing in our QA environment before you submit any real transactions. See Integration testing and submitting to the production environment on page 34 for details.
3. **Set up your EDI reporting preferences** - Availity's batch EDI processing generates response files for each batch file that you submit. The administrator for an organization can set reporting preferences that specify which response files are generated. See Configure EDI Reporting Preferences on page 40 for details.
4. **Enroll for transactions** - You might need to enroll for some transactions (such as claim submission) for particular health plans that you submit to. To determine if any of the health plans that you submit to require enrollments, see the Availity payer list. You can also enroll (if required) to have electronic remittance advice files (also known as ERAs and 835s) delivered to your Availity mailbox. Electronic remittance advice files display payment information from all claims, whether submitted electronically

or by paper. See the Availity payer list to determine if enrollment for ERAs is required for a particular health plan.

Note: If your ERAs are already delivered to Availity for the health plans that you submit claims to, you can skip the ERA transaction enrollment process.

5. **Set up your Availity Essentials users** - If other people in your organization need access to Availity Essentials, such as to view remittance advice information, you will need to create an Availity Essentials account for each such person. Log in to Availity Essentials at https://apps.availity.com, select your name or the avatar icon in the Availity Essentials menu, and then select **Add User**.

   Tip: Have a lot of users? On the Add Users page, select the option to upload users in a spreadsheet in CSV format.

Important: To manually upload transaction files through Availity Essentials, users will need the EDI Management role, which can be assigned by the administrator for your organization. Once the EDI Management role has been assigned to a user, it might take up to 24 hours before that user can upload files. Administrators automatically have the EDI Management role.

4.3.2 Integration testing and submitting to the production environment

Integration testing

Integration testing is coordinated through Availity Client Services at no charge to the submitter. Once you receive your user ID and password for your QA account from Availity Client Services, you'll be able to log in at https://qa-apps.availity.com. The process for uploading batches of transaction files, viewing response files, and setting up which response files you receive is exactly the same in the QA environment as it is in the production environment.

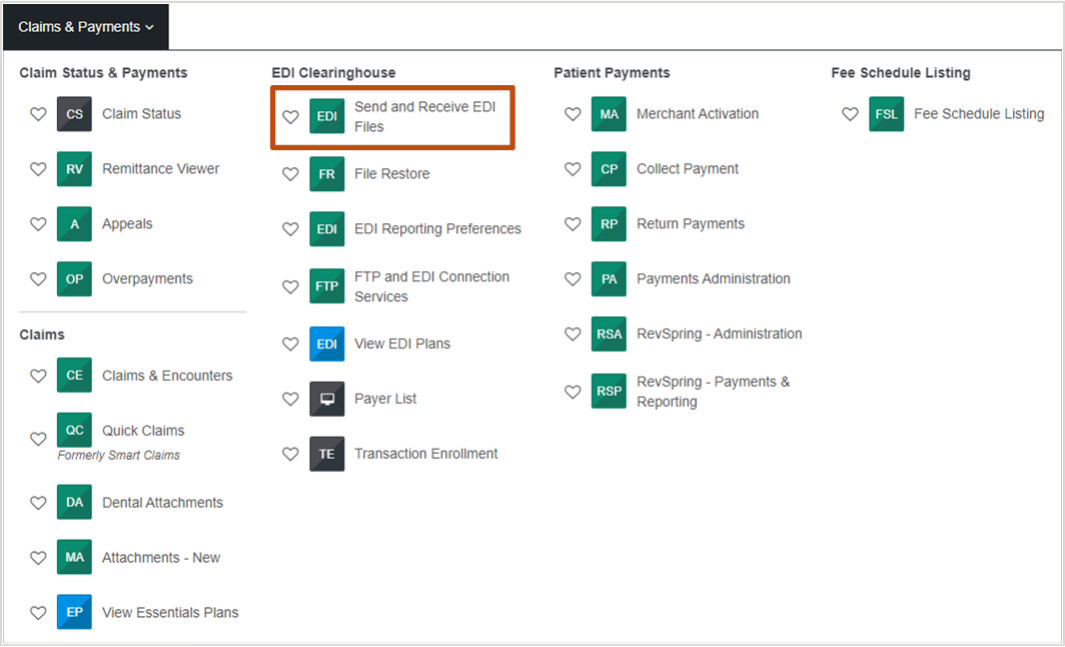
Submitting to the production environment

Once you complete desired testing in our QA environment, you are ready to submit transactions to our production environment through your Availity Essentials account. If you completed integration testing, please remember to log in through our production URL at https://apps.availity.com to submit your live transactions to our production environment.

4.3.3 Access the Send and Receive EDI Files application

Important: You must be assigned the **EDI Administration** role to access this application. If you cannot access the application, contact your Availity Essentials administrator to assign the role to you.

In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **Send and Receive EDI Files**.



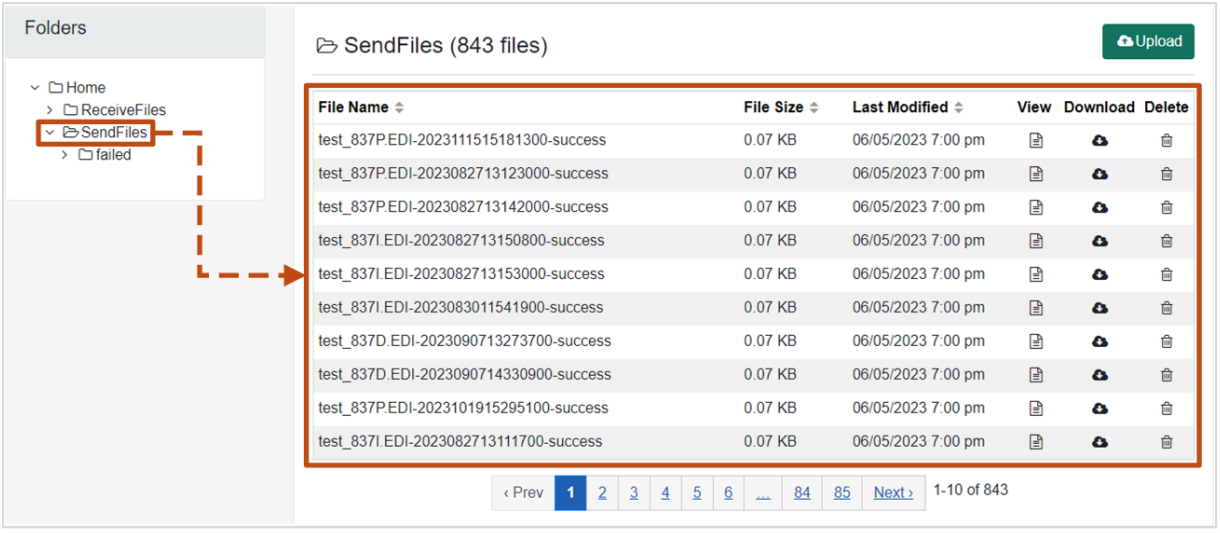
Tip: Select the heart icon ♡ next to an application to add it to your favorites. You can then access the application by selecting **My Favorites** at the top of Availity Essentials.

4.3.4 Upload EDI files to Availity Essentials (new interface)

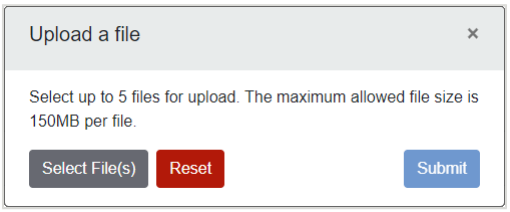
Use the Send and Receive EDI Files application to upload EDI transaction files from your computer to Availity Essentials. Users commonly use the upload feature to upload EDI batch transaction files to their **SendFiles** folder

1. In the **Folders** list, select **SendFiles**.

   When you select the SendFiles folder, the files stored in the folder display in the **SendFiles** section to the right of the **Folders** list.

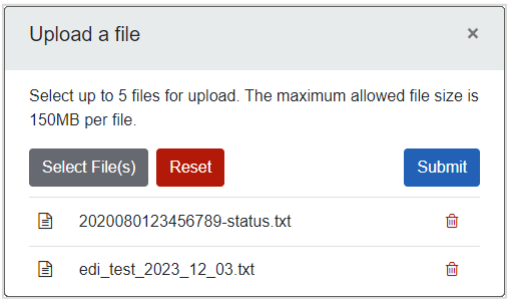


2. In the **SendFiles** section, select **Upload**.
3. In the Upload a file window, select **Select File(s)**.

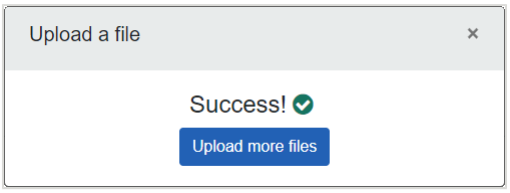


4. In your web browser's Open file dialog box, select the file(s) you want to upload, and then select **Open**.
   - You can select a maximum of five files to upload.
   - Each file can have a maximum size of 150 MB.
5. In the Upload a file window, verify you have selected the correct file(s) to upload, and then select **Submit**.

   Tip: To remove a file from the window, select the trash can icon next to the file.



6.



Availity returns a notification file to your **SendFiles** folder indicating whether a batch file was accepted for processing. For details, refer to Notification file on page 84.

Important: Availity removes and archives the notification files from the **SendFiles** folder each night, regardless if they have been downloaded.

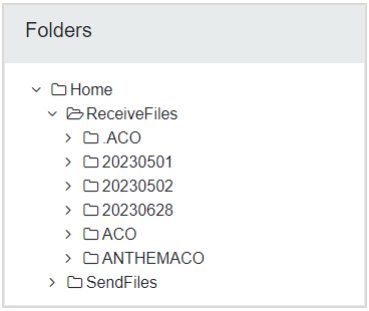
4.3.5 Download EDI files from Availity Essentials (new interface)

Use the Send and Receive Files application to download your organization's EDI files from Availity Essentials to your computer. Users commonly use the download feature to download the following types of files from their **ReceiveFiles** folder. Users also use the download feature to download EDI batch notification files from their **SendFiles** folder.

- Acknowledgements (file-level issues)
- Immediate Batch Reports (claim-level issues)
- Immediate Batch Reports Plus (claim-level issues)
- Electronic Batch Reports (claim-level issues)
- Delayed Payer Reports (claim-level issues)
- Electronic Remittance Advice (ERA) (835 files)

1. In the Folders section on the left side of the Send and Receive Files page, select the folder containing the file you want to download.

   Example:

2. Locate the file you want to download, and then select the download file icon in the Download column.

   Note: In most instances, files are saved to the Downloads folder on your computer.

3. Follow the prompts from your browser to access or open the downloaded file.

4.3.6 Delete EDI files from Availity Essentials (new interface)

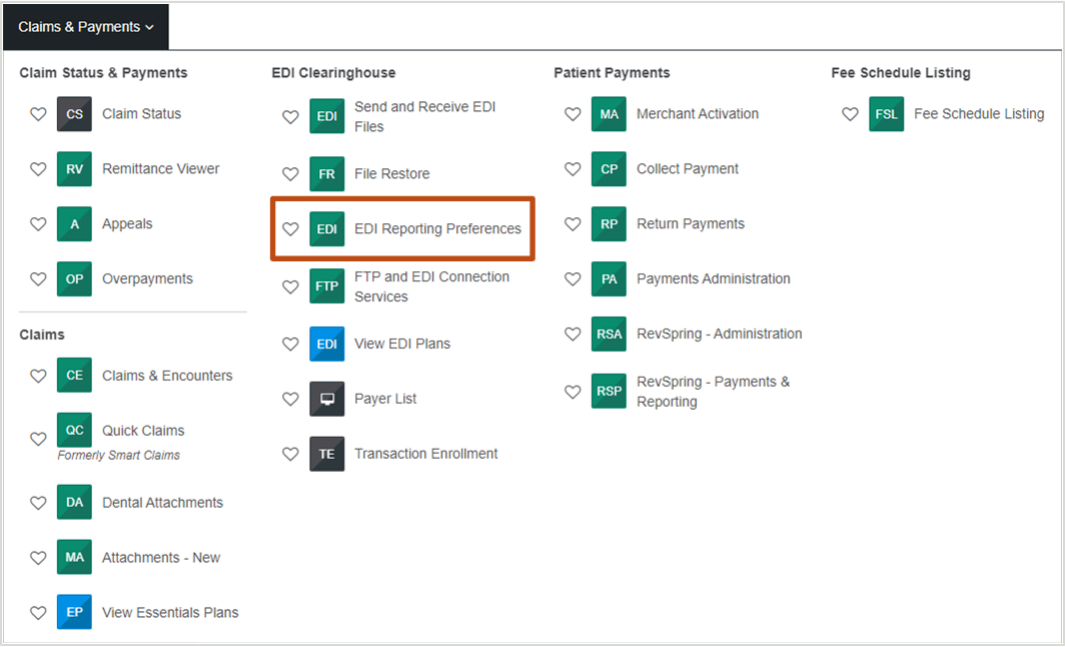
Use the Send and Receive Files application to delete EDI transaction files from Availity Essentials.

1. In the **Organization** field on the Send and Receive Files page, select the organization that owns the files you want to delete, and then select **Submit**.
2. In the **Folders** list, select the folder containing the file(s) you want to delete.
3. In the files list, locate the file you want to delete, and then select the delete icon in the **Delete** column.
4. In the Delete Confirmation window, select **Yes**.

4.4 Access the EDI Reporting Preferences application

Important: You must be assigned the **EDI Administration** role to access this application. If you cannot access the application, contact your Availity Essentials administrator to assign the role to you.

In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **EDI Reporting Preferences**.



4.5 Configure EDI Reporting Preferences

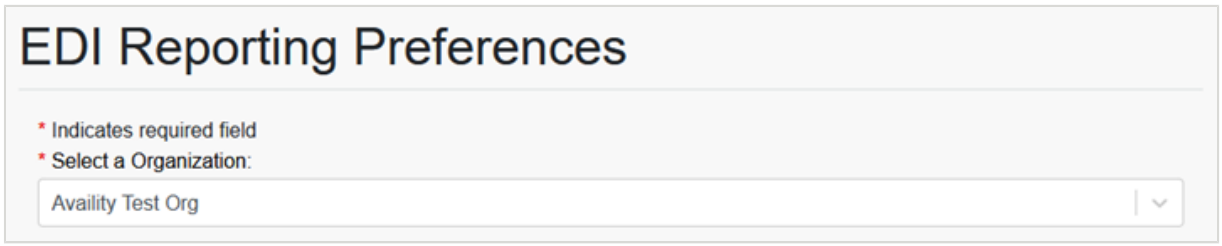
Availity's batch EDI processing generates response files (acknowledgements and reports) for each submitted batch file. Availity provides standard response files recommended in the official HIPAA implementation guides (called TR3s) and proprietary reports for end-to-end tracking and accountability of each submitted transaction.

The administrator for an organization can set up reporting preferences that specify which response files are generated. Response files are retrieved from your **ReceiveFiles** folder.

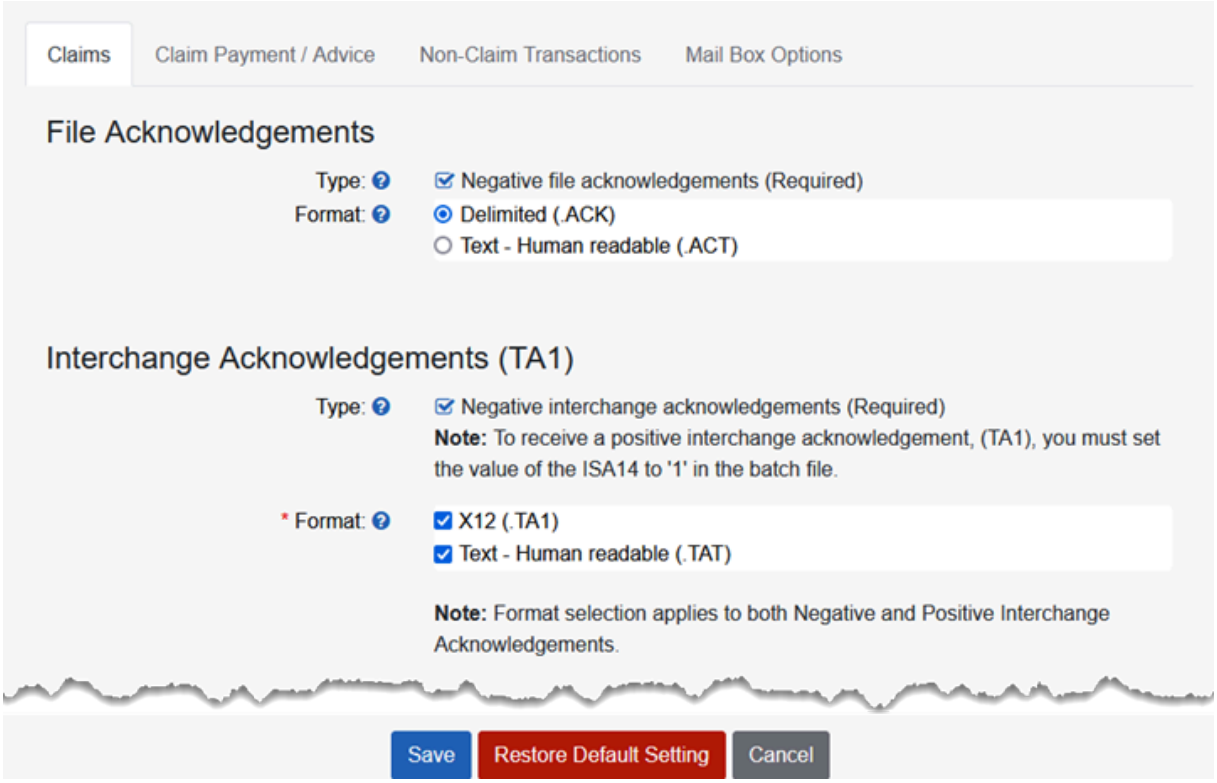
Note: Changes made to IBR, IBRPlus, EBR and DPR type EDI reporting preferences will now apply to claims received after the changes are made. Claims received before changes to the reporting preferences will continue to follow the preferences that were set at the time the claims were received.

To configure EDI reporting preferences, follow these steps:

1. On the EDI Reporting Preferences page, select the organization that you're setting preferences for.



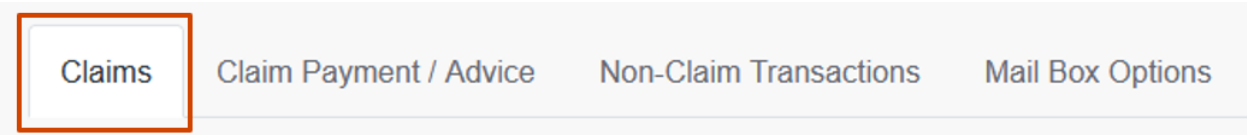
2. On each of the EDI Reporting Preferences tabs, for example the **Claims** tab (partial view) below, specify the preferences you want, and then click **Save** to save the preferences for that tab. **Changes are saved on a per tab basis**.



- Some responses, such as the **Negative interchange acknowledgement**, are required (per HIPAA guidelines) and are automatically generated. The associated check box is checked and grayed out to indicate that it can't be unchecked.
- You can view detailed information for a particular preference setting by clicking the blue question mark next to the label for the setting.
- File extensions for each report type are listed to the right of the report option, such as .ACK, .IBR, and others. The file extension consists of the characters that display after the period at the end of the file name for the report or response file. It indicates the type of file and can help you identify which report or response file types are listed in the **ReceiveFiles** folder.
- When you group EDI response files by payer on the EDI Reporting Preferences page, the response file returned to the **ReceiveFiles** folder will include the payer short name in the file name.
- Changing the file format (for example, from delimited to text-human readable) only affects response files that are created after you save the change to the file format. Response files that were created prior to the file format change will remain in their original format.

4.5.1 EDI reporting preferences for claims

The **Claims** tab of the EDI Reporting Preferences page is where you specify the types of responses that you want when you submit claims through Availity.



The following types of response files are associated with **Claims**:

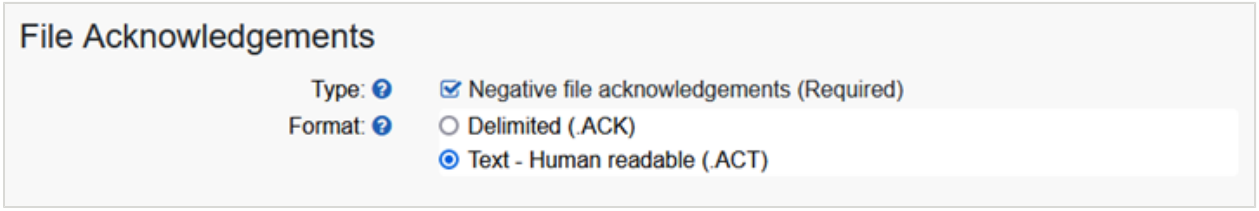
- File acknowledgements
- Interchange acknowledgements (TA1)
- Implementation acknowledgements (999)
- Immediate batch responses (IBR)
- Immediate batch responses Plus (IBRP)
- Electronic batch reports (EBR)
- Delayed payer reports (DPR)

We'll describe the preferences for each type of response file in a separate section below.

Important: When you are done making any changes on this tab, select **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

Preferences for File Acknowledgements

Availity automatically sends a negative file acknowledgement (ACK) to your organization's **ReceiveFiles** folder when a submitted batch file fails Availity's proprietary validation, most commonly when the file format is invalid.



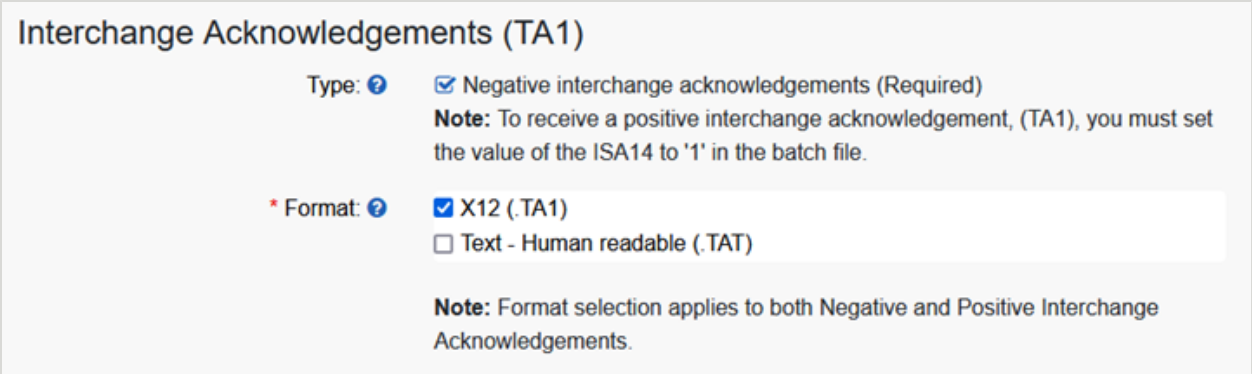
The **Negative file acknowledgements** check box is selected and grayed out, meaning that you always receive negative file acknowledgements.

You can receive this file in a computer-readable or human-readable format.

- Select **Delimited (.ACK)** to receive a delimited file format that you can import into a computer system.
- Select **Text - Human readable (.ACT)** to receive a text file that you can read. This is the default.
- Delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view this file.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Preferences for Interchange Acknowledgements (TA1)

Availity automatically sends negative interchange acknowledgements to your organization's **ReceiveFiles** folder. This file reports errors encountered within the interchange header or trailer, or functional group header, of the X12 file, particularly errors caused by duplicate interchange control numbers or an incorrect trading partner envelope.



- The **Negative interchange acknowledgements** check box is selected and grayed out, meaning that you always receive negative interchange acknowledgements.
- To receive positive interchange acknowledgements, the value of ISA14 must be set to 1 in the submitted batch file. Positive interchange acknowledgements are returned with the implementation acknowledgement file (999).

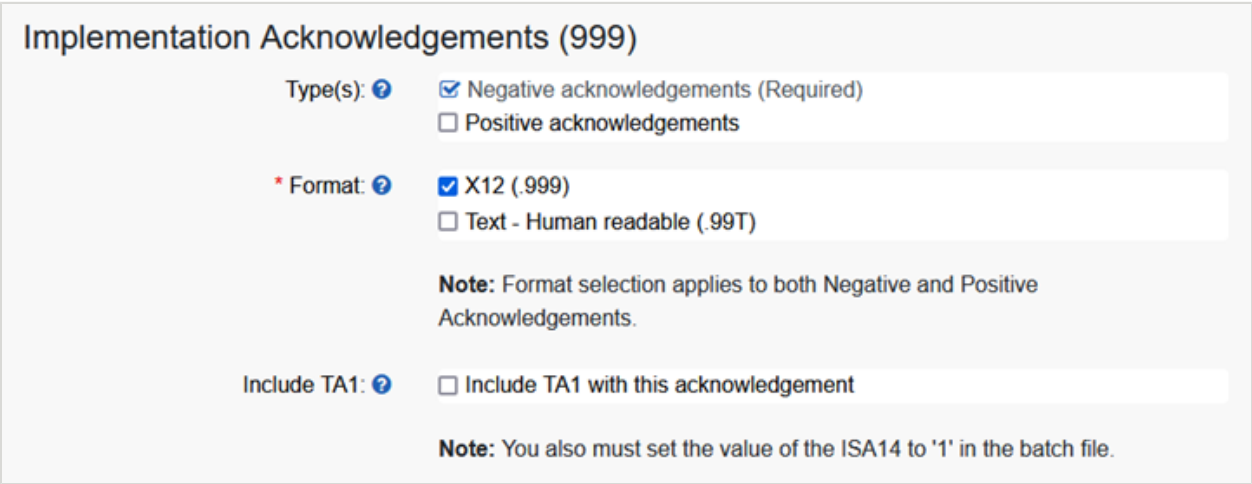
You can receive this file in a computer-readable or human-readable format.

- Select **X12 (.TA1)** to receive an X12 file that you can import into a computer system. This is the default.
- Select **Text - Human readable (.TAT)** to receive a text file that you can read.
- X12 files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view this file.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Note: The format selection applies to both negative and positive interchange acknowledgements.

Preferences for Implementation Acknowledgements (999)

Availity automatically sends negative implementation acknowledgements to your organization's **ReceiveFiles** folder. This file indicates that Availity received the transmission file and it had errors, particularly X12 and HIPAA syntax errors. Implementation acknowledgements are also referred to as 999 files.



- The **Negative acknowledgements** check box is selected and grayed out, meaning that you always receive negative implementation acknowledgements.
- To receive positive implementation acknowledgements that acknowledge the receipt and successful validation of each functional group within your batch files, select the **Positive acknowledgements** check box.

You can receive this file in a computer-readable or human-readable format.

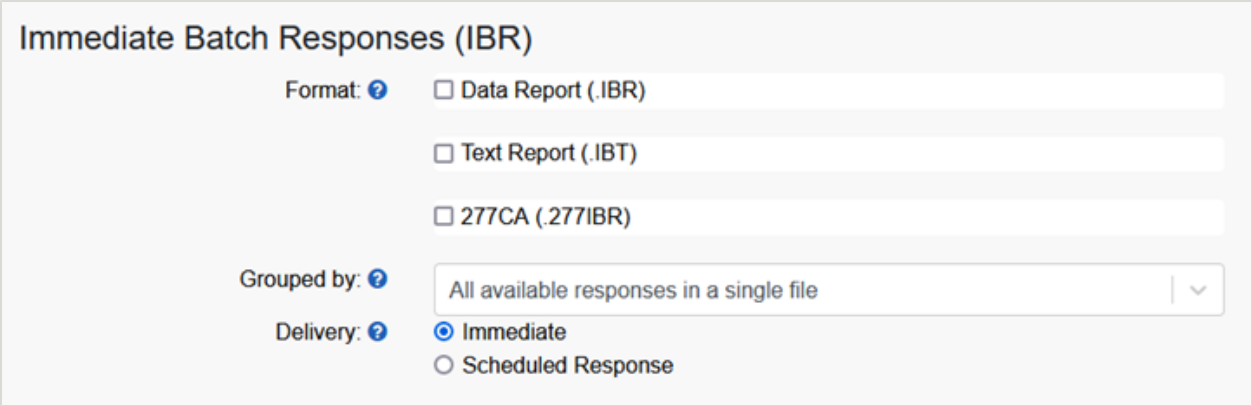
- Select **X12** to receive an X12 file format that you can import into a computer system. This is the default.
- Select **Text - Human readable** to receive a text file that you can read. These reports contain similar information as the data files, but are intended for viewing by non-technical users.
- If you will not be importing the file into a computer, we recommend that you select the text file.

Note: The format selection applies to both negative and positive implementation acknowledgements.

Select **Include TA1** to include the positive TA1 with the acknowledgement. To generate a positive TA1, the value of ISA14 must be set to '1' in the submitted batch file.

Preferences for Immediate Batch Response (IBR)

The immediate batch response (also referred to as an IBR) is a proprietary report that acknowledges accepted claims and identifies rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.



The Immediate Batch Response (IBR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive immediate batch responses in the 277CA claim acknowledgement format. All of these reports are optional.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

- Select **Data Report (.IBR)** to receive IBRs in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.IBT)** to receive IBRs in a text format intended for viewing by non-technical users.

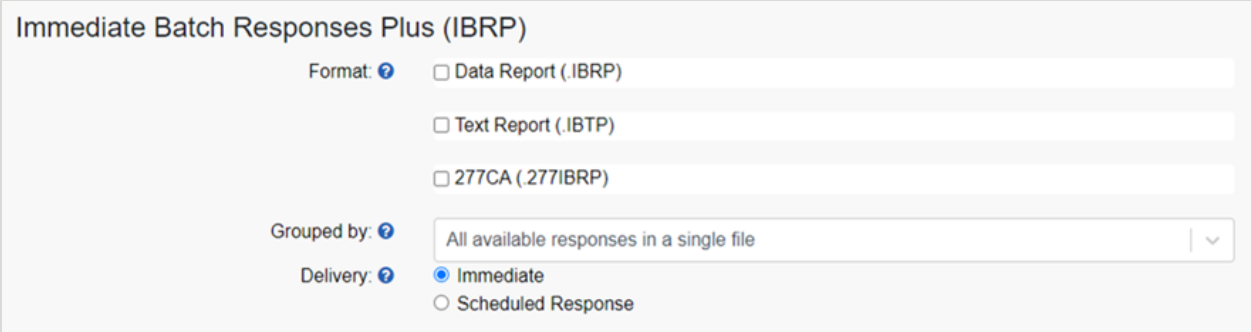
- Select **277CA (.277IBR)** to receive immediate batch responses in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Preferences for Immediate Batch Response Plus (IBRP)

The immediate batch response plus (also referred to as an IBRP) is a proprietary report that acknowledges accepted claims and identifies warning messages and rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note:

A warning on a claim is informational content from Availity on behalf of the payer and can be added to an accepted or rejected claim. Warnings are informational only and do not cause a claim to be rejected.



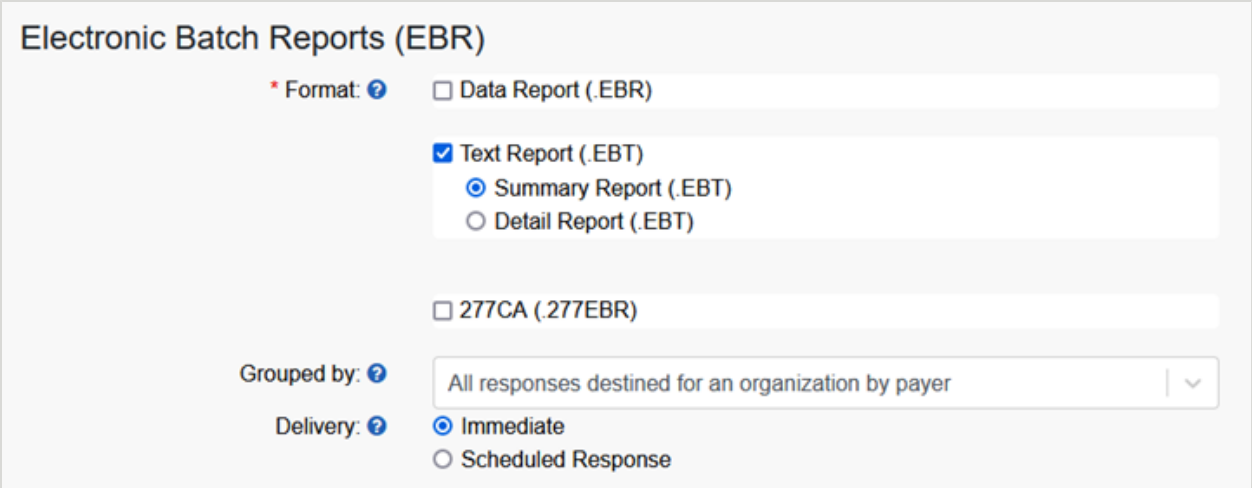
The Immediate Batch Response Plus (IBRP) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive immediate batch responses in the 277CA claim acknowledgement format. All of these reports are optional.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

- Select **Data Report (.IBRP)** to receive IBRPs in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.IBTP)** to receive IBRPs in a text format intended for viewing by non-technical users.
- Select **277CA (.277IBRP)** to receive immediate batch responses in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Preferences for Electronic Batch Reports (EBR)

The electronic batch report (also referred to as an EBR) is a proprietary report that provides the status (received from the payer) for each transaction in the original submission. The report contains summary counts of transactions received and accepted, and lists detailed information for rejected transactions, including payer specific edits (PSEs) and HIPAA edits. Only claims that passed file format and syntax validations are included in this report.



The Electronic Batch Report (EBR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive electronic batch reports in the 277CA claim acknowledgement format, in conjunction with the pipe-delimited or text report format. All of these reports are optional.

- Select **Data Report (.EBR)** to receive electronic batch reports in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
    - Select **Summary Data Report (.EBR)** to receive a summary which includes only prepayment details and errors for rejected claims. This report does not include accepted claims details.

      Note: The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
    - Select **Detail Data Report (.EBR)** to receive a report including acknowledgement of all claims in the transmission file. This option includes the results of edits at both Availity and the receiver or payer for accepted claims, prepayment details, and rejected claims and important messages from the health plan.

      Note: The detail report is recommended.
- Select **Text Report (.EBT)** to receive electronic batch reports in a text format intended for viewing by non-technical users.
    - Select **Summary Report (.EBT)** to receive a summary which includes only prepayment details and errors for rejected claims. This report does not include accepted claims details or rejection reasons. To receive rejection details, select the detail report.

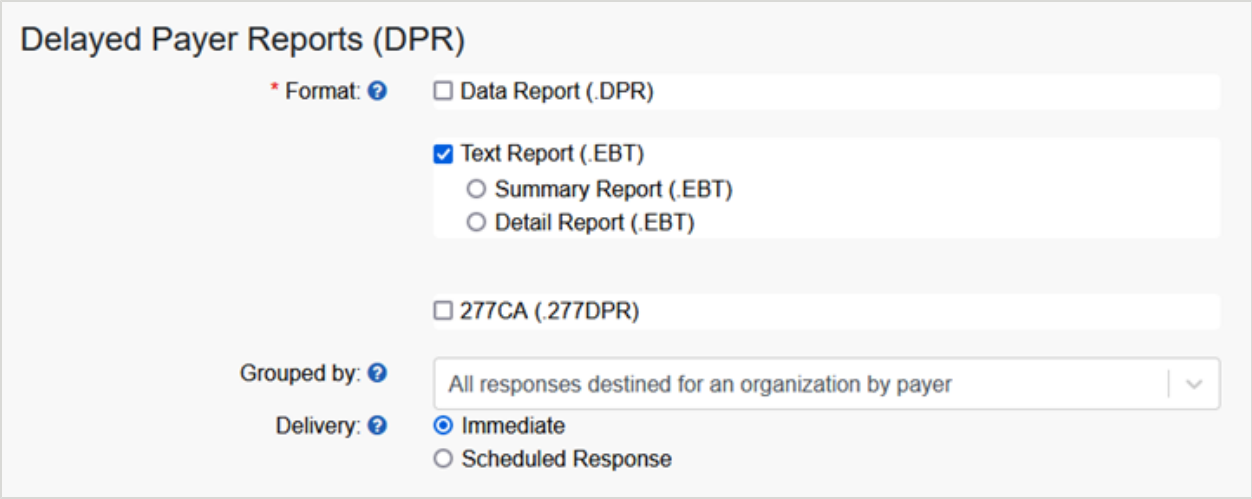
      Note: The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
    - Select **Detail Report (.EBT)** to receive a report including acknowledgement of all claims in the transmission file. This option includes the results of edits at both Availity and the receiver or payer for accepted claims, prepayment details, and rejected claims and important messages from the health plan.

      Note: The detail report is recommended.
- Select **277CA (.277EBR)** to receive electronic batch reports in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

Note: The .277EBR can only be received in combination with the .EBR or .EBT. If you do not select the .EBR or .EBT, the .277EBR will not be sent.

Preferences for Delayed Payer Reports (DPR)

The delayed payer report (also referred to as a DPR) includes information from payers that utilize batch processing or other non-real-time adjudication processes. The report includes transaction receipt acknowledgement, transaction reject messaging, warning, and informational messages, as well as adjudication responses returned by the destination payer.



The Delayed Payer Report (DPR) is available in both a pipe-delimited data file and a formatted-text report. You can also opt to receive delayed payer reports in the 277CA claim acknowledgement format, in conjunction with the pipe-delimited or text report format. All of these reports are optional.

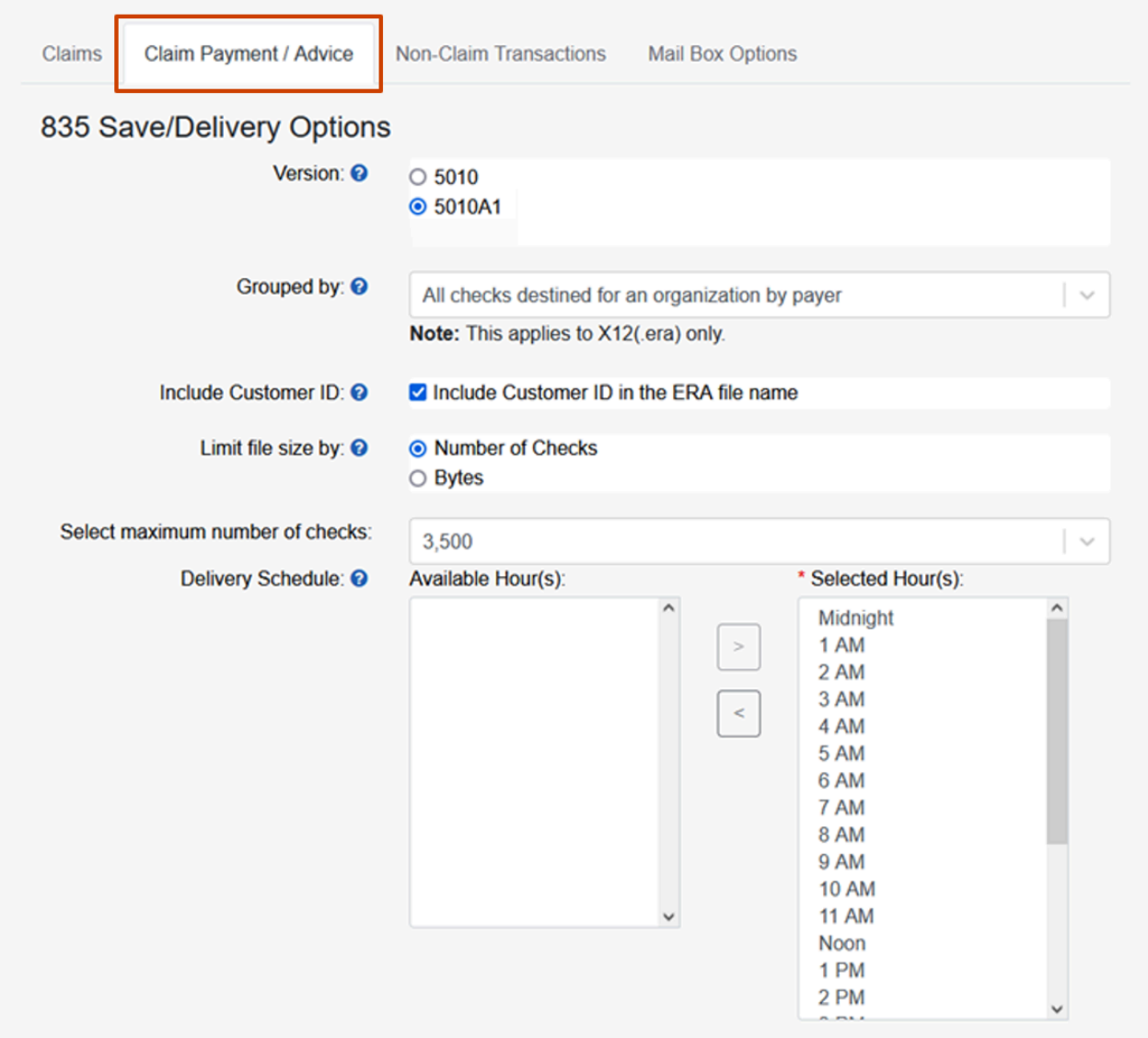
- Select **Data Report (.DPR)** to receive delayed payer reports in a pipe-delimited format. Pipe-delimited files can be imported into a PMS, HIS, or other automated system. Technical personnel who oversee computer systems in your organization might also open and view these files.
- Select **Text Report (.DPT)** to receive delayed payer reports in a text format intended for viewing by non-technical users.
  - Select **Summary Report (.DPT)** to receive a summary.
  - Select **Detail Report (.DPT)** to receive a detail report including acknowledgement of all claims in the payer's response and important messages from the health plan.

    Note: The detail report is recommended.
- Select **277CA (.277DPR)** to receive delayed payer reports in the 277CA claim acknowledgement format. The 277CA file is an X12 file that you can import into a computer system.

  Note: The .277DPR can only be received in combination with the .DPR or .DPT. If you do not select the .DPR or .DPT, the .277DPR will not be sent.

4.5.2 EDI reporting preferences for claim payment/advice

The **Claim Payment/Advice** tab of the EDI Reporting Preferences page is where you specify preferences for your claim payment/advice files. These files are referred to as electronic remittance advice (ERA) files or 835 files.



- You can select the HIPAA version (5010 or 5010A1) of your electronic remittance advice files. The default is 5010A1. If the payer sends a different version, Availity will convert the files for you.
- You can group your electronic remittance advice files by organization, provider, or payer.
- You can limit the maximum file size by number of checks or by number of bytes.
- You can schedule multiple deliveries of your electronic remittance advice files throughout the day.

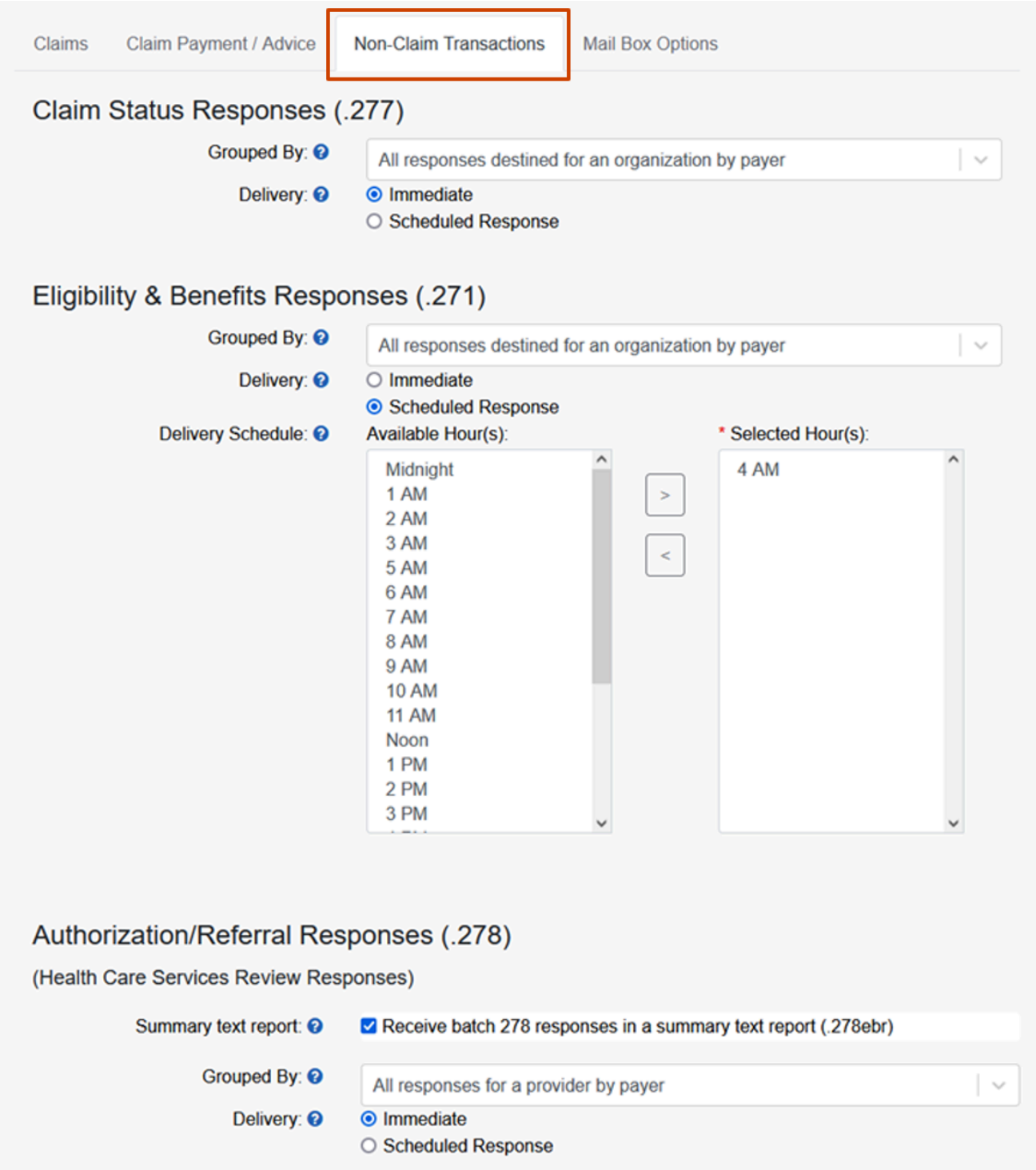
BCBSIL, BCBSNM, BCBSOK, BCBSTX

You cannot use the 835 Save/Delivery Options to convert (up or down-convert) the 835 version.

Important: When you are done making any changes on this tab, select **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

4.5.3 EDI reporting preferences for non-claim transactions

The **Non-Claim Transactions** tab of the EDI Reporting Preferences page is where you specify preferences for claim status responses, eligibility & benefits responses, and authorization/referral responses.

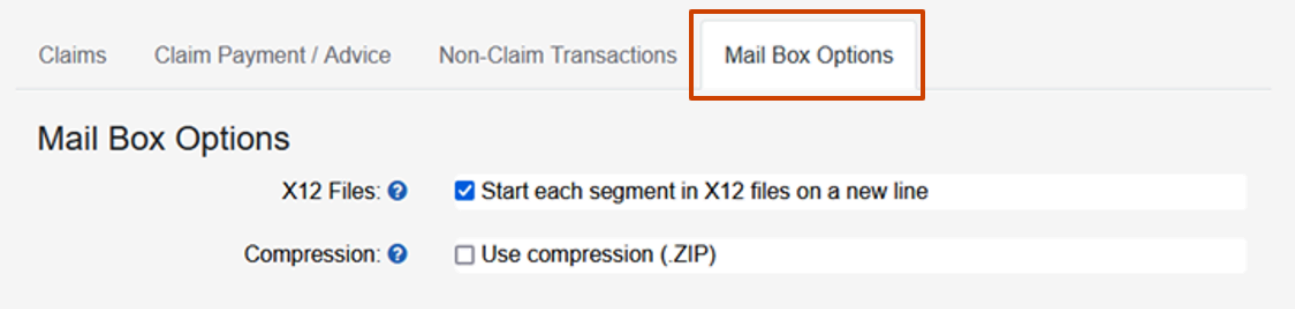


- You can group the response files for your non-claim transactions by organization and payer, or by provider and payer, or you can choose not to group the response files.
- You can choose to receive immediate responses or schedule multiple deliveries of your non-claim transaction response files throughout the day.
- For authorization and referral responses, you can receive a summary text report that displays the information in a form that's intended for non-technical users.

Important: When you are done making any changes on this tab, select **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

4.5.4 EDI reporting preferences for mail box options

The **Mail Box Options** tab of the EDI Reporting Preferences page is where you specify general preferences that apply to all response files.



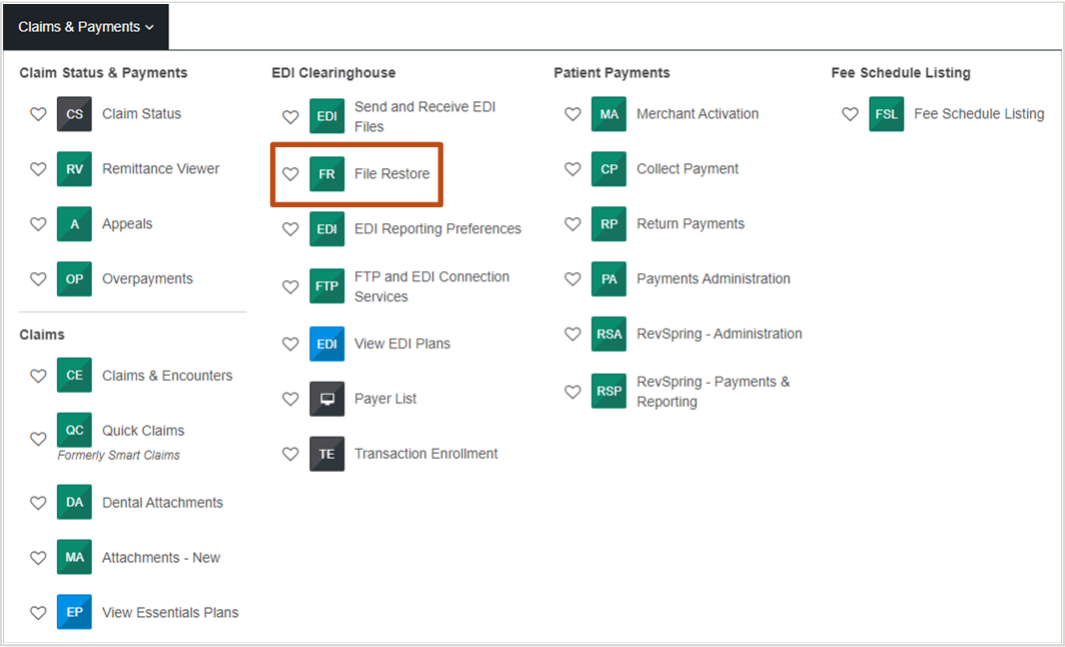
- You can choose to receive all of your X12 response files with carriage returns after each line, which makes the files easier to read. If your system can't accept carriage returns and line feeds or you'd like to receive one stream of data, uncheck this option.
- You can choose to have your response files delivered together in a single ZIP file.

Important: When you are done making any changes on this tab, select **Save** before moving on to another tab. **Changes are saved on a per tab basis**.

4.6 Access the File Restore application

Important: You must be assigned the **EDI Administration** role to access this application. If you cannot access the application, contact your Availity Essentials administrator to assign the role to you.

In the Availity Essentials secondary navigation bar, select **Claims & Payments** | **File Restore**.



4.7 Restore archived files

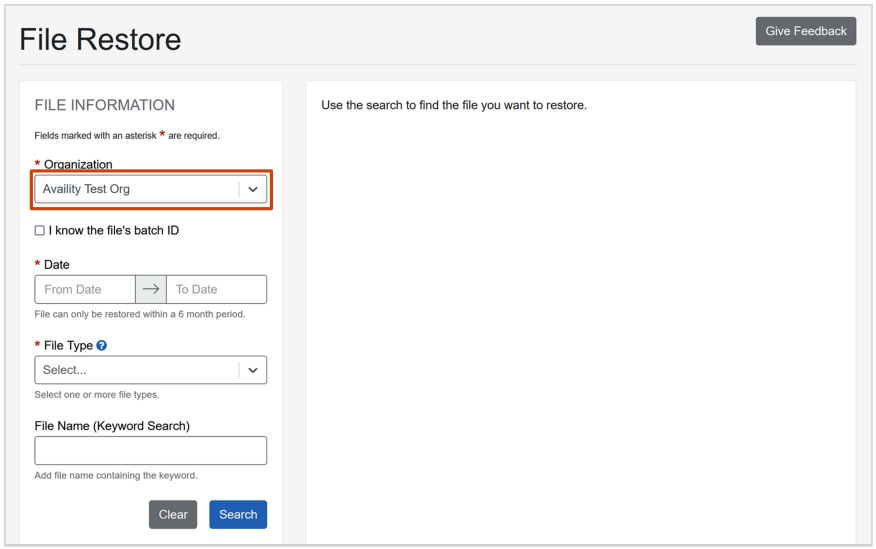
If you're looking for a particular response file in your **ReceiveFiles** folder and can't find it, note that Availity archives response files remaining in the **ReceiveFiles** folder after 30 days, whether or not they've been downloaded. You can, however, restore any files archived from your **ReceiveFiles** folder within the past six months without having to contact Availity Client Services. You can restore up to 50 files per request.

Note: To restore response files that are more than six months old, contact Availity Client Services.

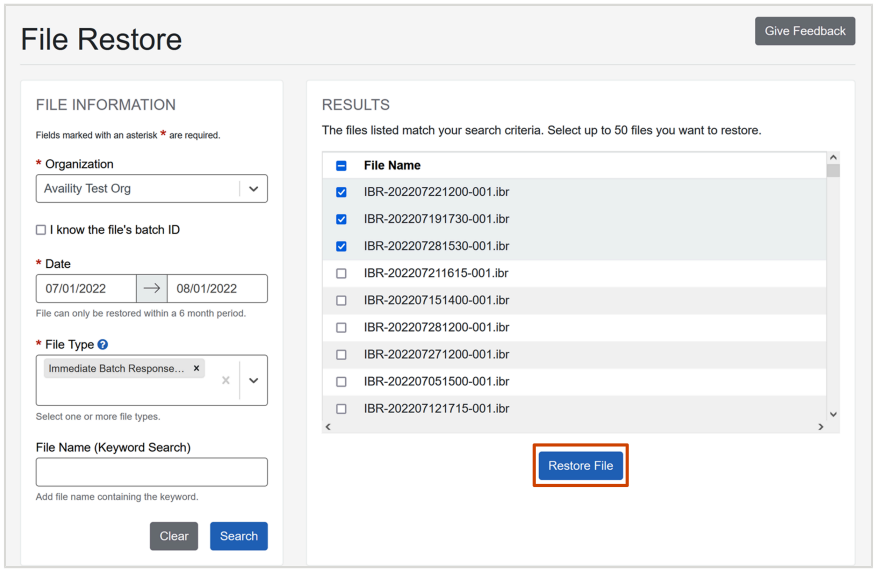
To restore archived files, follow these steps:

1. In the FILE INFORMATION section, enter the search criteria associated with the archived files you want to restore, and then select Search to find the files you want to restore.
   - Specify the organization associated with the files you want to restore by doing one of the following:
     - Enter the organization's customer ID in the **Customer ID** field. To display the **Customer ID** field, clear the **Toggle organization dropdown** check box.
     - Select the organization in the **Organization** field. To display the **Organization** field, select the **Toggle organization dropdown** check box.
   - To search for a single file by batch ID, select the **I know the file's batch ID** check box, and then enter the file's batch ID in the **Batch ID** field, and then select **Search**.
   - In the **Date** fields, enter the start and end dates for when the files were received.
   - In the **File Type** field, select the types of files you want to restore. You can select more than one file type.

     Tip: To remove a file type from the field, select the ✖ icon next to the file type.
   - In the **Keywords** field, enter one or more words contained in the names of the files you want to restore. Keywords are optional.
   - **Note:** The **Date**, **File Type**, and **Keywords** fields do not display when you select the **I know the file's batch ID** check box.



2. Select the check box next to each file you want to restore, and then select **Restore Selected Files**.



Note: Select **Cancel** to change your search criteria.

3. In the Restore Files dialog box, select **Restore** and then choose one of the following options:

   - To restore the files in a ZIP file, select **Restore as ZIP**.
   - To restore each file individually, select **Restore as File**.

   Note: ZIP file names begin with **RestoredFiles**, followed by the date range, and then the file extensions (e.g., DPT, EBT, ERA, IBT) of the files that were restored.

The selected files were restored. Select **Receive Files** on the results page to view the restored EDI files. You can also select **New Search** to search for and restore additional files.

4.8 Tips for successful batch file submissions

- Most errors occur due to data entry mistakes and accidentally skipped fields. To reduce errors, always verify the data you enter in your system before batching the claims, inquiries, and requests, and submitting them to Availity.
- If you are submitting a rebatched transaction file, be sure it contains a new interchange control number. Files with duplicate control numbers will be rejected.
- Verify you are using the most current procedure and diagnosis code lists available.
- Do not use decimals in procedure or diagnosis codes. For example, submit 525.25 as 52525.
- Do not use decimals in whole-dollar charge amounts. For example, submit $27.00 as 27.
- For charge amounts involving cents with more than two decimal places, round the amount to the nearest penny. HIPAA rejects amounts submitted with more than two decimal places. For example, submit $59.99223 as 59.99.
- Ensure all dates are valid date values using the correct format, YYYYMMDD.
- Do not enter dashes in zip codes.
- If you enter dashes in social security, federal tax ID, and employer ID numbers, Availity will remove them.
- Make sure the correct payer-assigned provider ID is in the **Provider ID** field, and the tax ID is in the **Tax ID** field.
- For Medicare claims, do not enter the subscriber's social security number.
- Do not use special characters, such as colons or asterisks (*). They might be confused with delimiters, which are special characters used to separate data in ANSI X12 files. Also, due to multiple conversions, the characters may translate differently.
- Do not enter trailing spaces in elements when it is not required for a minimum length.
- Submit up-to-date and specific ICD-10, CPT, and HCPCS codes. Availity applies the code set effective dates as established by code owners (administrators).
    - ICD-10 is updated annually on October 1 as directed by CMS
    - CPT and HCPCs are released on January 1 with quarterly updates
- Only bill claims for services that have already occurred. The claim dates of service must be prior to the transaction creation date. Other examples of dates that must be prior to the transaction creation date are:
    - Onset of Current Symptom/Illness
    - Subscriber Birth Date
    - X-ray Date
    - Date Last Seen
    - Initial Treatment Date
    - Last Certification Date

    - Service Date
    - Last Certification Date
- Always include the admission date on inpatient claims.
- Availity accepts up to 50 service lines per claim.
- Do not enter a value of `6` for Claim Frequency Codes.
- Do not enter e-codes for the primary diagnosis or the admitting or patient reason for visit.
- Do not use value `XV` for the National Plan ID.

For claims involving oxygen therapy

- The Service Line Date of Oxygen Saturation/Arterial Blood Gas Test is required on the initial oxygen therapy service line. Technically speaking, segment CR5 is used in loop 2400 and CR501 is I.
- Segment 2420E PER is required when services involving an oxygen therapy CMN are being billed/reported on this service line and segment DTP 'Date Oxygen Saturation/Arterial Blood Gas Test' in loop 2400 is used.

For authorization, referrals, and certifications

When the certification is for home health care, private duty nursing, or services by a nurses' agency, then the CR6 segment is required.

4.9 System status, scheduled maintenance, and cut-off times

System status

You can check the status of the Availity network by visiting the Availity Network Outage Notification page at https://www.availity.com/status/. The Availity Network Outage Notification page provides details about the following:

- Current outages
- Recently resolved outages
- Scheduled maintenance

Scheduled maintenance

So that we can keep the computer and network operations centers running smoothly, and provide you with new product features, Availity performs scheduled maintenance on the data center computers and network servers. Scheduled maintenance is posted on the **Scheduled Maintenance** tab on the Availity Network Outage Notification page at https://www.availity.com/status/.

- Availity makes every effort to complete all scheduled maintenance within the scheduled maintenance window.
- Major upgrades are scheduled during weekend hours. Major upgrades can include, but are not limited to, software upgrades, operating system upgrades, and reconfiguration of network routers.
- Upgrades requiring more than a day's work are scheduled for holiday periods.
- Some maintenance, either scheduled or emergency, might force interruptions to production services. In such cases, we'll post a notification in the **News and Announcements** section on the Home page of Availity Essentials. Outage details are also provided on the Availity Network Outage Notification page.
- Availity has a recovery plan for failed upgrades of software or hardware to ensure that services are unavailable for the least amount of time possible.

Cut-off times

Most payers and/or payer contractors have a designated cut-off time for transmission files to be processed in each day's cycle. To ensure that your files are processed in a particular day's cycle, you will need to contact the payer to determine their particular cut-off time, if any. For reference, Availity edits, bundles, and forwards accepted claims daily to each payer and/or payer contractor (receiver) and has no cut-off time for submissions.

Note: Payer responses reflect the date and time that Availity received the transactions.

4.10 Confidentiality and access, transaction platforms and deletion of transactions

- Availity treats all EDI submissions confidentially. The information is used for internal Availity business purposes only and always within the privacy and security guidelines established by HIPAA.
- Availity processes all transactions submitted to the Availity Health Information Network production environment/web site and forwards them to payers for adjudication and processing, regardless of the test/production indicator within the ISA segment of the transaction set.
- Availity does not delete any production transactions accepted through the Availity Health Information Network. If your office submits any transactions in error, your office must handle the issue with the payer.
- Availity rejects any transactions submitted with invalid payer identification and reports the transactions as invalid on the Availity Immediate Batch Reports (IBR or IBRP) (If you have chosen to receive the IBR or IBRP) unless the entire file is rejected for invalid payer identification. If the entire file is rejected, an Electronic Batch Report (EBR) is generated. You must review, correct, and resubmit these transactions in a new batch file containing a unique batch control number.

4.11 Transaction response aggregation

In support of the HIPAA-mandated EDI standard transactions, Availity accepts non-claim transactions (270/271, 276/277, and 278) in a batch file format, performs HIPAA compliance validation and forwards those that pass validation to the payers. Responses to these transactions and 835 remittance advice files are also received and processed by Availity for the payers supporting this functionality.

- Transactions submitted for real-time payers usually result in a response in your **ReceiveFiles** mailbox within 24 hours or less.
- Transactions for Blue plans outside of your home Blue plan can result in the following types of transaction responses: interim acknowledgement within 24 hours or less; payer benefit/rejection within 72 hours. The interim response is returned in the X12 standard paired response transaction format (i.e. 271, 277, 278).

Within the constraints of the hierarchy (HL) and loops defined in the ANSI ASC X12N HIPAA implementation standards, there can be a number of different ways of aggregating information for a given transaction. This is especially true in the paired transactions such as the 270/271 and the 276/277 and the 278. For example, inbound transaction sets (ST/SE) that have many business transactions can have a single business transaction in each ST/SE in the response transactions. This is compliant and any HIPAA-compliant PMS or system translator has no problem accepting the transactions in this format.

During processing, Availity breaks down inbound transactions to the smallest logical business transaction and sends that transaction content to the payer. For example, your inbound batch 837 EDI claims file contains a total of 100 claims for 60 unique patients for services rendered by 6 different providers in your provider group. Upon receipt and validation of the inbound EDI file, the Availity Health Information Network process creates 100 individual standalone ANSI ASC X12N 837 compliant transactions, each with their own ISA/IEA, to send to the designated payers.

5 Contact information

5.1 Availity Client Services

For questions, assistance, and support, log in to Availity Essentials. In the Availity Essentials primary navigation bar, select **Help & Training** | **Availity Support**. Or, contact an Availity Client Services representative at 800-282-4548 (800-AVAILITY).

Hours of operation: Monday through Friday

Eastern Time Zone	Central Time Zone	Mountain Time Zone	Pacific Time Zone
8:00 AM to 8:00 PM	7:00 AM to 7:00 PM	6:00 AM to 6:00 PM	5:00 AM to 5:00 PM

For issues with specific EDI transactions, please be prepared to provide the batch ID of the batch that contains your issue. The batch ID is a unique, 16-digit date-timestamp that Availity assigns to an EDI transmission file when you upload and submit it through Availity. The ID takes the format YYYYMMDDHHMMSSSS. For EDI transactions submitted through a third-party clearinghouse, contact that clearinghouse for the batch ID.

6 Control segments/envelopes

The Availity Health Information Network processing is operationally compliant with the Interchange and Application Control Structures standards defined in Appendix B of each 5010 HIPAA TR3. This section details the specific addressing and control values expected in the following segments of batch X12 files that are submitted to Availity:

- Interchange Control Header and Trailer (ISA/IEA)
- Functional Group Header and Trailer (GS/GE)
- Loop ID – 1000A Submitter Name (claims)
- Loop ID – 1000B Receiver Name (claims)

Adherence to these specifications is necessary to provide sufficient discrimination for the payer routing and acknowledgement process to function properly and to ensure that audit trails are accurate.

Note: The content in this section is intended for users who are setting up X12 files for submission to Availity. As such, it requires a detailed understanding of the structure and content of X12 files.

6.1 Interchange Control Header (ISA) and Interchange Control Trailer (IEA) segments

The ISA segment is the only EDI segment with a fixed length. A total of 105 positions are allowed in the ISA segment, including the letters ISA, the asterisk (*) or other value used as a data element separator (also known as an element delimiter), and the colon (:) or other sub-element separator (also known as a composite element delimiter). The value in position 106 is reserved for the tilde (~) or other segment terminator character used to denote the end of each segment.

Once specified in the interchange header, the delimiters and terminators cannot be used in a data element value elsewhere in the file. Availity can accept as a data element any value in the Basic and Extended Character Sets referenced in Appendix B.1.1.2 of 5010 ANSI X12N Implementation Guides, and accepted as X12 standard compliant.

When Availity processes your batch, we create a new ISA/IEA for each transaction we develop and send to the payer. Availity currently uses the following values for delimiters and terminators and requests that you not use these values in any element text.

Usage	Value
Data element separator	'*' Asterisk
Sub-element separator	':' Colon
Segment terminator	'~' Tilde
Repetition separator (5010)	'^' Caret

The following rules apply to multiple functional groups and multiple transaction sets:

- Multiple Functional Groups (GS/GE) within an Interchange (ISA/IEA) must be numbered uniquely, using the Group Control Number data element (GS06). It is recommended that the GS06 be unique within all transmissions over a period of time.

- Multiple Transaction Sets (ST/SE) within a Functional Group (GS/GE) must be numbered sequentially beginning with 1 in the first Transaction Set Control Number data element (ST02).

Interchange Control Header (ISA) segment

The following table defines the requirements for the Interchange Control Header (ISA) segment. When a value for a required field is specified in the **Specifications** column, the specified value is required in all files submitted to Availity.

Table 4: ISA segments

Name	Usage	Specifications	Segment
Authorization Information Qualifier	Code to ID the type of information in the authorization	• Required • Length: 2/2 • Required Value: 00 = No Authorization Information Present **Note:** For EDI batch mode, login credentials are not provided in the ISA header.	ISA01
Authorization Information	Info used for identification or authorization of the sender or the data interchange	• Required • Length: 10/10 • Required Value: *(10 blank spaces)*	ISA02
Security Information Qualifier	Code to ID the type of information in the Security Info	• Required • Length: 2/2 • Required Value: 00 = No Security Information Present **Note:** For EDI batch mode, login credentials are not provided in the ISA header.	ISA03
Security Information	Info used for identifying security information about the sender or the data interchange	• Required • Length: 10/10 • Required Value: *(10 blank spaces)*	ISA04
Interchange ID Qualifier	Qualifier to denote the system/method of code structure used to designate the sender	• Required • Length: 2/2 • Required Value: ZZ = Mutually Defined	ISA05

Name	Usage	Specifications	Segment
Interchange Sender ID	ID code for sender, as defined by Availity. This ID is qualified by the value in ISA05	• Required • Length: 15/15 • Required Value: AV09311993 *(+5 blank spaces)*	ISA06
Interchange ID Qualifier	Qualifier to denote the system/method of code structure used to designate the receiver	• Required • Length: 2/2 • Required Value: 01 = Duns (Dun & Bradstreet)	ISA07
Interchange Receiver ID	ID code published by the receiver. This ID is qualified by the value in ISA07.	• Required • Length: 15/15 • Required Value: 030240928 *(+6 spaces)*	ISA08
Interchange Date	Date of the interchange	• Required • Format: YYMMDD	ISA09
Interchange Time	Time of the interchange	• Required • Format: HHMM	ISA10
Repetition Separator	Provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure	• Required • Length: 1/1 • Recommended Value = ^	ISA11
Interchange Control Version Number	This version number covers the interchange control segments	• Required • Length: 5/5 • Required Value: 00501	ISA12
Interchange Control Number	A unique control number assigned by the sender	• Required • Length: 9/9 • Recommended Value: Must be identical to the value in IEA02	ISA13

Name	Usage	Specifications	Segment
Acknowledgement Requested	Code sent by the sender to request an interchange acknowledgement (TA1)	• Required • Length: 1/1 • Recommended Value = 1	ISA14
Usage Indicator	Code to indicate whether data enclosed is test or production. Test until all Availity validation testing is complete then set to P for Production.	• Required • Length: 1/1 • Recommended Values = T (Testing) or P (Production)	ISA15
Component Element Separator	The sender identifies the element separator used as a delimiter to separate the data within a composite data structure. Must be different from the data element separator and segment terminator.	• Required • Length: 1/1 • Recommended Value: Any value from the Basic Character Set.	ISA16
Segment Terminator	Always use tilde as segment terminator. There will be no line feed in X12 code.	• Required • Position 106 1/1 • Required Value = "~" [Tilde]	ISA

Interchange Control Trailer (IEA) segment

The following table define the requirements for the Interchange Control Trailer (IEA) segment, which is paired with the Interchange Control Header (ISA) segment.

Table 5: IEA segments

Name	Usage	Specifications	Segment
Number of Included Functional Groups	A count of the number of functional groups included in the interchange	• Required • Field Length: 1/5	IEA01
Interchange Control Number	A control number assigned by the sender	• Required • Field Length: 9/9 *(same as ISA13)*	IEA02

6.2 Functional Group Header (GS) and Functional Group Trailer (GE) segments

The Functional Group Header (GS) segment indicates the beginning of a functional group of transaction sets and provides control information for acknowledgements and other reporting. Availity can accept an interchange with multiple mixed transaction types GS/GE Functional Groups. Please review Appendices A & B in the HIPAA IGs and Appendices B & C in the HIPAA TR3s of the transaction being generated for additional details.

Functional Group Header (GS) segment

The following table defines the requirements for the Functional Group Header (GS) segment.

Table 6: GS segments

Name	Usage	Specifications	Segment

Functional Identifier Code	Code identifying a group of application related transaction sets	• Required
		• Field Length: 2/2
		• Recommended Values: [vary based on transaction type]
		  • HI = Health Care Services Review Information (278)
		  • HR = Health Care Claim Status Request (276)
		  • HN = Health Care Claim Status Notification (277)
		  • HC = Heath Care Claim (837)
		  • HS = Eligibility, Coverage or Benefit Inquiry (270)
		  • HB = Eligibility, Coverage or Benefit Information (271)
		  • HP = Health Care Claim Payment/Advice (835)
		  • FA = 999 Implementation Acknowledgement (5010)
		  • PI = Additional information to support a health care claim or encounter (275)
			GS01

Name	Usage	Specifications	Segment
Application Sender's Code	Code Identifying party sending transmission. Code agreed to by trading partners.	• Required • Field Length: 2/15 • Recommended Value (5010): Vendor partners should enter the vendor's customer ID.	GS02
Application Receiver's Code	Code identifying party receiving transmission. Code agreed to by trading partner.	• Required • Field Length: 2/15 • Required Value: 030240928	GS03
Date	Creation Date	• Required • Field Length: 8/8 • Format: CCYYMMDD	GS04
Time	Creation Time	• Required • Field Length: 4/8 • Format: HHMM (*GMT/UTC Standard*)	GS05
Group Control Number	Assigned number originated and maintained by the sender	• Required • Field Length: 1/9 **Note:** Do not use leading zeroes • Must be unique within interchange • Recommended to be unique over a 6-month period • Must match GE02	GS06
Responsible Agency Code	Code used to identify the issuer of the standard	• Required • Field Length: 1/2 • Recommended Value: X = Accredited Standards Committee X12	GS07

Name	Usage	Specifications	Segment

Version / Release / Industry Identifier Code	Code indicating the version, release, sub release, and industry identifier of the EDI standard being used	• Required
		• Field Length: 1/12
		• Recommended Values: [vary based on transaction type]
		  • **835** – 005010X221A1
		  • **270/271** – 005010X279A1
		  • **276/277** – 005010X212
		  • **278** – 005010X217
		  • **278N** – 005010X216
		  • **837 Institutional** – 005010X223A2
		  • **837 Professional** – 005010X222A1
		  • **837 Dental** – 005010X224A2
		  • **275 Medical** – 005010X210
			GS08

Functional Group Trailer (GE) segment

The following table defines the requirements for the Functional Group Trailer (GE) segment, which is paired with the Functional Group Header (GS) segment.

Table 7: GE segments

Name	Usage	Specifications	Segment
Number of Transaction Sets Included	Total number of transaction sets (ST/SE) included in the functional group or interchange	• Required • Field Length: 1/6	GE01
Group Control Number	Assigned number originated and maintained by the sender. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	• Required • Field Length: 1/9	GE02

6.3 Submitter (1000A) and Receiver (1000B) loops

The following table defines the requirements for the Submitter (1000A) and Receiver (1000B) loops.

Loop ID	Segment	Element Name	Description	Requirement
1000A	NM1	Submitter Name and ID	To supply the full name of an individual or organizational entity	Senders must submit the submitter name (NM103) and submitter identifier (NM109) assigned by the destination payer
1000B	NM1	Receiver Name and ID	To supply the full name of an individual or organizational entity	• Senders can submit the destination payer name (NM103) and payer ID (NM109) • For BCBSF (Florida Blue) use tax ID number 592015694. For Humana, use their Dun & Bradstreet number 049944143 • Other Payer IDs are available in Availity Health Plan Partners list • Senders can also submit with NM103 equal to Availity and the Availity Dun & Bradstreet number 030240928 in NM109

7 CAQH CORE Phase II connectivity

In support of the CAQH CORE Phase II mandate, Availity offers a fully compliant connectivity solution via the following URL:

https://gateway.availity.com:2021/core

Availity can receive batch files using either Envelope Standard A (HTTP MIME Multipart) or Envelope Standard B (SOAP+WSDL) and requires that Submitter Authentication Standard C (Username/Password) use the UserName and Password fields for Envelope Standard A and WS-security for Envelope Standard B. For more information, review Phase I CORE 153: Eligibility and Benefits Connectivity Rule and Phase II CORE 270: Connectivity Rule documents on the CAQH CORE Operating Rules page.

The following table displays the CORE Phase II field level requirements:

Field	Description
Payload Type	Specifies the type of payload included within the request. Must be one of the following: • `X12_270_Request_005010X279A1` • `X12_276_Request_005010X212` • `X12_278_Request_005010X215` • `X12_278_Request_005010X216` • `X12_278_Request_005010X217` • `X12_837_Request_005010X223A2` • `X12_837_Request_005010X222A1` • `X12_837_Request_005010X224A2`
ProcessingMode	RealTime or Batch
PayloadID	The unique payload identifier
TimeStamp	The following is an example of a valid timestamp: 20121130T22:30:06-5:00
SenderID	The submitting entity identifier
ReceiverID	The requested health plan identifier
CORERuleVersion	The CORE rule version that this envelope is using (not required)
Payload	Contains inline X12 transactions for real-time service or an attachment for batch

The following table displays the CORE Phase II services supported by Availity:

Service name	Description
realTimeTransaction	Submit a real time transaction, synchronous call.
batchSubmitTransaction	Submit a file to Availity for processing as an MTOM request. The payload contains an attachment to the web service call.
batchSubmitAckRetrievalTransaction	Retrieve a list of file names available for retrieval. The list of files, separated by a comma, is in the Response object, Payload element.
batchResultsRetrievalTransaction	Retrieve a single file (provide the file name in the payloadID) and receive the file as an MTOM attachment in the response.

8 CAQH CORE Phase IV connectivity

In support of CAQH CORE Phase IV, Availity offers fully compliant connectivity support for the 278 and 837 transactions via the following URL:

https://gateway.availity.com:2021/core

Availity can receive real-time 278 and batch 837 files using SOAP+WSDL with WS-security. For more information, review documents on the CAQH CORE Operating Rules page.

The following table displays the CORE Phase IV field level requirements:

Field	Description
Payload Type	Specifies the type of payload included within the request. Must be one of the following: • X12_837_Request_005010X222A1 • X12_837_Request_005010X223A1_2 • X12_837_Request_005010X224A1_2 • X12_278_Request_005010X217E1_2
ProcessingMode	RealTime or Batch
Payload ID	The unique payload identifier
Payload Length	The payload length
TimeStamp	The following is an example of a valid timestamp: 20121130T22:30:06-5:00
SenderID	The submitting entity identifier
ReceiverID	The requested health plan identifier
CORERuleVersion	V4.0.0
Payload	Contains inline X12 transactions for real-time service or an attachment for batch

The following table displays the CORE Phase IV services supported by Availity:

Service name	Description
realTimeTransaction	Submit a real time transaction, synchronous call.
batchSubmitTransaction	Submit a file to Availity for processing as an MTOM request. The payload contains an attachment to the web service call.

Service name	Description
batchSubmitAckRetrievalTransaction	Retrieve a list of file names available for retrieval. The list of files, separated by a comma, is in the Response object, Payload element.
batchResultsRetrievalTransaction	Retrieve a single file (provide the file name in the payloadID) and receive the file as an MTOM attachment in the response.

9 Acknowledgements and/or reports

Availity's batch EDI processing generates response files (acknowledgements and reports) for each submitted batch file. Availity provides standard response files recommended in the official HIPAA implementation guides (called TR3s) and proprietary reports for end-to-end tracking and accountability of each submitted transaction.

The following types of response files are available:

Notification file

Indicates whether a batch file was successfully received by Availity and recognized as a batch file.

File acknowledgement (ACK)

Indicates that a batch file failed Availity proprietary validation, and usually means that the format of the batch file (which is expected to be X12) is invalid.

Interchange acknowledgement (TA1)

Indicates that the interchange control header (ISA), interchange control trailer (IEA), or functional group header (GS) segments of a batch file are invalid.

Implementation acknowledgement (999)

Reports the acceptance or rejection of each transaction set (ST/SE) in a batch file, and the transactions they contain, based on whether any X12 syntax errors were detected.

Immediate batch response (IBR)

Acknowledges claims accepted by Availity and identifies claims that were rejected due to HIPAA edits, payer-specific edits (for example, duplicate transactions, member ID formatting issues), or clinical edits (for example, billing or coding issues) conducted by Availity on behalf of payers. These response files are typically available within minutes after submitting a batch file, but can take up to 24 hours depending upon the volume of claims processing at that time.

Immediate batch response plus (IBRP)

Acknowledges claims accepted by Availity and identifies warning messages and claims that were rejected due to HIPAA edits, payer-specific edits (for example, duplicate transactions, member ID formatting issues), or clinical edits (e.g, billing or coding issues) conducted by Availity on behalf of payers. These response files are typically available within minutes after submitting a batch file, but can take up to 24 hours depending upon the volume of claims processing at that time.

Electronic batch report (EBR)

Contains aggregated initial responses from payers and trading partners (such as other clearinghouses) about the status of submitted claims. The report is typically available 24-48 hours after claims accepted by Availity are submitted to a payer.

Delayed payer report (DPR)

Contains aggregated claim status information from payers that utilize batch processing or other non-real-time adjudication processes, or in cases where a payer response is received after Availity has already

sent an EBR to your organization. The report is typically available within 30 days after claims accepted by Availity are submitted to a payer. This report is not available for all payers.

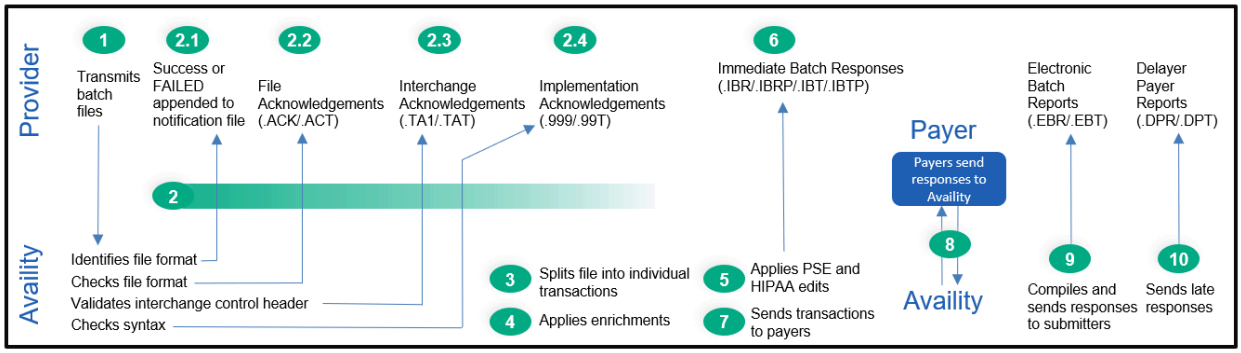
Payer responses for non-claim transactions

Response files for non-claim transactions include the following: eligibility & benefits responses (.271), claim status responses (.277), authorization/referral (.278), health care services review notification and acknowledgement (.278N), and health care services review (.278ebr) summary text report.

All response files, except notification files, are available from the **ReceiveFiles** folder for an organization. The administrator for an organization can set up reporting preferences that specify which response files are generated, the delivery schedule, and grouping options. Notification files are available from the **SendFiles** folder for an organization.

Note: If an organization registered to receive electronic remittance advice files (also known as ERAs and 835 files) through Availity, the ERA files are available from the **ReceiveFiles** folder for the organization.

The following figure shows the response files that can be generated as an EDI file is processed by Availity.



9.1 EDI response files by transaction

The type of response files generated depend on the transaction type and the edit level being reported. The following table lists each type of response file that an Availity non-payer submitter might receive, the file extension and applicable transactions.

File name	Extension	837	835	270/271	276/277	278/278	278N/278N	275
File Acknowledgement	.ACK	X		X	X	X	X	
File Acknowledgement Readable	.ACT	X		X	X	X	X	
Interchange Acknowledgement (TA1)	.TA1	X		X	X	X	X	
Interchange Acknowledgement -Readable (TA1)	.TAT	X		X	X	X	X	
Implementation Acknowledgement (999)	.999	X		X	X	X	X	X
Implementation Acknowledgement-Readable (999)	.99T	X		X	X	X	X	
Immediate Batch Response-Pipe Delimited Data	.ibr	X						
Immediate Batch Response Plus Pipe Delimited Data	.ibrp	X						
Immediate Batch Response-Readable Report	.ibt	X						
Immediate Batch Response Plus Readable Report	.ibtp	X						
Electronic Batch Report-Pipe Delimited Data	.ebr	X						

File name	Extension	837	835	270/271	276/277	278/278	278N/278N	275
Electronic Batch Report-Readable Report	.ebt	X						
Delayed Payer Report	.dpr	X						
Delayed Payer Report	.dpt	X						
Health Care Services Review Summary Text Report	.278ebr					X	X	
Electronic Remittance Advice	.era		X					
X12 Paired Response Transaction	.271			X				
X12 Paired Response Transaction	.277				X			
X12 Paired Response Transaction	.278					X		
X12 Paired Response Transaction	.278N						X	

Note: The delayed payer report is not received from all payers.

9.2 Response file and ERA file naming conventions

Response file naming conventions

File type	Naming convention
File Acknowledgement (ACK)	<<Availity Batch ID>>.ACK
File Acknowledgement-Readable (ACT)	<<Availity Batch ID>>.ACT
Interchange Acknowledgement (TA1)	<<Availity Batch ID>>.TA1
Interchange Acknowledgement-Readable (TAT)	<<Availity Batch ID>>.TAT
Implementation Acknowledgement (999)	<<Availity Batch ID>>.999
Implementation Acknowledgement-Readable (99T)	<<Availity Batch ID>>.99T
Immediate Batch Response (IBR)	IBR-<<CCYYMMDDHHMM>>-<<SEQ#>>.ibr
Immediate Batch Response-Readable (IBT)	IBT-<<CCYYMMDDHHMM>>-<<SEQ#>>.ibt
Health care claim acknowledgement - 277CA (277IBR)	277-<<CCYYMMDDHHMM>>-<<SEQ#>>.277ibr

File type	Naming convention
Electronic Batch Report (EBR)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.ebr **All responses for an organization, multiple payers** EBR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.ebr **All responses for a provider by payer** • EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebr • EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebr **All responses for a provider, multiple payers** • EBR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebr • EBR- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebr

File type	Naming convention
Electronic Batch Report-Readable (EBT)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.ebt **All responses for an organization, multiple payers** EBT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.ebt **All responses for a provider by payer** • EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebt • EBT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebt **All responses for a provider, multiple payers** • EBT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.ebt • EBT- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.ebt
Health care claim acknowledgement - 277CA (277EBR)	277-<<CCYYMMDDHHMMSS>>0<<SEQ#>>.277ebr

File type	Naming convention
Delayed Payer Report (DPR)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.dpr **All responses for an organization, multiple payers** DPR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.dpr **All responses for a provider by payer** • DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpr • DPR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpr **All responses for a provider, multiple payers** • DPR-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpr • DPR- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpr

File type	Naming convention
Delayed Payer Report-Readable (DPT)	One of the following based on selected grouping option: **All responses for an organization by payer** Default: DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>.dpt **All responses for an organization, multiple payers** DPT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>.dpt **All responses for a provider by payer** • DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpt • DPT-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpt **All responses for a provider, multiple payers** • DPT-MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>.dpt • DPT- MULTIPAYER-<<CCYYMMDDHHMM>>-<<seq#>>-<<Tax ID>>-<<NPI>>.dpt
Health care claim acknowledgement - 277CA (277DPR)	277-<<CCYYMMDDHHMMSS>>0<<SEQ#>>.277dpr
Eligibility Benefit Response (271)	One of the following based on selected grouping option: • Default: 271-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.271 • 271-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2100B NM109>>.271

File type	Naming convention
Claim Status Response (277)	One of the following based on selected grouping option: • Default: 277-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.277 • 277-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2100B NM109>>.277
Health Care Services Review Response (278)	One of the following based on selected grouping option: • Default: 278-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278 • 278-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278
Health Care Services Review Notification and Acknowledgement (278N)	One of the following based on selected grouping option: • Default: 278N-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278N • 278N-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278N
Health Care Services Review Summary Text Report (278ebr)	One of the following based on selected grouping option: • Default: 278EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.278ebr • 278EBR-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<2010B NM109>>.278ebr

Legend:

- **<<Availity Batch ID>>** – Availity assigned
- **<<CCYYMMDDHHMM>>** – Date-time stamp to an accuracy of minutes
- **<<CCYYMMDDHHMMSS>>** – Date-time stamp to an accuracy of seconds
- **<<Payer Short Name>>** – Representation of payer full name, up to 10-bytes
- **<<SEQ#>>** – 3-byte sequence number starting at '001' and incrementing by 1 for each file within same CCYYMMDDHHMM
- **<<2100B NM109>>** – Information receiver identification number in 271 or 277

- **<<2010B NM109>>** – Information receiver identification number (requester identifier) in 278, 278N or 278EBR

ERA file naming conventions

Grouping option	Naming convention
One check per file	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL-200902201240-001.era
All checks destined for an organization by payer **Note:** This method is the default setting for all current 835 recipients.	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001.era
All checks for an organization from multiple payers	ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-MULTIPAYER-200902201240-001.era
All checks for a provider by payer, and where every check in the file bears the same tax ID, but not the same NPI or the NPI is missing	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001-987654321.era
All checks for a provider by payer, and where every check in the file bears the same tax ID and same NPI	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>-<<NPI>>.era **Example:** ERA-BCBS_OF_FL -200902201240-001-987654321-1234567890.era
All checks for a provider by payer, and where at least two different tax IDs appear in the file	ERA-<<Payer Short Name>>-<<CCYYMMDDHHMM>>-<<SEQ#>>.era **Example:** ERA-BCBS_OF_FL-200902201240-001.era

Grouping option	Naming convention
All checks for a provider from multiple payers	• If there is a Tax ID in the file, the convention is as follows: ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<Tax ID>>.era **Example:** ERA-MULTIPAYER- 200902201240-001-987654321.era • If there isn't a Tax ID in the file, the NPI is used in place of the Tax ID, and the convention is as follows: ERA-MULTIPAYER-<<CCYYMMDDHHMM>>-<<SEQ#>>-<<NPI>>.era

Legend:

- **<<CCYYMMDDHHMM>>** – Date-time stamp
- **<<Payer Short Name>>** – Representation of payer full name, up to 10-bytes
- **<<SEQ#>>** – 3-byte sequence number starting at ‘001' and incrementing by 1 for each file within a set of files that otherwise would have the same name. Sequence numbers are generated for ERA files under the following conditions:
  - When the system creates additional ERA files to accommodate checks that exceed the user-defined file size limit.
  - When the user selects the 'one check per file' aggregation method and the date-time stamp on the resulting files is the same.
  - When the user selects the 'all checks for a provider by payer' aggregation method and the same date-time stamp, payer short name, and ID combination occurs for multiple files.
- **<<Tax ID>>** – The federal tax ID for the pay-to provider named in the checks.
- **<<NPI>>** – The NPI for the pay-to provider.

Note: If you choose to receive compressed files, the ERAs are contained in a ZIP file with file extension `.zip`.

9.3 Notification file

When a submitted batch file is received, Availity attempts to recognize the file by validating the following criteria:

- File contains content
- Acceptable file type
- Acceptable file format, identified by ISA in first three bytes

Batch file accepted by Availity

If an error does not occur at this point, the next step in validation begins and a notification file, indicating success, is delivered to the **SendFiles** folder. The name of the notification file is the name of the original batch file, concatenated with the Availity batch ID that assigned to the file, and the suffix `-success`. The batch ID is simply the date/time that the file submitted.

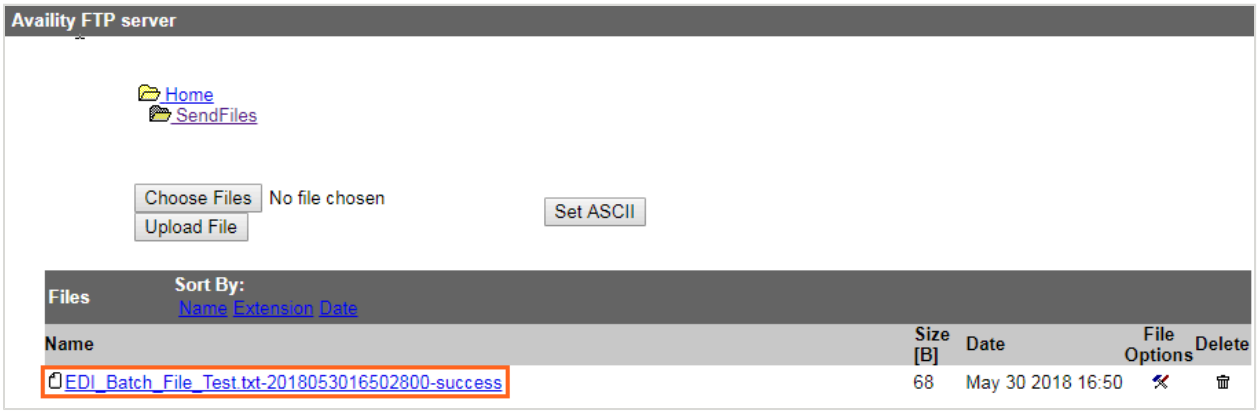


Figure 1: Example: -success file (batch file submitted through browser)

Tip: If you submitted the batch file through a browser, you can delete the notification file from the **SendFiles** folder by clicking the trash can icon in the **Delete** column of the file you want.

Batch file rejected by Availity

If an error occurs at this point, Availity does not process the batch file any further. A notification file, containing an error message, is delivered to the **SendFiles** folder. The name of the notification file is the name of the original batch file, concatenated with the Availity batch ID that assigned to the file, and the suffix `-FAILED`. The batch ID is simply the date/time that the file submitted.

To view the reason for the failure, do one of the following:

- If you submitted the batch file through a file transfer client software, use the tools in your software to open the `-FAILED` file, to view the errors.

- If you submitted the batch file through Availity Essentials or via Availity EDI site, select the tools icon in the **File Options** column of the file you want, and then select a download option such as **text/plain**, under **Download and Delete Files**. You can also download the file directly through your browser.

When a failed file upload occurs, one of the following error messages displays in the `-FAILED` file:

Empty file received - please review and resubmit

- **Cause** — This error occurs when the transmission file has zero bytes (is empty).
- **Troubleshooting** — Rebatch the file in your PMS, HIS, or other system using a new interchange control number, and then resubmit it, ensuring the file contains data. If the problem occurs again with the rebatched transmission file, contact your vendor. Your system may be creating files incorrectly.

Invalid file type received - please review and resubmit

- **Cause**— This error occurs when the transmission file is not a text (.txt) file. It may contain one of these incorrect file extensions instead: .exe, .jpg, .tif, .tiff, .emf, .jpeg, .jff, .jpe, .png, .bmp, .bid, .rle, .bmz, .gif, .gfa, .wpg.
- **Troubleshooting** — Rebatch the transmission file in your PMS, HIS, or other system using a new interchange control number and the extension .txt. If you are certain the file is a text file, but merely contains the wrong extension, you can change the file extension manually to .txt without rebatching it. Then resubmit the file. If the problem occurs again with the rebatched file, contact your vendor. Your system may be applying an incorrect file extension.

Invalid file format received - please correct and resubmit

- **Cause** — This error can occur when the first three bytes in a transmission file are not ISA.
- **Troubleshooting** — Rebatch the transmission file in your PMS, HIS, or other system using a new interchange control number. Ensure the first three bytes contain ISA, and then resubmit it. If the problem occurs again with the rebatched file, contact your vendor. Your file may contain control characters that are not viewable in text format or your system may be creating files incorrectly.

9.4 File acknowledgement (ACK)

Availity automatically sends a negative file acknowledgement (ACK) to your organization's **ReceiveFiles** folder when a submitted batch file fails Availity's proprietary validation, most commonly when the file format is invalid.

File extensions

- `.ACK` (delimited file)
- `.ACT` (human readable text file) – This is the default format.

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative file acknowledgements are not optional.
- Positive file acknowledgements are not sent.

If you do not receive the acknowledgement, please contact Availity Client Services.

Additional details

This response file reports errors in acceptable file format. The following criteria are validated:

- The first three characters in the file are ISA.
- The ISA segment is valid.

Next steps

When a file acknowledgement (ACK) is generated, processing of the batch file terminates. You must correct and resubmit the entire batch, using a new interchange control number.

File Acknowledgement (ACT)

```
------------------------------------------------------------------------------
                      AVAILITY PROPRIETARY ACKNOWLEDGEMENT
------------------------------------------------------------------------------
Customer ID: 0012345                    File Status: REJECTED
Date Received: 2020-01-01               Time Received: 10:58:01.101
Filename: 837_202001011058.txt
File Control Number: 000000000
******************************************************************************
1E - Availity does not recognize the interchange data starting at position 0 as valid.
------------------------------------------------------------------------------
                                END OF REPORT
------------------------------------------------------------------------------
```

File Acknowledgement (ACK) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|Availity Customer ID|CCYYMMDDXXXXXXXX
 - Batch ID|000000000
1E|Error message
```

File Acknowledgement (ACK)

```
1|2020-07-15|12.06.05.726|0012345|2009031511593700|000000000
1E|Availity does not recognize the interchange data starting at position 0 as valid.
```

9.4.1 Interpret file acknowledgements ACK

File acknowledgements are available in a formatted text version that is easy to read. The data file version of this file is intended to be imported into computers, although technical personnel may be able to view and interpret them.

File acknowledgements are delivered only when Availity rejected the transmission file in the first step of validation, usually due to an unacceptable file format.

1. Open the negative file acknowledgement and look at line 1E for the error.
2. See below for troubleshooting the error displayed in 1E.
3. After successfully troubleshooting and correcting the problem, rebatch the entire transmission file in your PMS, HIS, or other system and resubmit it to Availity, using a new interchange control number. Be sure that all control segments adhere to Availity's requirements for X12 files, as specified in the section on Control segments/envelopes.
4. If the error is not covered below or you are unable to resolve the problem, contact Availity Client Services for assistance.

9.4.1.1 Availity does not recognize the interchange data starting at position 0 as valid

Cause

This error is usually caused by one of the following conditions:

- File does not begin with ISA.
- Invalid ISA segment due to invalid numbers of spaces or characters in one or more data elements.

  Note: The ISA segment is the only fixed-length record in the X12 transaction. The total length of the ISA segment must be 106 characters, and all elements must have exactly the specified number of spaces or characters.
- Incorrect control segment identifier; for example, specifying a GE segment where an SE segment is expected.
- Missing control segments; for example, missing a trailer segment for an ISA, GS or ST segment.
- Invalid paragraph returns inserted into the transaction file, particularly in the control segments.

9.5 Interchange acknowledgement

Availity automatically sends negative interchange acknowledgements to your organization's **ReceiveFiles** folder. This file reports errors encountered within the interchange header or trailer, or functional group header, of the X12 file, particularly errors caused by duplicate interchange control numbers or an incorrect trading partner envelope.

File extensions

- `.TA1` (X12 file) – This is the default format.
- `.TAT` (human readable text file)

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative interchange acknowledgements are not optional.
- To receive positive interchange acknowledgements, the value of ISA14 must be set to 1 in the submitted batch file. Positive interchange acknowledgements are returned with the implementation acknowledgement file (999).

Additional details

This response file reports errors (TA104) in the interchange control header (ISA) or trailer (IEA), or functional group header (GS). The following criteria are validated:

- Duplicate interchange control number (ISA13).
- Incorrect trading partner envelope, signified by an invalid value in either the interchange control header (ISA) or functional group header (GS) segments.

Next steps

When an interchange acknowledgement is generated, processing of the batch file terminates. You must correct and resubmit the entire batch, using a new interchange control number.

9.5.1 Interchange acknowledgement - format and examples

The following table specifies the elements on the TA1 segment.

Field	Description	HIPAA segment ID
Interchange Control Number (File Control Number)	• Required • Field Length: 9/9	TA101
Interchange Date	• Required • Format: YYMMDD	TA102
Interchange Time	• Required • Format: HHMM	TA103
Interchange Acknowledgement Code	• Required • Field Length: 1/1	TA104
Interchange Note Code	• Required • Field Length: 3/3	TA105

Interchange Acknowledgement (TA1) example

```
ISA*00* *00* *01*030240928 *ZZ*AV09311993 *190103*1440*^*00501*185486211*0*T*:~
TA1*219381897*181207*2204*R*025~
IEA*0*185486211~
```

Human readable Interchange Acknowledgement (TAT) example

```
                        AVAILITY TA1 INTERCHANGE ACKNOWLEDGEMENT


Customer ID: 0002176                                              File  Status: ACCEPTED
Date Received: 2010-12-07                                    Time Received: 11:58:26.137
Filename: RespReport_test3.TXT
File Control Number: 000164875
*************************************************************************************************************
Interchange acknowledged: TA101
*************************************************************************************************************
********************Interchange Date: 101201                                          Interchange Time:
 0933
Interchange Status: A
Interchange Note: 000
-------------------------------------------------------------------------------------------------------------
                                          END OF REPORT
-------------------------------------------------------------------------------------------------------------
```

9.5.2 Interpret interchange acknowledgement files TA1

Tip: Availity offers a text version of this file, which is easier to read than the data file. To receive this text report, ask your Availity Essentials administrator to select the **Text – Human Readable (.TAT)** check box in your organization's EDI reporting preferences.

Interchange acknowledgements are delivered only when Availity rejected the transmission file in the first step of validation, usually due to one of these issues:

- Duplicate interchange control number (ISA13).
- Incorrect trading partner envelope, signified by an invalid value in either the interchange control header (ISA) or functional group header (GS) segments.

1. Follow these steps:

1. Open the negative interchange acknowledgement and look for the error.

   Tip: You'll know you're viewing a TA1 data file if it contains only the segments ISA, TA1 and IEA. If the date file includes an ST*999 segment, it is an implementation acknowledgement (999), which is a different type of acknowledgement. In that case, see Interpret implementation acknowledgement data files 999 on page 96 instead of the procedure described here.

2. See the appropriate section below for common errors.
3. After successfully troubleshooting and correcting the problem, rebatch the entire transmission file in your PMS, HIS, or other system and resubmit it to Availity, using a new interchange control number.
4. If the error is not covered below or you are unable to resolve the problem, contact Availity Client Services for assistance.

9.5.2.1 The trading partner agreement for interchange level could not be found

Cause

The transmission file has a trading partner identifier that we do not recognize or is not registered with Availity. This value may occur in either the interchange control header (ISA) or functional group header (GS) segments.

Troubleshooting

- See the related topics on interchange control segments and functional group segments, which explain the requirements for these segments in the file.
- If your knowledge about EDI is limited, see the related topic on understanding EDI X12 batch file structure for a brief explanation of these segments.
- You might also see the related topic on loops and segments in EDI claims (X12 837P Files).
- If necessary, contact the vendor for your EDI transactions system to discuss Availity's specifications for EDI files and how they apply to your system.

9.5.2.2 Duplicate file: The same control number has already been received

Cause

This error usually occurs when a transmission file is submitted using the same interchange control number. In other words, the interchange control number (ISA13) was used in a previous file submitted to Availity.

Troubleshooting

Rebatch the transmission file in your PMS, HIS, or other system, ensuring a new, unique interchange control number is assigned, and then resubmit it. If the problem occurs again with the rebatched file, contact your vendor. Your system may be reusing the same interchange control number.

9.6 Implementation acknowledgement

Availity automatically sends negative implementation acknowledgements to your organization's **ReceiveFiles** folder. This file indicates that Availity received the transmission file and it had errors, particularly X12 and HIPAA syntax errors. Implementation acknowledgements are also referred to as 999 files.

File extensions

- `.999` (X12 file) – This is the default format.
- `.99T` (human readable text file)

When is this response file sent?

Within 24 hours, and only if errors occur.

- Negative implementation acknowledgements are not optional.

Additional details

The X12N EDI standard 999 Implementation Acknowledgement transaction (.999) is used to report the acceptance or rejection of each transaction set (ST/SE) within each functional group (GS/GE) contained in the inbound file of ASC X12N 5010 EDI transactions.

- **Negative implementation acknowledgement** - If the entire file does not pass the validation, AvailityAvaility rejects it entirely and sends a negative implementation acknowledgement (999) to your organization's **ReceiveFiles** mail box. The file is not processed further, and the transactions are not routed to the payer.
- **Partial implementation acknowledgement** - If the file contains multiple transaction sets and some of them pass validation and others do not, Availity partially rejects the file. This means that Availity rejects or accepts the file at the transaction-set level. For partially rejected files, Availity sends an implementation acknowledgement (999) to your organization's **ReceiveFiles** mail box. Rejected transaction sets are not processed further, and they are not routed to the payer. Accepted transaction sets continue through processing.
- **Positive implementation acknowledgement** - If the entire file passes validation in this step and you set up your EDI reporting preferences to receive positive implementation acknowledgements (999), Availity sends a positive acknowledgement file to your organization's **ReceiveFiles** mail box. The accepted transaction sets proceed to the next step in processing.
- If the file contains multiple ISA/IEA segments, Availity sends an acknowledgement for each ISA/IEA pairing.

Next steps

If Availity rejects or partially rejects any or all transaction sets, you must correct the errors in your EDI billing system, rebatch all transactions in the rejected transaction sets, and upload the new file to Availity again.

Important: You must rebatch even those transactions in the rejected transaction set that do not need correction, because as part of the rejected transaction set, they have not been routed to the payer yet. Also, you must upload the corrected transaction sets using a new interchange control number. If you attempt to upload them using the previous interchange control number, Availity rejects the file as a duplicate.

9.6.1 Implementation acknowledgement 999 - format and examples

Table 8: Implementation acknowledgement 999 format

837 claim	999 acknowledgement
ISA GS - 837 ST *837*0001 SE ST *837*0002 SE GE GS - 837 ST *837*0001 SE GE IEA	ISA GS - 999 ST AK1(AK102 equals GS06 in the functional group being acknowledged) AK2 (AK202 equals ST02 in the transaction set being acknowledged) IK5 AK2 (AK202 equals ST02 . . .) IK5 AK9 SE GE GS ST AK1 (AK102 equals GS06 . . .) AK2 (AK202 equals ST02 . . .) IK5 AK9 SE GE IEA

The most important segments, for troubleshooting purposes, in an implementation acknowledgement file are the following:

IK3

Segment IK3 in 999 implementation acknowledgement files identifies the location of errors in the transaction segment. Multiple IK3 segments can display if the transaction set contains multiple errors.

CTX

Segment CTX in 999 implementation acknowledgement files is used for the following:

- When a syntax error occurs within a business unit, the CTX segment identifies the business unit (such as the patient control number for a claim) that generated the error.
- When a syntax error is triggered by a situational requirement, the CTX segment identifies the data element that triggered the situational requirement.

IK4

Segment IK4 in 999 implementation acknowledgement files identifies the data element, or field, in the transaction set that is in error. Multiple IK4 segments can display if multiple transaction sets have data elements in error.

IK5

Segment IK5 in 999 implementation acknowledgement files identifies the status of a transaction set in the transmission file whether or not it contains errors. Multiple IK5 segments are associated with a single AK9 segment if the transmission file contains more than one transaction set in the associated functional group.

AK9

Segment AK9 in 999 acknowledgement files identifies the status of the functional group in the transmission file. A single AK9 segment has multiple IK5 segments associated with it if the functional group in the transmission file includes more than one transaction set.

More information about how to interpret these segments is available in the topics that follow. Detail implementation specifications for the 999 Implementation Acknowledgement can also be found in the Implementation Acknowledgment For Health Care Insurance.

As shown in the following examples, the 999 transaction is intended to be imported into an automated system such as an EDI X12N compatible practice management system, and therefore is not formatted for human readability. A human-readable version is provided by the 99T format.

999 file rejected

```
ISA*00*     *00*     *01*030240928   *ZZ*AV09311993*031204*1109*U*00501*000090091*0*P*:~
TA1*000001732*031204*1101*A*000~
GS*FA*030240928*AV01101957*20031204*1109*80180*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*17321*005010X223A2~
AK2*837*000000001*005010X223A2~
IK3*CL1*24*2300*8~
CTX*CLM01:393931D_1310~
IK4*2*1314*5*AA~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*80180~
IEA*1*000090091~
```

999 file accepted

```
ISA*00*     *00*     *01*030240928   *ZZ*AV09311993*030306*1356*U*00501*000000000*0*P*:~
GS*FA*030240928*AV01101957*20030306*1356*000000000*X*005010X231A1~
ST*999*000000000*005010X231A1~
AK1*HC*103136*005010X222A1~
AK2*837*000003136*005010X222A1~
IK5*A~
AK9*A*1*1*1~
SE*6*000000000~
GE*1*000000000~
IEA*1*000000000~
```

9.6.2 Implementation acknowledgement 99T - readable format

The 99T format of the 999 Implementation Acknowledgement provides the same information as the X12 format of the 999 acknowledgement, but in a readable format. Like the X12 version, it reports the acceptance or rejection of each transaction set (ST/SE) within each functional group (GS/GE) contained in the inbound file of ASC X12N 5010 EDI transactions.

The following figure shows an example of the Availity 999 Implementation Acknowledgement in its readable format.

```
                    AVAILITY 999 FUNCTIONAL ACKNOWLEDGEMENT

Date Received:06/04/2012                File Status:ACCEPT
Time:1015                               Test or Prod:T
Trans ID:010103560

*******************************************************************************
Batch and Claim Accept/Reject Totals at END of Report
*******************************************************************************

Batch Details                           Submitter ID:1234567893
Group Control#:1                        Submitter:AVAILITY TEST ORG
Transaction Set#:0001                   Receiver:BCBSTX
Batch ID:10103560                       Receiver ID:84980
Batch Status:ACCEPT                     Trans Type:005010X222A1
-------------------------------------------------------------------------------

*******************************************************************************
BATCH(S) ACCEPT:1         BATCH(S) REJ:0         CLAIM(S) REJ:0
*******************************************************************************
                       *******END OF REPORT*******
```

9.6.3 Interpret implementation acknowledgement data files 999

The most common acknowledgement file is the implementation acknowledgement (999). You might find interpreting implementation acknowledgement data files difficult unless you understand their basic structure. If you already understand acknowledgement data files, proceed with this topic, which explains how to interpret them as implemented at Availity.

Tip:

- Availity offers a text version of this file, which is easier to read than the data file. To receive this text report, ask your Availity Essentials administrator to select the **Text – Human Readable** check box in your organization's EDI reporting preferences.
- If the implementation acknowledgement (999) file contains a TA1 segment, you can use the value of TA101 to tie the 999 file back to the transmission file, because TA101 is set to the interchange control number (ISA13) of the associated transmission file. To set up your 999 files to always include a TA1 segment, set ISA14 to '1' in the transmission file and select **Include TA1 with this acknowledgement**, in the **Implementation Acknowledgements (999)** section of the **Claims** tab on the EDI Reporting Preferences page.

Each functional group from the initial transmission file is represented by one sequence of segments that starts with AK1 and ends with AK9. To determine the type of error (if any) and the cause, you'll need to look at the values of the AK1 through AK9 segments. The following sections describe the general types of errors that you can encounter, including the case where no errors occurred.

No errors occurred

If AK901=A, Availity has accepted all transaction sets in the associated functional group. No other action is required.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a functional group that was accepted by Availity:

```
AK1*HC*3456*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK9*A*1*1*1~
```

Functional group level errors

If AK901=R and there are no IK5 segments, an error occurred at the functional group level (i.e., in the GS and/or GE segments in the transmission file).

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a functional group that has an error at the functional group level in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK9*R*1*1*0*<<AK905 code>>~
```

- The presence of the AK905 element (indicated by the <<AK905 code>> placeholder in the example) indicates a functional group error, and its value specifies the cause of the error. For a list of AK905 values and their meaning, see Interpret AK9 in implementation acknowledgement files 999 on page 106.
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.

Transaction set level errors

If AK901=R or P and there are no IK3 segments, the error either occurred at the transaction set level (i.e., in the ST and/or SE segments in the transmission file), or in the functional group header (but not detected until later).

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a transaction level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK5*R*<<IK502 code>>~
AK9*<<R or P>>*1*1*0~
```

- Use the value of IK502 (indicated by the <<IK502 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK502 values and their meaning, see Interpret IK5 in implementation acknowledgement files 999 on page 104.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).

- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Segment level errors

If AK901=R or P and there are IK3 segments but no IK4 segments, the error occurred at the segment level. Examples of segment level errors include missing segments or missing segment identifiers.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a segment level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK3*<<segment ID>>*<<position>>*<<loop>>*<<IK304 code>>~
CTX*<<business unit element ID>>:<<business unit value>>~
IK5*R*5~
AK9*<<R or P>>*1*1*0~
```

- Use the value of IK304 (indicated by the <<IK304 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK304 values and their meaning, see Interpret IK3 in implementation acknowledgement files 999 on page 100.
- If the error occurred within a business unit (e.g., a claim), a CTX segment will be present, as in the above example.
- Use the value of IK301 and CTX01 (if present) to locate the segment that has the error. And use other IK3 elements, if necessary, to help locate the error.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Data element level errors

If AK901=R or P and IK4 segments are present, the error occurred at the data element level. Examples of data level errors include missing elements or invalid values.

The following is an example of the AK1 through AK9 segments in a 999 file, associated with a data element level error in the transmission file:

```
AK1*HC*111222*005010X222A1~
AK2*837*000000001*005010X222A1~
IK3*<<segment ID>>*<<position>>*<<loop>>*<<IK304 code>>~
CTX*<<business unit element ID>>:<<business unit value>>~
IK4*<<element ID>>*<<element ref number>>*<<IK403 code>>*<<bad value>>~
IK5*R*5~
AK9*<<R or P>>*1*1*0~
```

- The value of IK304 (indicated by the <<IK304 code>> placeholder in the example) is often 8, which simply indicates that the associated segment has data element errors. For other values of IK304, see Interpret IK3 in implementation acknowledgement files 999 on page 100.
- Use the value of IK403 (indicated by the <<IK403 code>> placeholder in the example) to diagnose the cause of the error. For a list of IK403 values and their meaning, see Interpret IK4 in implementation acknowledgement files 999 on page 102.
- If the error occurred within a business unit (e.g., a claim), a CTX segment will be present, as in the above example.
- Use the value of IK301 and CTX01 (if present) to locate the data element that has the error. And use other IK3 and IK4 elements, if necessary, to help locate the error.
- The value of AK901 (indicated by the <<R or P>> placeholder in the example) specifies whether all transaction sets in the functional group were rejected (AK901=R), or whether only some of the transaction sets in the functional group were rejected (AK901=P).
- If the transmission file contains multiple functional groups, you can use the value of AK102 to identify the functional group that has the error, since AK102 is set to the group control number (GS06) of the associated functional group.
- You can use the value of AK202 to identify the transaction set that has the error, since AK202 is set to the transaction set control number (ST02) of the associated transaction set.

Note:

- If AK901=E, Availity accepted the associated functional group but noted some minor errors. An example of a minor error might be a leading zero in front of an amount, such as the zero in front of the decimal in the amount 0.10. You do not need to correct these types of errors.
- If you have problems interpreting the implementation acknowledgement (999) file, contact Availity Client Services for assistance. To expedite the process, please obtain the batch ID before contacting Availity Client Services.

9.6.4 Interpret IK3 in implementation acknowledgement files 999

Segment IK3 in 999 implementation acknowledgement files identifies the location of errors in the transaction segment. Multiple IK3 segments can display if the transaction set contains multiple errors.

Each value in IK3 represents specific information, as follows:

IK301 (First Value)

Identifies the segment in the transaction containing the error. Use this value with IK302 to identify the location of the error. Example, in bold: `IK3*N4*10*2300*8~`

IK302 (Second Value)

Identifies the line number in the transaction set containing the error. Use this value with IK301 to identify the location of the error. Example, in bold: `IK3*N4*10*2300*8~`

IK303 (Third Value)

Identifies the loop number containing the segment in error. The loop number corresponds to a section of the transaction. Example, in bold: `IK3*N4*10*2300*8~`

Note: If you contact the vendor for your EDI transactions system, knowing the meaning of the loop number can help you communicate with the vendor. For more information, see the topic on loops and segments in EDI claims (X12 837P Files).

IK304 (Fourth Value)

Identifies the type of error at the segment level. Example, in bold: `IK3*N4*10*2300*8~`

Note: An IK304 value of 8 is the most common. For other values, contact your technical resource or vendor for assistance.

Table 9: IK304 values

Value	Definition
1	Unrecognized segment ID, often indicating a typographical error in the segment ID.
2	Unexpected segment, indicating the segment is not normally used for the transaction set.
3	Mandatory segment missing, meaning the transaction set is missing a required or expected segment.
4	Loop occurs over maximum times, meaning the transaction set contains too many instances of the loop.
5	Segment exceeds maximum use, meaning the transaction set contains too many instances of the segment.

Value	Definition
6	Segment not in defined transaction set, meaning the segment is not used for the type of transaction.
7	Segment not in proper sequence. In other words, the segment occurs out of the expected order.
8	Segment has field errors, meaning the fields within the segment contain errors.
I4	Implementation "Not Used" segment present
I6	Implementation dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation dependent "Not used" segment present

Example

```
IK3*N4*10*2300*8~
```

- The IK301 is N4, indicating the error is located in the N4 segment.
- The IK302 is 10, identifying the line in the transaction set in which the error is located. The error occurs in the tenth line from the beginning of the transaction set, counting the ST segment as line 1.
- The IK303 is 2300, indicating the error is located in loop 2300. The HIPAA Implementation Guide indicates this is the claim-level information.
- The IK304 is 8, indicating the segment identified in IK301 has field errors.

In other words, the tenth line in the transaction set is the N4, or address, segment, which contains field errors related to the claim-level information loop.

Note: An IK4 segment may follow the IK3 segment and specifically identifies the data element in error. Interpret the IK4 segment to help you further pinpoint the error.

9.6.5 Interpret CTX in implementation acknowledgement files 999

Segment CTX in 999 implementation acknowledgement files is used for the following:

- When a syntax error occurs within a business unit, the CTX segment identifies the business unit (such as the patient control number for a claim) that generated the error.
- When a syntax error is triggered by a situational requirement, the CTX segment identifies the data element that triggered the situational requirement.

CTX for business unit identifier

In the case that the CTX segment specifies a business unit identifier, the segment contains only the CTX01 element.

- For claims, CTX01 consists of the context name CLM01, followed by a colon (:) and then followed by the patient control control. The patient control number can be either the patient account number or the claim control number. The following is an example of a CTX segment for a claim with a patient control number of 1234567:

  ```
  CTX*CLM01:1234567~
  ```

- For eligibility and benefits inquiries, CTX01 consists of the context name TRN02, followed by a colon (:) and then followed by the trace number (TRN02). The following is an example of a CTX segment for an eligibility and benefits inquiry with a trace number of 1234567:

  ```
  CTX*TRN02:1234567~
  ```

- For authorization and referral transactions, CTX01 consists of the context name NM109, followed by a colon (:) and then followed by the subscriber ID (NM109). The following is an example of a CTX segment for an authorization or referral transaction with a subscriber ID of ABC123456789:

  ```
  CTX*NM109:ABC123456789~
  ```

CTX for situational trigger

In the case that the CTX segment specifies a data element that triggered a situational requirement, the CTX01 element always has the value SITUATIONAL TRIGGER. The remaining elements in the CTX segment identify the data element that triggered the situational requirement causing the error. In the following example, the trigger is the composite data element CLM05-3, which is the forty-third segment in the transaction set, as counted from the ST segment:

```
CTX*SITUATIONAL TRIGGER*CLM*43**5:3~
```

9.6.6 Interpret IK4 in implementation acknowledgement files 999

Segment IK4 in 999 implementation acknowledgement files identifies the data element, or field, in the transaction set that is in error. Multiple IK4 segments can display if multiple transaction sets have data elements in error.

Each value in IK4 represents specific information, as follows:

IK401 (First Value)

Identifies the location, or position, of the erroneous value in the transaction segment identified in IK301 and IK302. Example, in bold: `IK4*1*1069*7*00~`

Note: In rare cases, IK401 includes two or more numbers separated by colons, indicating the transaction segment is a composite data element. The extra value(s) identifies the component of the data element containing the error. For example, if IK401 is `1:2`, the error is located in the second component of the first data element in the transaction segment.

IK402 (Second Value)

Identifies the data element number. Example, in bold: `IK4*1*`**`1069`**`*7*00~`. For more information, see the topic on loops and segments in EDI claims (X12 837P files).

IK403 (Third Value)

Identifies the cause of the error Availity found during syntax validations. Example, in bold: `IK4*1*1069*`**`7`**`*00~`

Table 10: IK403 values

Value	Definition
1	Mandatory field missing.
2	Conditional required field missing.
3	Too many fields.
4	Field too short.
5	Field too long.
6	Invalid character in field.
7	Invalid code value.
8	Invalid date.
9	Invalid time.
10	Exclusion condition violated. In other words, the segment includes two values that should not occur together. Only one of them can be present. See the appropriate HIPAA Implementation Guides or contact the vendor of your PMS, HIS, or other system for more information. For more information, see the topic on loops and segments in EDI claims (X12 837P files).
12	Too many repetitions
13	Too many components
I10	Implementation "Not Used" data element present
I11	Implementation too few repetitions
I12	Implementation pattern match failure

Value	Definition
I13	Implementation dependent "Not Used" data element present
I6	Code value not used in implementation
I9	Implementation dependent data element missing

IK404 (Fourth Value)

Displays a copy of the erroneous value. It displays only if the IK403 is 6, 7, 8, or 9. Example, in bold: `IK4*1*1069*7*`**`00`**`~`

Example

```
IK4*1*1069*7*00~
```

- The IK401 is 1, indicating the data element is located in the first position of the transaction segment identified in IK301 and IK302.
- The IK402 is 1069, which the X12N Data Element Dictionary defines as the individual relationship code.
- The IK403 is 7, indicating the individual relationship code is an invalid code value.
- The IK404 is 00, which is a copy of the erroneous value in the claim segment.

In other words, the IK4 segment indicates that 00, found in the first position of the transaction segment identified in IK301 and IK302, is an invalid value for the individual relationship.

9.6.7 Interpret IK5 in implementation acknowledgement files 999

Segment IK5 in 999 implementation acknowledgement files identifies the status of a transaction set in the transmission file whether or not it contains errors. Multiple IK5 segments are associated with a single AK9 segment if the transmission file contains more than one transaction set in the associated functional group.

Each value in the IK5 represents specific information, as follows:

IK501 (First Value)

Identifies whether Availity accepted or rejected the transaction set. This value can help you determine if a problem exists in the transaction set. Example, in bold: `IK5*`**`R`**`*5~`.

Value	Definition
A	Accepted advised, meaning Availity accepted the transaction set.
E	Accepted, but errors were noted. This code means minor errors occurred that did not cause Availity to reject the transaction set. Instead, Availity has continued processing the transaction set and routed the transactions to the payer.
R	Rejected advised, meaning Availity rejected the transaction set. Availity rejects the entire transaction set, even if most of the transactions in the set passed validation.

IK502 - IK506 (Second through Sixth Values)

The IK5 segment can display up to five additional values to identify the syntax errors in the transaction set. The segment does not display these values if the IK501 is A, indicating the transmission file is accepted. Example, in bold: `IK5*R*`**`5`**`~`

Note: The most common value is 5, indicating one or more segments are in error. If a different value is present, you might need to contact the vendor for your PMS, HIS, or other system for assistance.

Value	Definition
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available

Value	Definition
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
18	Transaction Set not in Functional Group
19	Invalid Transaction Set Implementation Convention Reference
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment
I5	Implementation One or More Segments in Error
I6	Implementation Convention Not Supported

Example

```
IK5*R*5~
```

- The IK501 is R, indicating Availity rejected the transaction set.
- The IK502 is 5, indicating one or more segments in the transaction set are in error.

9.6.8 Interpret AK9 in implementation acknowledgement files 999

Segment AK9 in 999 acknowledgement files identifies the status of the functional group in the transmission file. A single AK9 segment has multiple IK5 segments associated with it if the functional group in the transmission file includes more than one transaction set.

Each value in AK9 represents specific information, as follows:

AK901 (First Value)

Identifies whether Availity accepted or rejected the transaction sets in the functional group. Example, in bold: `AK9*R*8*8*0*3~`

Value	Definition
A	Accepted advised, meaning Availity accepted all transaction sets in the functional group.
E	Accepted, but errors were noted. Minor errors occurred that did not cause Availity to reject the transaction sets in the functional group. Instead, Availity has continued processing the transactions and routed them to the payer.
M	Rejected, message authentication code (MAC) failed. Because Availity does not perform this type of validation at this stage in processing, this code never displays.
P	Partially accepted, meaning at least one transaction set, but not all of them, in the functional group was rejected. Rejected transaction sets are indicated by an R in IK501.
R	Rejected advised, meaning that Availity rejected all transaction sets in the functional group. All IK501s associated with the AK9 segment display R.
W	Rejected, assurance failed validity tests. Because Availity does not perform this type of validation at this stage in processing, this code never displays.
X	Rejected, content after decryption could not be analyzed. Because Availity does not perform this type of validation at this stage in processing, this code never displays.

AK902 (Second Value)

Identifies the number of transaction sets in the functional group, as specified in the transmission file. Example, in bold: `AK9*R*`**`8`**`*8*0*3~`

AK903 (Third Value)

Identifies the number of transaction sets in the functional group, as identified by Availity upon receiving the transmission file. Example, in bold: `AK9*R*8*`**`8`**`*0*3~`

AK904 (Fourth Value)

Identifies the number of transaction sets in the functional group that Availity accepted. Example, in bold: `AK9*R*8*8*`**`0`**`*3~`

AK905 (Fifth Value)

Identifies the syntax errors in the functional group header or trailer in the transmission file. If the group header or trailer does not contain syntax errors, this value is missing. Example, in bold: `AK9*R*8*8*0*`**`3`**`~`

Value	Definition
1	Functional Group Not Supported
2	Functional Group Version Not Supported
3	Functional Group Trailer Missing
4	Group Control Number in the Functional Group Header and Trailer Do Not Agree
5	Number of Included Transaction Sets Does Not Match Actual Count
6	Group Control Number Violates Syntax
10	Authentication Key Name Unknown
11	Encryption Key Name Unknown
12	Requested Service (Authentication or Encryption) Not Available
13	Unknown Security Recipient
14	Unknown Security Originator
15	Syntax Error in Decrypted Text
16	Security Not Supported

Value	Definition
17	Incorrect Message Length (Encryption Only)
18	Message Authentication Code Failed
19	Functional Group Control Number not Unique within Interchange
23	S3E Security End Segment Missing for S3S Security Start Segment
24	S3S Security Start Segment Missing for S3E End Segment
25	S4E Security End Segment Missing for S4S Security Start Segment
26	S4S Security Start Segment Missing for S4E Security End Segment

Example

```
AK9*R*8*8*0*3~
```

- The AK901 is R, indicating all transaction sets in the functional group are rejected.
- The AK902 is 8, indicating the functional group includes eight transaction sets, as specified in the transmission file.
- The AK903 is 8, indicating the functional group includes eight transaction sets, as received by Availity.
- The AK904 is 0, indicating Availity accepted no transaction sets for the functional group.
- The AK905 is 3, indicating the functional group trailer is missing.

In other words, Availity rejected all of the eight transaction sets it received. If the entire acknowledgement file were shown in this example, you would see eight IK5 segments preceding the AK9 segment to identify each of the transaction sets in error. Finally, the AK905 indicates that the trailer for the functional group is missing from the transmission file.

9.7 Immediate batch responses

Immediate Batch Response

The immediate batch response (also referred to as an IBR) is a proprietary report that acknowledges accepted claims and identifies rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

File extensions

- `.IBR` (delimited file) – This is the default format.
- `.IBT` (human readable text file)
- `.277IBR` – 277CA claim acknowledgement format.

When is this response file sent?

Within minutes after transmission or up to 24 hours depending upon the volume of claims processing at that time.

- Immediate batch responses are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Availity generates the IBR after an accepted (A), accepted with errors (E), or a partial accepted (P) Implementation Acknowledgement (999) has been posted to your **ReceiveFiles** mailbox.
- If any errors display in this report, you can correct the claims, rebatch them, and resubmit them. This response file benefits you because it allows you to correct problems without having to wait for the payer to finish processing the rest of the transmission file.
- Unless your administrator selected grouping options, each IBR represents one ISA – IEA. If a file contains multiple ISA – IEA, Availity generates an IBR for each ISA – IEA.
- Rejected claims on the IBR also appear as rejected claims on the electronic batch report (EBR).
- Availity does not generate or return an IBR in the following situations:
  - If the complete batch file rejected on a negative ACK, TA1 or 999 file.
  - If the batch file contained non-claims transactions (27x.).

Next steps

For every claim identified as rejected in the IBR, you must correct the errors in your EDI transactions system or practice management system, rebatch the claims with a new interchange control number, and

upload the new file to Availity again. Claims that contain no HIPAA-compliance errors or payer-specific errors are routed to the payer.

Immediate Batch Response Plus

The immediate batch response plus (also referred to as an IBRP) is a proprietary report that acknowledges accepted claims and identifies warning messages and rejected claims due to HIPAA edits and payer-specific edits (PSEs) that Availity conducted on behalf of payers. The report also includes claim counts and charges at the claim level and file level. Only claims that passed file format and syntax validations are included in this report.

Note: The IBR and IBRP are the same report with the exception that the IBRP includes payer-specific warning messages that Availity relays on behalf of the payer. You only need to select one immediate batch report.

File extensions

- `.IBRP` (delimited file) – This is the default format.
- `.IBTP` (human readable text file)
- `.277IBRP` – 277CA claim acknowledgement format.

When is this response file sent?

Within minutes after transmission or up to 24 hours depending upon the volume of claims processing at that time.

- Immediate batch responses are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Availity generates the IBRP after an accepted (A), accepted with errors (E), or a partial accepted (P) Implementation Acknowledgement (999) has been posted to your **ReceiveFiles** mailbox.
- If any errors display in this report, you can correct the claims, rebatch them, and resubmit them. This response file benefits you because it allows you to correct problems without having to wait for the payer to finish processing the rest of the transmission file.
- Unless your administrator selected grouping options, each IBRP represents one ISA – IEA. If a file contains multiple ISA – IEA, Availity generates an IBRP for each ISA – IEA.
- Rejected claims on the IBRP also appear as rejected claims on the electronic batch report (EBR).
- A warning on a claim is informational content from Availity on behalf of the payer and can be added to an accepted or rejected claim. Warnings are informational only and do not cause a claim to be rejected.
- Warnings are only available on the IBRP and not IBR.
- Availity does not generate or return an IBRP in the following situations:
  - If the complete batch file rejected on a negative ACK, TA1 or 999 file.

- If the batch file contained non-claims transactions (27x.).

Next steps

For every claim identified as rejected in the IBRP, you must correct the errors in your EDI transactions system or practice management system, rebatch the claims with a new interchange control number, and upload the new file to Availity again. Claims that contain no HIPAA-compliance errors or payer-specific errors are routed to the payer.

9.7.1 Immediate Batch Response (IBR) - pipe delimited format

The pipe-delimited IBR file provides claim detail for all claims within the file (accepted and rejected) and is intended to be imported into an automated system.

Immediate Batch Response (IBR) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|blank - Internal Use
 Only|CCYYMMDDXXXXXXXX - Availity Batch ID (assigned by Availity)|Inbound ISA13 value - File
 Control Number|99999 - Total Submitted Claims|000000.00 - Total Submitted Charges|00000
 - Total Accepted Claims| 000000.00 - Total Accepted Charges |00000 - Total Rejected
 Claims|0000.00 Total Rejected Charges|Availity Messages|Availity Customer ID| Availity File ID
 | Original File Name |
2|Payer Name|NA| NA|NA| NA| NA|NA|Payer ID|
3|Patient Last Name, First Name|CCYYMMDD - From Date |CCYYMMDD - To Date|Echo inbound CLM01 -
 Patient Control Number|00000.00 - Echo inbound CLM02 Total Claim Charge |Provider Billing ID
 - 2010AA, NM109| Clearinghouse Trace # |NA|Availity Trace #|Submitter Batch ID|"I", "W, "A" or
 "R" - Status |
3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |
```

Note:

- Line 1 will occur once per ISA.
- Line 2 will occur for every payer within the ISA.
- Line 3 will occur once per claim for a payer.
- Line 3e will occur if the claim is rejected by an Availity, HIPAA or Payer Specific Edit (PSE). Multiple 3e lines per claim can occur.
- If no error message number is available, field 3 will equal NA.

Sample report structure

```
Line 1 (ISA Level)
   Line 2 (Payer 1 Level Claim Rejects/Accepts) Repeat > 1
           Rejects = > Line 3 (Claim Level) Repeat > 1
                       Line 3e (Claim Level Error) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
   Line 2 (Payer 2 Level Claim Rejects/Accepts) Repeat > 1
           Rejects => Line 3 (Claim Level) Repeat > 1
                      Line 3e (Claim Level Error) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
   Repeat by payer…..
```

Immediate Batch Response (IBR)

```
1|2010-08-17|15.26.05.222|NA|2017092718492800|000001869|18|3829.00|15|2954.00|3|875.00|NA|
0001815|1-41025630|UHCtext.txt|
2|UNITED HEALTHCARE (UHC)|NA|NA|NA|NA|NA|NA|87726|
3|DUCK, DON|20170927|20170927|123456|336.00|1760438840|NA|NA|NA|1464|R|
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '336.00' does not
 equal sum of line charge amounts (SV102) '337.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 336|2300|CLM|02||||5010|
2|UNICARE|NA|NA|NA|NA|NA|NA|80314|
3|STAR, RINGO|20170927|20170927|888|230.00|1760438840|NA|NA|128799450_1|1464|A|
3|KEYS, PIANO|20170927|20170927|856301|210.00|1760438840|NA|NA|128799450_2|1464|A|
3|CHILDS, JULIA|20170927|20170927|856320|337.00|1760438840|1234567|NA|12345678901|1464|R|
3e|HIPAA|R|3939612|HCPCS Procedure Code is invalid in Professional Service. Invalid data:
 90772|2400|SV1|01||||5010|
2|HUMANA|NA|NA|NA|NA|NA|NA|61101|
3|SMART, PHONE|20170927|20170927|850043|174.00|1760438840|NA|NA|128799450_4|1464|A|
3|JUNGLE, JIM|20170927|20170927|899935|117.00|1760438840|NA|NA|128799450_5|1464|A|
3|POP, MUSIC|20170927|20170927|8594|202.00|1760438840|NA|NA|128799450_6|1464|A|
```

9.7.2 Immediate Batch Response Plus (IBRP) - pipe delimited format

The pipe-delimited IBRP file provides claim detail for all claims within the file (accepted and rejected) and is intended to be imported into an automated system.

Immediate Batch Response Plus (IBRP) layout

```
1|CCYY-MM-DD - Date Received|HH.MM.SS.SSS - Time Received|blank - Internal Use
 Only|CCYYMMDDXXXXXXXX - Availity Batch ID (assigned by Availity)|Inbound ISA13 value - File
 Control Number|99999 - Total Submitted Claims|000000.00 - Total Submitted Charges|00000
 - Total Accepted Claims| 000000.00 - Total Accepted Charges |00000 - Total Rejected
 Claims|0000.00 Total Rejected Charges|Availity Messages|Availity Customer ID| Availity File ID
 | Original File Name |
2|Payer Name|NA| NA|NA| NA| NA|NA|Payer ID|
3|Patient Last Name, First Name|CCYYMMDD - From Date |CCYYMMDD - To Date|Echo inbound CLM01 -
 Patient Control Number|00000.00 - Echo inbound CLM02 Total Claim Charge |Provider Billing ID
 - 2010AA, NM109| Clearinghouse Trace # |NA|Availity Trace #|Submitter Batch ID|"I", "W, "A" or
 "R" - Status |
3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |
3w|Warning Initiator|W|Warning Code - if available, otherwise NA|Warning Message | NA|NA|NA
 |||| Version |
```

Note:

- Line 1 will occur once per ISA.
- Line 2 will occur for every payer within the ISA.
- Line 3 will occur once per claim for a payer.
- Line 3e will occur if the claim is rejected by an Availity, HIPAA, or Payer Specific Edit (PSE). Multiple 3e lines per claim can occur.
- Line 3w will occur if the claim has an informational warning message. Warnings do not cause a claim to be rejected. Multiple 3w lines per claim can occur.
- Lines 3e and 3w can occur for the same claim if the claim was rejected for an error and an informational warning also occurred.
- If no error or warning message number is available, field 3 will equal NA.

Sample report structure

```
Line 1 (ISA Level)
   Line 2 (Payer 1 Level Claim Rejects/Accepts) Repeat > 1
           Rejects = > Line 3 (Claim Level) Repeat > 1
                       Line 3e (Claim Level Error) Repeat > 1
                       Line 3w (Claim Level Warning) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
   Line 2 (Payer 2 Level Claim Rejects/Accepts) Repeat > 1
           Rejects => Line 3 (Claim Level) Repeat > 1
                      Line 3e (Claim Level Error) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
           Accepts => Line 3 (Claim Level) Repeat > 1
                      Line 3w (Claim Level Warning) Repeat > 1
   Repeat by payer…..
```

Immediate Batch Response Plus (IBRP)

```
1|2010-08-17|15.26.05.222|NA|2017092718492800|000001869|18|3829.00|15|2954.00|3|875.00|NA|
0001815|1-41025630|UHCtext.txt|
2|UNITED HEALTHCARE (UHC)|NA|NA|NA|NA|NA|NA|87726|
3|DUCK, DON|20170927|20170927|123456|336.00|1760438840|NA|NA|NA|1464|R|
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '336.00' does not
 equal sum of line charge amounts (SV102) '337.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 336|2300|CLM|02||||5010|
2|UNICARE|NA|NA|NA|NA|NA|NA|80314|
3|STARFISH, SALLY|20170927|20170927|888|230.00|1760438840|NA|NA|128799450_1|1464|A|
3|KEYS, PIANO|20170927|20170927|856301|210.00|1760438840|NA|NA|128799450_2|1464|A|
3|BEACH, SANDY|20170927|20170927|856320|337.00|1760438840|1234567|NA|12345678901|1464|R|
3e|HIPAA|R|3939612|HCPCS Procedure Code is invalid in Professional Service. Invalid data:
 90772|2400|SV1|01||||5010|
3w|PSW|W|AP9999|59 modifier requires additional information|NA|NA|NA||||5010A1|
2|HUMANA|NA|NA|NA|NA|NA|NA|61101|
3|SMART, PHONE|20170927|20170927|850043|174.00|1760438840|NA|NA|128799450_4|1464|W|
3w|PSW|W|AP9999|59 modifier requires additional information|NA|NA|NA||||5010A1|
3|JUNGLE, JIM|20170927|20170927|899935|117.00|1760438840|NA|NA|128799450_5|1464|A|
3|POP, MUSIC|20170927|20170927|8594|202.00|1760438840|NA|NA|128799450_6|1464|A|
```

9.7.3 Immediate Batch Response (IBT) - readable format

The IBT format of the Immediate Batch Response report provides the same information as the pipe-delimited format, but in a readable format. Like the pipe-delimited version, it provides claim detail for all claims within the file (accepted and rejected). The layout of the report is as follows:

```
                            Availity Customer ID: <<0>>
                          Immediate Batch Text Response
Availity Messages: <<1>>
-------------------------------------------------------------------------------------
                                   BATCH SUMMARY
Date Received:          <<2>>                 Time Received:           <<3>>
Availity Batch ID:      <<4>>                 File Control Number:     <<5>> ISA #1
Availity File ID:       <<6>>
File Name:              <<7>>
Submitted Claims:       <<8>>                 Total Submitted Charges: <<9>>
Accepted Claims:        <<10>>                Total Accepted Charges:  <<11>>
Rejected Claims:        <<12>>                Total Rejected Charges:  <<13>>
-------------------------------------------------------------------------------------
Payer Name: Payer #1    <<14>>                Payer ID: <<15>>
-------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                Status:                  <<17>>
Patient Name:           <<18>>                Patient Control Number: <<19>>
From Date:              <<20>>                To Date:                 <<21>>
Charge:                 <<22>>                Provider Billing ID:     <<23>>
Clearinghouse Trace #: Claim #1               Availity Trace #:        <<25>>
Error Initiator:        <<26>>                Loop:                    <<27>>
Segment ID:             <<28>>                Element #:               <<29>>
Error Message:          <<30>>                Version:                 <<31>>
-------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                Status:                  <<17>>
Patient Name:           <<18>>                Patient Control Number: <<19>>
From Date:              <<20>>                To Date:                 <<21>>
Charge:                 <<22>>                Provider Billing ID:     <<23>>
Clearinghouse Trace #: Claim #2               Availity Trace #:        <<25>>
Error Initiator:        <<26>>                Loop:                    <<27>>
Segment ID:             <<28>>                Element #:               <<29>>
Error Message:          <<30>>                Version:                 <<31>>
```

```
--------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                 Payer ID: <<15>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                Status:                 <<17>>
Patient Name:          <<18>>                Patient Control Number: <<19>>
From Date:             <<20>>                To Date:                <<21>>
Charge:                <<22>>                Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #3              Availity Trace #:       <<25>>
Error Initiator:       <<26>>                Loop:                   <<27>>
Segment ID:            <<28>>                Element #:              <<29>>
Error Message:         <<30>>                Version:                <<31>>
--------------------------------------------------------------------------------
--------------------------------------------------------------------------------
                                  BATCH SUMMARY

Date Received:         <<2>>                 Time Received:          <<3>>
Availity Batch ID:     <<4>>                 File Control Number:    ISA #2
Availity File ID:      <<6>>
File Name:             <<7>>
Submitted Claims:      <<8>>                 Total Submitted Charges: <<9>>
Accepted Claims:       <<10>>                Total Accepted Charges:  <<11>>
Rejected Claims:       <<12>>                Total Rejected Charges:  <<13>>
--------------------------------------------------------------------------------
Payer Name: Payer #1 <<14>>                  Payer ID: <<15>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                Status:                 <<17>>
Patient Name:          <<18>>                Patient Control Number: <<19>>
From Date:             <<20>>                To Date:                <<21>>
Charge:                <<22>>                Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #4              Availity Trace #:       <<25>>
Error Initiator:       <<26>>                Loop:                   <<27>>
Segment ID:            <<28>>                Element #:              <<29>>
Error Message:         <<30>>                Version:                <<31>>
--------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                Payer ID: <<15>>
--------------------------------------------------------------------------------
Submitter Batch ID:    <<16>>                Status:                 <<17>>
Patient Name:          <<18>>                Patient Control Number: <<19>>
From Date:             <<20>>                To Date:                <<21>>
Charge:                <<22>>                Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #5              Availity Trace #:       <<25>>
Error Initiator:       <<26>>                Loop:                   <<27>>
Segment ID:            <<28>>                Element #:              <<29>>
Error Message:         <<30>>                Version:                <<31>>
--------------------------------------------------------------------------------
                                  END OF REPORT
     ------------------------------------------------------------------
```

Descriptions of fields in the IBT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Availity Messages	NA - at this time
2	Date Received	CCYY-MM-DD
3	Time Received	HH.MM.SS.SSS
4	Availity Batch ID	File name assigned by Availity: INTERNAL_FILENAME
5	File Control Number (Interchange Control Number)	ISA13

Field number	Field	Note
6	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
7	File Name	Original incoming file name: EXCHANGE_FILENAME
8	Submitted Claims	Count of 2300 CLM per ISA
9	Total Submitter Charges	Sum of all 2300 CLM02; 9,999.99 format
10	Accepted Claims	Count of 2300 CLM accepted per ISA
11	Total Accepted Charges	Sum of accepted 2300 CLM02; 9,999.99 format
12	Rejected Claims	Count of 2300 CLM rejected
13	Total Rejected Charges	Sum of rejected 2300 CLM02, 9,999.99
14	Payer Name	Availity payer name | UNKNOWN
15	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
16	Submitter Batch ID	BHT03
17	Status	A | R | W | I
18	Patient Name	2010BA/CA NM103, NM104
19	Patient Control Number	2300 CLM01
20	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
21	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
22	Charge	2300 CLM02; 9,999.99 format
23	Provider Billing ID	2010AA NM109

Field number	Field	Note
24	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
25	Availity Trace #	Outbound REF*D9 | NA – For the rejected claims, this will always be NA in the IBT/IBR.
26	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
27	Loop	Loop ID
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow United States currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Immediate Batch Response (IBT) example

```
                        Availity Customer ID:  0002176
                         Immediate Batch Text Response
Availity Messages:     NA
-------------------------------------------------------------------------------
                            BATCH SUMMARY
Date Received:          2010-12-08          Time Received:           15.20.18.018
Availity Batch ID:      2010120815201500    File Control Number:     000100495
Availity File ID:       1-41025630
File Name:              UHCtest.TXT
Submitted Claims:       1                   Total Submitted Charges: 251.00
Accepted Claims:        1                   Total Accepted Charges:  251.00
Rejected Claims:                            Total Rejected Charges:  0.00
-------------------------------------------------------------------------------
Payer Name:             UNITED HEALTHCARE (UHC)     Payer ID:               87726
-------------------------------------------------------------------------------
Submitter Batch ID:     AAS100494           Status:                  A
Patient Name:           DOE, JOHN           Patient Control Number:  AAS0000068
From Date:              2010-05-21          To Date:                 2010-05-21
Charge:                 251.00              Provider Billing ID:     1164748786
Clearinghouse Trace #: AAS100494            Availity Trace #:        27254
-------------------------------------------------------------------------------
                                  END OF REPORT
-------------------------------------------------------------------------------
```

9.7.4 Immediate batch response plus (IBTP) - readable format

The IBTP format of the Immediate Batch Response plus report provides the same information as the pipe-delimited format, but in a readable format. Like the pipe-delimited version, it provides claim detail for all claims within the file (accepted and rejected). The layout of the report is as follows:

```
Availity Customer ID: <<0>>
                        Immediate Batch Text Plus Response
Availity Messages: <<1>>
-------------------------------------------------------------------------------
                                BATCH SUMMARY
Date Received:          <<2>>               Time Received:           <<3>>
Availity Batch ID:      <<4>>               File Control Number:     <<5>> ISA #1
Availity File ID:       <<6>>
File Name:              <<7>>
Submitted Claims:       <<8>>               Total Submitted Charges: <<9>>
Accepted Claims:        <<10>>              Total Accepted Charges:  <<11>>
Rejected Claims:        <<12>>              Total Rejected Charges:  <<13>>
-------------------------------------------------------------------------------
Payer Name: Payer #1    <<14>>              Payer ID: <<15>>
-------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>              Status:                 <<17>>
Patient Name:           <<18>>              Patient Control Number: <<19>>
From Date:              <<20>>              To Date:                <<21>>
Charge:                 <<22>>              Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #1             Availity Trace #:       <<25>>
Error Initiator:        <<26>>              Loop:                   <<27>>
Segment ID:             <<28>>              Element #:              <<29>>
Error Message:          <<30>>              Version:                <<31>>
-------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>              Status:                 <<17>>
Patient Name:           <<18>>              Patient Control Number: <<19>>
From Date:              <<20>>              To Date:                <<21>>
Charge:                 <<22>>              Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #2             Availity Trace #:       <<25>>
Error Initiator:        <<26>>              Loop:                   <<27>>
Segment ID:             <<28>>              Element #:              <<29>>
Error Message:          <<30>>              Version:                <<31>>
-------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>              Status:                 <<17>>
Patient Name:           <<18>>              Patient Control Number: <<19>>
From Date:              <<20>>              To Date:                <<21>>
```

```
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #2                 Availity Trace #:       <<25>>
Warning Initiator:      <<32>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Warning Message:        <<33>>                  Version:                <<31>>

-------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                    Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #3                 Availity Trace #:       <<25>>
Error Initiator:        <<26>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Error Message:          <<30>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------
                                  BATCH SUMMARY

Date Received:          <<2>>                   Time Received:          <<3>>
Availity Batch ID:      <<4>>                   File Control Number:    ISA #2
Availity File ID:       <<6>>
File Name:              <<7>>
Submitted Claims:       <<8>>                   Total Submitted Charges: <<9>>
Accepted Claims:        <<10>>                  Total Accepted Charges:  <<11>>
Rejected Claims:        <<12>>                  Total Rejected Charges:  <<13>>
-------------------------------------------------------------------------------------------
Payer Name: Payer #1 <<14>>                     Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #4                 Availity Trace #:       <<25>>
Error Initiator:        <<26>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Error Message:          <<30>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
Payer Name: Payer #2  <<14>>                   Payer ID: <<15>>
-------------------------------------------------------------------------------------------
Submitter Batch ID:     <<16>>                  Status:                 <<17>>
Patient Name:           <<18>>                  Patient Control Number: <<19>>
From Date:              <<20>>                  To Date:                <<21>>
Charge:                 <<22>>                  Provider Billing ID:    <<23>>
Clearinghouse Trace #: Claim #5                 Availity Trace #:       <<25>>
Warning Initiator:      <<32>>                  Loop:                   <<27>>
Segment ID:             <<28>>                  Element #:              <<29>>
Warning Message:        <<33>>                  Version:                <<31>>
-------------------------------------------------------------------------------------------
                                  END OF REPORT
     ---------------------------------------------------------------------
```

Descriptions of fields in the IBTP layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Availity Messages	NA - at this time
2	Date Received	CCYY-MM-DD
3	Time Received	HH.MM.SS.SSS
4	Availity Batch ID	File name assigned by Availity: INTERNAL_FILENAME

Field number	Field	Note
5	File Control Number (Interchange Control Number)	ISA13
6	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
7	File Name	Original incoming file name: EXCHANGE_FILENAME
8	Submitted Claims	Count of 2300 CLM per ISA
9	Total Submitter Charges	Sum of all 2300 CLM02; 9,999.99 format
10	Accepted Claims	Count of 2300 CLM accepted per ISA
11	Total Accepted Charges	Sum of accepted 2300 CLM02; 9,999.99 format
12	Rejected Claims	Count of 2300 CLM rejected
13	Total Rejected Charges	Sum of rejected 2300 CLM02, 9,999.99
14	Payer Name	Availity payer name | UNKNOWN
15	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
16	Submitter Batch ID	BHT03
17	Status	A | R | W | I
18	Patient Name	2010BA/CA NM103, NM104
19	Patient Control Number	2300 CLM01
20	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
21	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
22	Charge	2300 CLM02; 9,999.99 format

Field number	Field	Note
23	Provider Billing ID	2010AA NM109
24	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
25	Availity Trace #	Outbound REF*D9 | NA – For the rejected claims, this will always be NA in the IBT/IBR.
26	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
27	Loop	Loop ID
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010
32	Warning Initiator	PSW – Used when there is a payer-specific warning that Availity relays on behalf of the payer.
33	Warning Message	Detailed claim warning message

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow United States currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Immediate Batch Text Plus Response (IBTP) example

```
Availity Customer ID:  0001194
                        Immediate Batch Text Plus Response
Availity Messages:     NA
--------------------------------------------------------------------------------
                            BATCH SUMMARY
Date Received:          2021-11-16                  Time Received:           15.42.07.007
Availity Batch ID:      mp2611-16-warn              File Control Number:     267551429
Availity File ID:       1-266501
File Name:              mp2611-16-warn
Submitted Claims:       1                           Total Submitted Charges: 59.00
Accepted Claims:        1                           Total Accepted Charges:  59.00
Rejected Claims:        0                           Total Rejected Charges:  0.00
--------------------------------------------------------------------------------
Payer Name:             WELLMARK BCBS (IOWA, SOUTH DAKOTA)Payer ID:          88848
--------------------------------------------------------------------------------
Submitter Batch ID:     67459                       Status:                  W
Patient Name:           LNAME, FNAME                Patient Control Number:  RXA000687484
33
From Date:              2021-11-04                  To Date:                 2021-11-04
Charge:                 59.00                       Provider Billing ID:     1053680678
Clearinghouse Trace #:  ARSF0011211706              Availity Trace #:        117963
Warning Initiator:      PSW                         Loop:                    NA
Segment ID:             NA                          Element #:               NA
Version #:              5010A1                      Warning Message          59 modifier
requires additional information
--------------------------------------------------------------------------------
                                    END OF REPORT
--------------------------------------------------------------------------------
```

9.7.5 277IBR Examples

Example: 277CA Positive Immediate Batch Response (IBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1305*^*00501*000356253*0*T*:~
GS*HN*030240928*AV01101957*20110517*1305*356254*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356255*20110517*130522*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20110517130522167~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356254~
IEA*1*000356253~
```

Example: 277CA Negative Immediate Batch Response (IBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110524*1645*^*00501*000448848*0*T*:~
GS*HN*030240928*AV01101957*20110524*1645*448849*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*448850*20110524*164536*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*2011052416453672~
DTP*050*D8*20110524~
DTP*009*D8*20110524~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239745576~
STC*A1:20*20110524*WQ*75~
QTY*AA*1~
AMT*YY*75~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1154374825~
TRN*1*0~
REF*TJ*561853990~
QTY*QC*1~
AMT*YY*75~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*W1234567890~
TRN*2*110549~
STC*A3:448*20110524*U*75********TRANSACTION SET HEADER IS INVALID. INVALID DATA  005010X222~
REF*D9*239745576_0~
DTP*472*RD8*20101001-20101001~
SE*26*1001~
GE*1*448849~
IEA*1*000448848~
```

9.7.6 277IBRP Examples

Example: 277CA Positive Immediate Batch Response Plus (IBRP)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1305*^*00501*000356253*0*T*:~
GS*HN*030240928*AV01101957*20110517*1305*356254*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356255*20110517*130522*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20110517130522167~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356254~
IEA*1*000356253~
```

Example: 277CA Positive Immediate Batch Response Plus (IBRP) with a warning

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *211221*0001*^*00501*123456789*0*P*:~
GS*HN*030240928*AV01101957*20211221*0001*234234234*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*234234234*20211221*000100*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*20211221000100000~
DTP*050*D8*20211221~
DTP*009*D8*20211221~
HL*2*1*21*1~
NM1*41*2*ABC CLINIC*****46*AV09311993~
TRN*2*000654321~
STC*A1:20*20211221*WQ*500~
QTY*90*1~
AMT*YU*500~
HL*3*2*19*1~
NM1*85*1*PROVIDER****XX*1234567890~
TRN*1*0~
REF*TJ*111223333~
QTY*QA*1~
AMT*YU*500~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*ABC12345678~
TRN*2*22222~
STC*A1:20*20211221*WQ*500********59 modifier requires additional information~
REF*D9*AB123D12341234~
DTP*472*RD8*20211221-20211221~
SE*26*1001~
GE*1*234234234~
IEA*1*123456789~
```

Example: 277CA Negative Immediate Batch Response Plus (IBRP)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110524*1645*^*00501*000448848*0*T*:~
GS*HN*030240928*AV01101957*20110524*1645*448849*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*448850*20110524*164536*TH~
HL*1**20*1~
NM1*AY*2*AVAILITY LLC*****46*030240928~
TRN*1*2011052416453672~
DTP*050*D8*20110524~
DTP*009*D8*20110524~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239745576~
STC*A1:20*20110524*WQ*75~
QTY*AA*1~
AMT*YY*75~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1154374825~
TRN*1*0~
REF*TJ*561853990~
QTY*QC*1~
AMT*YY*75~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*W1234567890~
TRN*2*110549~
STC*A3:448*20110524*U*75********TRANSACTION SET HEADER IS INVALID. INVALID DATA  005010X222~
REF*D9*239745576_0~
DTP*472*RD8*20101001-20101001~
SE*26*1001~
GE*1*448849~
IEA*1*000448848~
```

9.7.7 Interpret IBR files

After each file transmission, check your **ReceiveFiles** mail box for an immediate batch response (IBR) file and interpret it to determine if errors occurred in the transmission file at Availity.

Note: If you don't receive this report now, contact your administrator, who can set your organization's EDI reporting preferences to receive IBR files in text format (for viewing) or data file format (for importing into a PMS, HIS, or other system).

The file immediately provides information about the initial validation of your file and the claims it includes, enabling you to correct and resubmit erroneous claims and avoid payment delays. This report, which you can download to your computer or print, includes the following information:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer
- Accepted claims
- Claim counts and charges for submitted and rejected claims at the claim level and transmission file level. If you received a partial negative implementation acknowledgement because some transaction sets in the file were rejected during file format, structure, and syntax validations, the count of total claims submitted excludes the claims in those rejected transaction sets.
- Both accepted and rejected claims are itemized and included in this report

Header Information

- If an IBR with a .ibt extension is present, open that file. It's a readable text report. The IBR file ending in .ibr is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ibr and it is intended to be imported into your PMS or HIS system.

- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data response file, and the payer, coinciding with line 2 in a data file.
- The following two fields display in the first section (coinciding with line 1 in a data file):
    - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
    - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- In the header information of the IBR text file at the claim level, the **Submitted Claims**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.

Claim Information

- Information about the claims display below the header and coincide with line 3 in the data file.
- Some fields, such as the **Availity Trace #** field and some payer-specific fields, may display NA (not applicable).

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the data file: **Error Initiator**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as <payer ID>-PSE (for a payer-specific error detected at Availity), HIPAA (for a HIPAA-compliance edit), or Availity (for an invalid payer ID error).
- The **Version** field displays the X12 version the claim was in when the error occurred.
- If you must contact the vendor of your EDI transactions system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.
- If Availity rejects any claims at this stage, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been routed to the payer. See the sections below for more information on these errors.
- If you encounter any problems while interpreting errors in the IBR and cannot resolve them yourself, contact Availity for assistance.

9.7.7.1 Legacy identifier may not be used error

Error message

The legacy identifier, <identifier in REF01 is shown>, may not be used for this payer after the National Provider ID (NPI) is mandated for use. Please correct and resubmit.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The payer's legacy identifier is not allowed for payers following NPI Mandate guidelines. Remove the legacy identifier from REF01 and resubmit the transaction.

Note: State license numbers (0B) continue to be accepted.

9.7.7.2 NPI format not valid error

Error message

The National Provider ID (NPI) submitted is not in the valid NPI format. Please correct and resubmit. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

A transaction in the transmission file contains an NPI that is not in the proper format. The NPI must be a 10-digit number consisting of nine numeric digits followed by one numeric check digit. This error occurs if the ‘XX' qualifier displays in NM108 and an improperly formatted NPI displays in NM109. Correct the identifier in NM109 and resubmit the transaction.

9.7.7.3 NPI is required for payer error

Error message

The National Provider ID (NPI) is required for this payer. Expected value for NM108 is 'XX.' Please add the Provider's NPI to this claim and resubmit the claim(s) for processing. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The valid qualifier sent for an NPI in NM108 is ‘XX.' This message occurs if you send any qualifier other than ‘XX' when NPI is mandated for use. Change the qualifier in NM108 to XX and be sure the identifier in NM109 is a valid NPI. Then resubmit the transaction.

9.7.7.4 Segment REF (Billing/Pay-To Provider Secondary ID) is missing

Error message

Segment REF (Billing/Pay-To Provider Secondary Identification) is missing. Either EIN or SSN of Provider must be carried in this REF segment when NM108 is 'XX'.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing professional or facility claims.

Toubleshooting

This error applies to professional and facility claims only. If the NPI is sent in the NM1 loop for the Billing Provider (2010AA) or Pay-to Provider (2010AB), then either the provider's Employer Identification Number (EIN) or Social Security Number (SSN) must be sent in the REF segment of the same loop.

9.7.8 Interpret IBRP files

After each file transmission, check your **ReceiveFiles** mail box for an immediate batch response plus (IBRP) file and interpret it to determine if errors occurred in the transmission file at Availity.

Note: If you don't receive this report now, contact your administrator, who can set your organization's EDI reporting preferences to receive IBRP files in text format (for viewing) or data file format (for importing into a PMS, HIS, or other system).

The file immediately provides information about the initial validation of your file and the claims it includes, enabling you to correct and resubmit erroneous claims and avoid payment delays. This report, which you can download to your computer or print, includes the following information:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer

- Payer-specific warnings that Availity relays on behalf of the payer
- Accepted claims
- Claim counts and charges for submitted and rejected claims at the claim level and transmission file level. If you received a partial negative implementation acknowledgement because some transaction sets in the file were rejected during file format, structure, and syntax validations, the count of total claims submitted excludes the claims in those rejected transaction sets.
- Both accepted and rejected claims are itemized and included in this report

Header Information

- If an IBRP with a .ibtp extension is present, open that file. It's a readable text report. The IBRP file ending in .ibrp is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ibrp and it is intended to be imported into your PMS or HIS system.
- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data response file, and the payer, coinciding with line 2 in a data file.
- The following two fields display in the first section (coinciding with line 1 in a data file):
    - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
    - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- In the header information of the IBRP text file at the claim level, the **Submitted Claims**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.

Claim Information

- Information about the claims display below the header and coincide with line 3 in the data file.
- Some fields, such as the **Availity Trace #** field and some payer-specific fields, may display NA (not applicable).

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the data file: **Error Initiator**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as <payer ID>-PSE (for a payer-specific error detected at Availity), HIPAA (for a HIPAA-compliance edit), or Availity (for an invalid payer ID error).
- The **Version** field displays the X12 version the claim was in when the error occurred.
- The **Warning Initiator** field displays PSW, which means payer specific warning.
- The **Warning Message** field displays informational payer messages to the submitter.
- If you must contact the vendor of your EDI transactions system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.

- If Availity rejects any claims at this stage, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been routed to the payer. See the sections below for more information on these errors.
- If you encounter any problems while interpreting errors in the IBRP and cannot resolve them yourself, contact Availity for assistance.

9.7.8.1 Legacy identifier may not be used error

Error message

The legacy identifier, <identifier in REF01 is shown>, may not be used for this payer after the National Provider ID (NPI) is mandated for use. Please correct and resubmit.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The payer's legacy identifier is not allowed for payers following NPI Mandate guidelines. Remove the legacy identifier from REF01 and resubmit the transaction.

Note: State license numbers (0B) continue to be accepted.

9.7.8.2 NPI format not valid error

Error message

The National Provider ID (NPI) submitted is not in the valid NPI format. Please correct and resubmit. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

A transaction in the transmission file contains an NPI that is not in the proper format. The NPI must be a 10-digit number consisting of nine numeric digits followed by one numeric check digit. This error occurs if the ‘XX' qualifier displays in NM108 and an improperly formatted NPI displays in NM109. Correct the identifier in NM109 and resubmit the transaction.

9.7.8.3 NPI is required for payer error

Error message

The National Provider ID (NPI) is required for this payer. Expected value for NM108 is 'XX.' Please add the Provider's NPI to this claim and resubmit the claim(s) for processing. Providers can apply for an NPI online at https://nppes.cms.hhs.gov.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing claims.

Toubleshooting

The valid qualifier sent for an NPI in NM108 is ‘XX.' This message occurs if you send any qualifier other than ‘XX' when NPI is mandated for use. Change the qualifier in NM108 to XX and be sure the identifier in NM109 is a valid NPI. Then resubmit the transaction.

9.7.8.4 Segment REF (Billing/Pay-To Provider Secondary ID) is missing

Error message

Segment REF (Billing/Pay-To Provider Secondary Identification) is missing. Either EIN or SSN of Provider must be carried in this REF segment when NM108 is 'XX'.

Scenario

This error might display in the immediate batch report file after you submit a transmission file containing professional or facility claims.

Toubleshooting

This error applies to professional and facility claims only. If the NPI is sent in the NM1 loop for the Billing Provider (2010AA) or Pay-to Provider (2010AB), then either the provider's Employer Identification Number (EIN) or Social Security Number (SSN) must be sent in the REF segment of the same loop.

9.8 Electronic batch report

The electronic batch report (also referred to as an EBR) is a proprietary report that provides the status (received from the payer) for each transaction in the original submission. The report contains summary counts of transactions received and accepted, and lists detailed information for rejected transactions, including payer specific edits (PSEs) and HIPAA edits. Only claims that passed file format and syntax validations are included in this report.

File extensions

- `.EBR` (delimited file)
- `.EBT` (human readable text file) – This is the default format.
  - Summary report (errors and prepayment responses) – This is the default report.
  - Detail report (all claims acknowledged)
- `.277EBR` – 277CA claim acknowledgement format.

  Note: The .277EBR can only be received in combination with the .EBR or .EBT.

When is this response file sent?

When all expected responses are received from the payer; typically within 24-48 hours. If a payer fails to send any response within five business days, Availity contacts the payer to obtain a status on the transaction set.

- Electronic batch reports are sent only for claims, not non-claim transactions.
- This is an optional response file.

Additional details

- Batches and/or claims received with an invalid or unrecognized payer will generate the standard EBR report. The impacted claims display in the rejected claims section of the EBR.
- Information returned on accepted claims includes the following: patient name, claim service dates, patient control number, charge, provider billing id, clearinghouse trace number, payer claim number, Availity trace number, the message source (usually the payer name), and any message codes and message text.
- If the payer does NOT normally send a claim response, but sends a positive acknowledgement, indicating it has received the claims and found no errors during any file processing performed by this point, Availity sends the EBR containing the Availity validation information to your organization's **ReceiveFiles** mail box. Payers unable to return a claim response, such as some small payers, fall into this category and are referred to as "999-only payers."
- If the payer normally sends a claim response, Availity waits for the claim response for all claims in the file from the payer, and then compiles the information into the EBR with the Availity validation information and sends it to your **ReceiveFiles** mail box.
- Uncommonly, a payer may send a negative acknowledgement, meaning it has found errors in the transaction sets during validation. In this case, Availity contacts the payer to determine the cause of the error. If the error requires you to fix and resubmit the transaction sets, Availity contacts you (the provider) to discuss the issue.

- Because Availity generates a response file for each payer in each transaction set, you might receive multiple response files for a single file, and you probably won't receive them all at the same time. If you need to change the delivery times of the response files, contact your administrator to adjust the delivery options for electronic batch reports.
- Sometimes claims are routed to the payer through other clearinghouses or intermediaries, who also perform validations on the claims. These additional validations are the reason you might receive an error in the EBR stating a claim was rejected at another clearinghouse even though you submitted it through Availity.
- If an organization submits claims using Availity online claim forms and the payer processes claims in batches, the payer's response also displays in the **ReceiveFiles** folder in an Electronic Batch Report (EBR) file. If the EDI reporting preferences are set up to receive EBRs together in a single file, the payer's responses for Web claims are mingled with payer responses for transmission files that were uploaded.
- For certain payers, such as Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are a direct pass through without any mapping or editing by Availity.

Next steps

Monitor status of transactions, correct and resubmit transactions with errors.

If the payer rejects any transactions (claims) at this stage (identified by the payer's name in the **Error Initiator** field), you must correct and rebatch the rejected claims in your system using a new interchange control number, and then upload and resubmit a new file.

Note: You do not need to include accepted claims in the new file, since those claims have already been processed and accepted at the payer level. Also, if you already corrected and rebatched any rejected claims identified in the IBR, you do not need to do it again, although those errors may display in the EBR with either HIPAA or Availity in the **Error Initiator** field.

9.8.1 Electronic Batch Report (EBR) - pipe delimited format

The pipe-delimited EBR file is intended to be imported into an automated system.

Electronic Batch Report (EBR) layout

```
1|Date of Batch Receipt - CCYY-MM-DD|Time of Batch Receipt- HH.MM.SS.SSS|Internal
 Usage|Availity Batch ID|File Control Number|Availity Customer ID|Availity File ID |Original
 File Name|||

2|Payer Name - from Availity Payer File|Claim Responses Returned| Total Accepted Claim
 Count|Total Claim Responses Returned Charges|Total Accepted Claim Charges|Total Rejected Claim
 Count|Total Rejected Claim Charges|Payer ID|

3|Patient Last Name, First Name|From Service Date - CCYYMMDD|To Service Date - CCYYMMDD|Patient
 Control Number|Total Claim Charges |Billing Provider ID| Clearinghouse Trace Number |Payer
 Claim Number or NA |Availity Trace Number||

3e|Error Initiator|R|Error Code - if available, otherwise NA|Error Message | Loop|Segment
 ID|Element # |||| Version |

3a|Bill Type|Allowed Amount|Non-Covered Amount |Deductible Amount |Co-Pay Amount |Co-insurance
 Amount |Withhold Amount |Estimated Payment Amount |Patient Liability|Message Code|Message
 Text|

3c|Error Initiator | Message Type| Error Code |Error Message | Loop|Segment ID | Element # |
```

Note:

- Line 1 is the file/ISA level.
- Line 2 is the payer level.
- Line 3 will occur once per claim. Line 3 will always have a line 3e, 3a, or 3c following. All 3/3e lines will occur first followed by all 3/3a lines, followed by all 3/3c lines.
- Line 3e will occur minimum of once for each Availity, HIPAA or PSE reject. Multiple 3e lines per claim can occur.
- Line 3a will occur if a claim is accepted by both Availity and the Receiver and the payer returns adjudication information in their response file.
- Line 3c indicates a clean claim without adjudication information. Line 3c will occur if a claim is accepted by both Availity and the receiver and there is no adjudication information.

Example 1: Electronic Batch Report (EBR)

```
1|2010-08-27|14.05.33.434|NA|2010082713594600-UPL|008271053|0060000|||
2|MEDICARE B - TEXAS|2|2|200.00|200.00|0|0.00|04402|
3|DUCK, DONALD|20100728|20100728|1218|100.00|1457382525|NA|NA|230038742_0||
3c|TRAILBLAZER|NA|NA|This claim has been accepted for further processing|NA|NA|NA|
3|MOUSE, MINNIE|20100707|20100707|1262|100.00|1457382525|NA|NA|230038742_1||
3c|TRAILBLAZER|NA|NA|This claim has been accepted for further processing|NA|NA|NA|

1|2010-08-31|12.56.06.182|NA|2010083112541900|369998138|0001815|||
2|Arkansas BCBS|1|0|75.00|0.00|1|75.00|00520|
3|DOE, JOHN|20091019|20091019|GOOKA000|75.00|1225057391|155835019_0|NA|NA||
3e|HIPAA|R|3938ed5|Claim balancing is failed: total charge amount (CLM02) '75.00' does not
 equal sum of line charge amounts (SV102) '76.00'. Segment CLM is defined in the guideline at
 position 130. Invalid data: 75|2300|CLM|02||||
```

Example 2: Electronic Batch Report (EBR)

```
1|2010-12-07|11.58.23.023|NA|2010120711582200|000164875|0002176|2010120711582200|
RespReport_test3.TXT|||
2|HUMANA|2|0|290.00|0.00|2|290.00|61101|
3|SMITH, JADA|20101105|20101105|16386|165.00|9876543213|467484130|NA|27080||
3e|HUMANA|R|42|Invalid use of Null|NA|NA|NA||||5010|
3|WOMAN, WONDER|20101107|20101107|16386|125.00|9876543213|467484132|NA|27081||
3e|HUMANA|R|42|Invalid use of Null|NA|NA|NA||||5010|
```

9.8.2 Electronic batch report (EBT) - readable format

The EBT format of the Electronic Batch Report provides the same information as the pipe-delimited format, but in a readable format. The layout of the report is as follows:

```
                    Availity Customer ID: <<0>>
                  Availity Electronic Batch Report
--------------------------------------------------------------------------------
Date Received:            <<1>>                 Time Received:          <<2>>
Availity Batch ID:        <<3>>                 File Control Number:    <<4>>
Availity File ID:         <<5>>
File Name:                <<6>>
--------------------------------------------------------------------------------
Payer:                    <<7>>                 Payer ID:               <<8>>
Claim Responses Returned: <<9>>                 Charges:                <<10>>
Accepted Claims:          <<11>>                Charges:                <<12>>
Rejected Claims:          <<13>>                Charges:                <<14>>
--------------------------------------------------------------------------------
Patient Name:             <15>>
From Date:                <<16>>                To Date:                <<17>>
Patient Control Number:   <<18>>                Charge:                 <<19>>
Provider Billing ID:      <<20>>                Clearinghouse Trace #:  <<21>>
Payer Claim #:            <<22>>                Availity Trace #:       <<23>>

Error Initiator:          <<24>>                Message Type: <<25>> Error Code: <<26>>
Error Message:            <<27>>
Loop:                     <<28>>                Segment ID: <<29>>   Element #:  <<30>>
Version:                  <<31>>
```

Descriptions of fields in the EBT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Date Received	CCYY-MM-DD
2	Time Received	HH.MM.SS.SSS
3	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
4	File Control Number (Interchange Control Number)	ISA13 on submitted file
5	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
6	File Name	Original incoming file name: EXCHANGE_FILENAME
7	Payer Name	Availity payer name | UNKNOWN

Field number	Field	Note
8	Payer ID	2010BB NM109 (professional) | 2010BC NM109 (institutional)
9	Claim Responses Returned	Count of responses for this payer breakdown
10	Charges	Total of related charges for this payer breakdown: 9,999.99 format
11	Accepted Claims	Count of accepted claims for this payer breakdown
12	Charges	Total of accepted charges for this payer breakdown: 9,999.99 format
13	Rejected Claims	Count of rejected claims for this payer breakdown
14	Charges	Total of rejected charges for this payer breakdown: 9,999.99 format
15	Patient Name	2010BA/CA NM103, NM104
16	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
17	To Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
18	Patient Control Number	2300 CLM01
19	Charge	2300 CLM02; 9,999.99 format
20	Provider Billing ID	2010AA NM109
21	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
22	Payer Claim #	If provided in payer response, else NA
23	Availity Trace #	Outbound REF*D9

Field number	Field	Note
24	Error Initiator	Availity | PSE | HIPAA – We use the 'Availity' value when we reject for unrecognized payer or submission of a test file in the production environment.
25	Message Type	A | R | W | I
26	Error Code	If provided, else NA
27	Loop	Loop
28	Segment ID	Segment ID
29	Element #	Element number
30	Error Message	Detailed claim error message
31	Version	5010
32	Bill Type	Adjudicated claim information returned by some real time payers.
33	Allowed Amount	Adjudicated claim information returned by some real time payers.
34	Non-Covered Amount	Adjudicated claim information returned by some real time payers.
35	Deductible Amount	Adjudicated claim information returned by some real time payers.
36	Co-Pay Amount	Adjudicated claim information returned by some real time payers.
37	Co-Insurance Amount	Adjudicated claim information returned by some real time payers.
38	Withhold Amount	Adjudicated claim information returned by some real time payers.

Field number	Field	Note
39	Estimated Payment Amount	Adjudicated claim information returned by some real time payers.
40	Patient Liability Amount	Adjudicated claim information returned by some real time payers.

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow United States currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Electronic Batch Report (EBT) example

```
Availity Customer ID:  0002176
                              Availity Electronic Batch Report
--------------------------------------------------------------------------------
Date Received:          2010-12-07           Time Received:           11.58.23.023
Availity Batch ID:      2010120711582200     File Control Number:     000164875
Availity File ID:       2010120711582200
File Name:              RespReport_test3.TXT
--------------------------------------------------------------------------------
Payer:                  HUMANA               Payer ID:                61101
Claim Responses Returned:2                   Charges:                 290.00
Accepted Claims:        0                    Charges:                 0.00
Rejected Claims:        2                    Charges:                 290.00
--------------------------------------------------------------------------------
Patient Name:           SMITH, JADA
From Date:              20101105             To Date:                 20101105
Patient Control Number:16386                 Charge:                  165.00
Provider Billing ID:    9876543213           Clearinghouse Trace #:   467484130
Payer Claim #:          NA                   Availity Trace #:        27080

Error Initiator:        HUMANA               Message Type:            R
Error Code:             42
Error Message:          Invalid use of Null
Version:                5010                 Loop:                    NA
Segment ID:             NA                   Element #:               NA
--------------------------------------------------------------------------------
Patient Name:           WOMAN, WONDER
From Date:              20101107             To Date:                 20101107
Patient Control Number:16386                 Charge:                  125.00
Provider Billing ID:    9876543213           Clearinghouse Trace #:   467484132
Payer Claim #:          NA                   Availity Trace #:        27081

Error Initiator:        HUMANA               Message Type:            R
Error Code:             42
Error Message:          Invalid use of Null
Version:                5010                 Loop:                    NA
Segment ID:             NA                   Element #:               NA
--------------------------------------------------------------------------------
--------------------------------------------------------------------------------
                                  END OF REPORT
--------------------------------------------------------------------------------
```

9.8.3 277EBR Examples

Example: 277CA Positive Electronic Batch Report (EBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110517*1345*^*00501*000356276*0*T*:~
GS*HN*030240928*AV01101957*20110517*1345*356277*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*356278*20110517*134514*TH~
HL*1**20*1~
NM1*PR*2*CORRECTCARE*****PI*CCIH~
TRN*1*20110517134514367~
DTP*050*D8*20110517~
DTP*009*D8*20110517~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*030240928~
TRN*2*239097104~
STC*A1:20*20110517*WQ*259.5~
QTY*90*1~
AMT*YU*259.5~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
QTY*QA*1~
AMT*YU*259.5~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*K11111~
TRN*2*TEST00013537401~
STC*A1:20*20110517*WQ*259.5~
REF*D9*239097104_16~
DTP*472*RD8*20100831-20100831~
SE*25*1001~
GE*1*356277~
IEA*1*000356276~
```

Example: 277CA Negative Electronic Batch Report (EBR)

```
ISA*00*          *00*          *01*030240928      *ZZ*AV09311993
 *110526*1500*^*00501*000465756*0*T*:~
GS*HN*030240928*AV01101957*20110526*1500*465757*X*005010X214~
ST*277*1001*005010X214~
BHT*0085*08*465758*20110526*150014*TH~
HL*1**20*1~
NM1*PR*2*ADVOCATE HEALTH PARTNERS*****PI*65093~
TRN*1*20110526150014602~
DTP*050*D8*20110526~
DTP*009*D8*20110526~
HL*2*1*21*1~
NM1*41*2*AVAILITY LLC*****46*UB924010THIN~
TRN*2*85371405~
STC*A1:20*20110526*WQ*11591.49~
QTY*AA*1~
AMT*YY*11591.49~
HL*3*2*19*1~
NM1*85*2*PROVIDER*****XX*1234567890~
TRN*1*0~
REF*TJ*363695814~
QTY*QC*1~
AMT*YY*11591.49~
HL*4*3*PT~
NM1*QC*1*LASTNAME*FIRSTNAME****MI*123456-000~
TRN*2*008990~
STC*A3:448*20110526*U*11591.49********MISSING OR INVALID DATA PREVENTS CARRIER FROM PROCESSING
 THIS CLAIM~
REF*D9*85371405~
REF*BLT*214~
DTP*472*RD8*20100801-20100824~
SE*27*1001~
GE*1*465757~
IEA*1*000465756~
```

9.8.4 Interpret EBR files

Periodically check your **ReceiveFiles** mail box for new electronic batch report (EBR) file items and interpret them to determine if errors occurred in the transmission file at the payer or payer intermediary.

Note: If you receive only EBR data files, you can contact your administrator, who can set your organization's EDI reporting preferences to receive EBR files also in text format, which are easier to read. Data files are intended to be imported into a PMS, HIS, or other system, while EBR text files can be viewed by people.

An EBR file includes any of the following information, which you can download to your computer or print:

- HIPAA-compliance errors that Availity detects
- Payer-specific errors that Availity detects on behalf of the payer
- Errors that the payer or payer intermediary detects
- Any warning and informational messages that the payer sends
- Possibly pre-adjudication information, depending on the payer
- Possibly information for accepted claims, if your organization's reporting preferences are set up to receive EBRs with all claims acknowledged

Header Information

- If an EBR with a .ebt extension is present, open that file. It's a readable text report. The EBR file ending in .ebr is the data file, intended to be imported into your system. Providers can also select to receive the claim acknowledgement 277CA. The file extension is .277ebr and it is intended to be imported into your PMS or HIS system.
- The first two sections of the text file contain header information about the transmission file, coinciding with line 1 in a data file, and the payer, coinciding with line 2 in a data file.
    - The following two fields display in the first section (coinciding with line 1 in a data file):
        - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
        - **File Name** – The name the submitter assigned to the file being submitted to Availity.
    - In the second section (coinciding with line 2 in a data file), the **Claim Responses Returned**, **Accepted Claims**, and **Rejected Claims** fields and accompanying charges shown are calculated during the processing step at Availity.
- If you receive EBRs only for claims with errors, and the payer or payer intermediary accepted all claims in the transmission file and returned no pre-adjudication information, the file contains only the header information.

Claim Information

- If errors occurred for any claims, or if you receive EBRs for both accepted and rejected claims, information about the claims display below the header, coinciding with line 3 in the data file. The section for each claim is separated from subsequent claims by a dashed line.
- For some payers, the payer's internal reference number for the claim displays in the **Payer Claim #** field. This field is empty if the payer did not pass the information in the file.

- For some payers, the **Availity Trace #** field displays the transaction ID, the internal Availity control number that identifies the claim. This field may also display NA (not applicable). Refer to this number, if available, when calling Availity Client Services for assistance.

Errors, Warnings, and Informational Messages

- If errors occurred in a claim, the following fields identifying the errors display in the lower part of the claim section, coinciding with line 3e in the response data file: **Error Initiator**, **Message Type**, **Error Code**, **Loop**, **Segment ID**, **Element #**, **Error Message**, and **Version**.
- The **Error Initiator** field identifies the entity that initiated the error, such as the payer, Availity, or a payer-specific edit or HIPAA-compliance edit performed at Availity. If you already corrected errors identified in the IBR, you only need to correct errors initiated by the payer.
- The **Version** field displays the X12 version the claim was in when the error occurred.
- If you must contact the vendor of your EDI billing system for assistance, the vendor might ask for the loop number, the segment ID, and the data element number.
- Some payers may also return warnings and informational messages.
- If the payer returns multiple messages, they all display together in the message field.

Adjudication information (on EBRs with All Claims Acknowledged)

- If the payer can pre-adjudicate claims and determined it will probably accept and pay the claim, the following fields indicating the status display in the lower part of the information section, coinciding with line 3a in the data file: **Allowed Amt**, **Co-Pay Amt**, **Co-Insurance Amt**, **Without Amt**, **Estimated Payment Amt**, and **Patient Liability Amt**.
- The EBR indicates processing status for claims with no errors that have not been pre-adjudicated. The following fields display in the lower part of the claim section: **Message Initiator**, **Message Code**, and **Message**.
- The **Message Code** and **Message** fields indicate claim-level adjudication messages from the payer and display data only for payers who pass this information in the file.
- If the payer rejects a claim at this stage, you must correct and rebatch the rejected claims in your billing system, and then upload and resubmit the transmission file. You do not need to include accepted claims in the file, since those claims have already been processed and accepted at the payer.
- If you encounter any problems while interpreting errors in the EBR and cannot resolve them yourself, contact the payer for assistance.

9.8.4.1 Sender code is invalid error

Error message

Sender Code is Invalid

Scenario

This error might display in the EBR file after you submit a transmission file to Florida Blue.

Toubleshooting

A transaction in the transmission file either contains a sender code not beginning with "G" or "H" or contains no sender code. Follow these guidelines to troubleshoot the problem:

- **Is the sender code present?** – Open the transmission file and look for the segment containing the sender code: Loop 1000A, NM1*41, NM109. The sender code must be present.
- **Does the sender code begin with "G" or "H"?** – If the sender code is present, verify that it begins with "G" or "H."
- **Need assistance?** – If you are having further problems, contact the vendor of your EDI transactions system for assistance. When explaining the problem, communicate the loop and segment information: Loop 1000A, NM1*41, NM109.

Note: If you are not able to complete these troubleshooting steps because you do not know how to open and view transmission files, contactAvaility Client Services for assistance.

9.9 Delayed payer report

The delayed payer report (also referred to as a DPR) includes information from payers that utilize batch processing or other non-real-time adjudication processes. The report includes transaction receipt acknowledgement, transaction reject messaging, warning, and informational messages, as well as adjudication responses returned by the destination payer.

File extensions

- `.DPR` (delimited file)
- `.DPT` (human readable text file) – This is the default format.
  - Summary report (errors and responses) – This is the default report.
  - Detail report (all claims acknowledged)
- `.277DPR` – 277CA claim acknowledgement format.

  Note: The .277DPR can only be received in combination with the .DPR or .DPT.

When is this response file sent?

If late responses are received from the payer; typically within 30 days.

- Delayed payer reports are sent only for claims, not non-claim transactions.
- This is an optional response file.

Humana

Delayed payer reports are not generated for claims submitted to Humana.

Florida Blue

Delayed payer reports are not generated for claims submitted to Florida Blue.

Additional details

- If Availity does not receive delayed payer responses, we do not generate a report.
- If the payer processes claims on a batch schedule, rather than in real-time, or sends information after Availity has sent the EBR to your organization, Availity generates a delayed payer report. This may occur with small payers, non-direct payers, or payers who accept claims through another clearinghouse.

Next steps

Monitor status of transactions, correct and resubmit transactions with errors. If a delayed payer report indicates the payer has rejected claims (line 2), you must correct and rebatch the rejected claims in your system, and then upload and resubmit the file. Do not include accepted claims in the file.

9.9.1 Delayed payer report (DPR) - pipe delimited format

The pipe-delimited DPR file is intended to be imported into an automated system.

Delayed Payer Report (DPR) layout

```
DPR|Report Creation Date & Time|Availity Customer ID-Availity Batch ID|File Control
 Number|Customer ID| Availity File ID |Original File Name|
CST|Availity Batch ID|Patient Account Number|Payer ID| Billing Provider ID|Patient
Last Name, First Name| From Date|Total Charges|Process Date|Message Text|NA|Status|Payer Claim
 Number|Submitter
Name|Billing Provider Name| Payer Name|Trace ID||
```

Note:

- Line 1 is the file/interchange level.
- Line 2 will occur for each patient loop in the file.

Delayed Payer Report (DPR)

```
DPR|20101123133022000|0015515-2010112313302000|101019034|0015515|2010112313302000|
PhysiciansHC_837P.txt|||
CST|2010112313302000|CN1975-10|PHCS1|1234567893|LOCKLEAR, HEATHER|20100930|410.00|2010-11-23|
A^^This claim has been accepted for further processing^^^|NA|ACK|CLM_001|AVAILITY LLC|DOCTOR,
 INDIVIDUAL|PHC TEXAS|240076456_0||
```

9.9.2 Delayed payer report (DPT) - readable format

The DPT format of the Delayed Payer Report provides the same information as the pipe-delimited format, but in a readable format. The layout of the report is as follows:

```
Availity Customer ID: <<0>>
                          Availity Delayed Payer Report
------------------------------------------------------------------------
Date Received:          <<1>>           Time Received:       <<2>>
Availity Batch ID:      <<3>>           File Control Number: <<4>>
Availity File ID:       <<5>>
File Name:              <<6>>
------------------------------------------------------------------------
----5----10---15---20---25---30---35---40---45---50---55---60---65---70---75---8
Patient Account Number: <<7>>           Total Charges:       <<8>>
Patient Name:           <<9>>           Process Date:        <<10>>
From Date:              <<11>>          Status:              <<12>>
Billing Provider Name:  <<13>>          Billing Provider ID: <<14>>
Billing Provider NPI:   <<15>>          Submitter Name:      <<16>>
Payer Name:             <<17>>          Payer Claim Number:  <<18>>
Payer ID:               <<19>>          Payer Seq Number:    <<20>>
Availity Batch ID:      <<21>>          Trace ID:            <<22>>
Claim Sequence #:       <<23>>
Message Type:           <<24>>          Message Code:        <<25>>
Message Loop:           <<26>>          Message Segment:     <<27>>
Message Element:        <<28>>
Message Text:           <<29>>
```

Descriptions of fields in the DPT layout

Field number	Field	Note
0	Availity Customer ID	Entity customer ID
1	Date Received	Date response received: CCYY-MM-DD
2	Time Received	Time response received: HH.MM.SS.SSS
3	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
4	File Control Number (Interchange Control Number)	ISA13 on submitted file
5	Availity File ID	Availity assigned - DB_INSTANCE_NUM<->DOCUMENT_SEQ Example: 1-123456789
6	File Name	Original incoming file name: EXCHANGE_FILENAME
7	Patient Account Number	2300 CLM01
8	Total Charges	2300 CLM02; 9,999.99 format
9	Patient Name	2010BA/CA NM103, NM104 Max length = 25 If Patient Loop 2010CA is present and different from the Subscriber loop, the Patient NM103, NM104 is displayed. The last name will be included in its entirety then the remaining bytes will reflect the first name.
10	Process Date	Date response was processed by Availity: CCYY-MM-DD
11	From Date	2400 DTP03 | 2300 DTP03; CCYYMMDD format
12	Status	ACK | REJ
13	Billing Provider Name	2010BB, NM103

Field number	Field	Note
14	Billing Provider ID	2010BB, NM109
15	Billing Provider NPI	NA (it is provided in the above field or is absent for nontraditional providers)
16	Submitter Name	1000A, NM103
17	Payer Name	Availity database payer name associated with payer ID
18	Payer Claim Number	If provided in payer response, else NA
19	Payer ID	2010BB- NM109 - Professional 2010BC – NM109 - Institutional
20	Payer Seq Number	NA – Availity does not create this sequence
21	Availity Batch ID	File name assigned by Availity or Batch of One: INTERNAL_FILENAME
22	Clearinghouse Trace #	2300 REF02 from inbound submitter REF*D9 | NA
23	Claim Sequence #	NA – Availity doesn't create a claim sequence number
24	Message Type	A | R | W | I
25	Message Code	If provided, else NA
26	Message Loop	Loop
27	Message Segment	Segment ID
28	Message Element	Element number
29	Message Text	Claim error message

Note:

- Detailed error messages display. The error message field wraps within the allotted byte length 88.
- All fields containing monetary amounts (currency) will follow United States currency format standards.
  - The currency format display includes commas denoting thousands of dollars.
  - The currency format display includes two decimal places denoting cents.

Delayed Payer Report (DPT) example

```
Availity Customer ID:  0015515
                              Availity Delayed Payer Report
--------------------------------------------------------------------------------
Date Received:          2010-11-23           Time Received:           13.30.22.022
Availity Batch ID:      2010112313302000     File Control Number:     101019034
Availity File ID:       2010112313302000
File Name:              PhysiciansHC_837P.txt
--------------------------------------------------------------------------------
Patient Account Number:CN1975-10             Total Charges:           410.00
Patient Name:           LOCKLEAR, HEATHER    Process Date:            2010-11-23
From Date:              20100930             Status:                  ACK
Billing Provider Name: DOCTOR, INDIVIDUAL    Billing Provider ID:     1234567893
Billing Provider NPI:   NA                   Submitter Name:          Availity LLC
Payer Name:             PHC TEXAS            Payer Claim Number:      NA
Payer ID:               PHCS1                Payer Seq Number:        NA
Availity Batch ID:      2010112313302000     Trace ID:                240076456_0
Claim Sequence #:       NA
Message Type:           A                    Message Code:            NA
Message Loop:           NA                   Message Segment:         NA
Message Element:        NA
Message Text:           This claim has been accepted for further processing
--------------------------------------------------------------------------------
                                    END OF REPORT
--------------------------------------------------------------------------------
```

9.9.3 Interpret DPR files

Periodically check your **ReceiveFiles** mail box for new delayed payer report (DPR) file items and interpret them to determine if delayed errors occurred at the payer level.

- If a DPR with a .dpt extension is present, open that file. It's a readable text report. The DPR file ending in .dpr is the data file, intended to be imported into your system.
- The following two fields display in the first section (coinciding with line 1 in a data file):
  - **Availity File ID** – A unique number assigned by the Availity system in the following format: 1-123456789.
  - **File Name** – The name the submitter assigned to the file being submitted to Availity.
- The DPR may include multiple messages for rejects, warnings, and informational messages.
- If a DPR indicates the payer rejects any claims, you must correct and rebatch the rejected claims in your EDI transactions system, and then upload and resubmit the transmission file. You do not need to include accepted claims or claims with warning or informational messages in the file.
- You can download the text file to your computer or print it.

  Note: The administrator can select to receive the text file in a summary or detail format. The rejected claims display the message text and other information from the payer but the accepted claims do not display this information.
- If you encounter problems interpreting errors in the DPR and cannot resolve them yourself, contact the payer for assistance.

9.10 Health care services review (278ebr) summary text report

In addition to the 278 ANSI ASC X12N response transactions, Availity also produces the Health Care Services Review (278ebr) summary text report.

278 summary text report layout, with errors, with HIPAA segment information

When errors are received as the response to the 278 request batch transaction, the layout of the report is as shown in the following table.

Date Received:		**Time Received:**	
Availity Batch ID:		**File Control Number:**	
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Patient Tracking Number:			
Patient Name:	**Sub**: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820) **Dep**: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)	**Patient Date of Birth:**	**Sub**: 2010CA – DMG02 (DMG_0960) **Dep**: 2010DA – DMG02 (DMG_1320)
Member ID:	**Sub**: 2010CA – NM109 (NM1_0820) **Dep**: 2010DA – NM109 (NM1_1190)	**Patient Gender:**	**Sub**: 2010CA – DMG03 (DMG_0960) **Dep**: 2010DA – DMG03 (DMG_1320)
Subscriber Name:	2010CA – NM103, NM104, NM105, NM107 (NM1_0820)	**Supplemental ID:**	**Sub:** 2010CA – REF02 (REF_0830) **Dep:** 2010DA – REF02 (REF_1200)
Error Message:			
Error Code			
Loop:			
Message: 2000E – MSG01 (MSG_1510)			

278 summary text report layout, no errors, with HIPAA segment information

When the 278 request transaction has passed all HIPAA validation, it is sent to the payer. The payer responds with the 278 Health Care Services Review response transactions. The layout of the report is as shown in the following table.

Date Received:		**Time Received:**	
Availity Batch ID:		**File Control Number:**	
HCSR(s) Received:		**HCSR(s) Accepted:**	
Message 2000E – MSG01 (MSG_1510)			
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Payer:	2010A – NM103 (NM1_0200)	**Type of Request:**	2000F – UM01 (UM_1690)
Patient Tracking Number:			
Patient Name:	**Sub**: 2010CA – NM103, NM104, NM105, NM107 (NM1_0820) **Dep**: 2010DA – NM103, NM104, NM105, NM107 (NM1_1190)	**Patient Date of Birth:**	**Sub**: 2010CA – DMG02 (DMG_0960) **Dep**: 2010DA – DMG02 (DMG_1320)
Member ID:	**Sub**: 2010CA – NM109 (NM1_0820) **Dep**: 2010DA – NM109 (NM1_1190)	**Patient Gender:**	**Sub**: 2010CA – DMG03 (DMG_0960) **Dep**: 2010DA – DMG03 (DMG_1320)
Subscriber Name:	2010CA – NM103, NM104, NM105, NM107 (NM1_0820)	**Supplemental ID:**	**Sub:** 2010CA – REF02 (REF_0830) **Dep:** 2010DA – REF02 (REF_1200)
Certification #:	2000F – HCR02 (HCR_1700)	**Status:**	2000F – HCR01 (HCR_1700)
Type of Service #1:	2000F – UM03 (UM_1690) – 1st loop		
Type of Service #2:	2000F – UM03 (UM_1690) – 2nd loop		
Type of Service #3:	2000F – UM03 (UM_1690) – 3rd loop		

Type of Service #4:	2000F – UM03 (UM_1690) – 4th loop		
Admission Date:	2000F – DTP03 (DTP_1730)	**Service Date:**	2000F – DTP03 (DTP_1720)
Effective Date:	2000F – DTP03 (DTP_1780)		
Expiration Date:	2000F – DTP03 (DTP_1770)	**Certification Date:**	2000F – DTP03 (DTP_1760)
Referred by Provider			
Name:	2010B - NM103, NM104, NM105, NM107 (NM1_0480)		
Tax ID:	2010B – NM109 (NM1_0480)		
Payer Assigned ID:	2010B - REF02 (REF_0490)		
Referred to Provider/ Facility	(This loop can repeat up to 10 times.)		
Name:	2010E - NM103, NM104, NM105, NM107 (NM1_1520)		
Tax ID:	2010E – NM109 (NM1_1520)		
Payer Assigned ID:	2010E - REF02 (REF_1530)		
Lab & Clinical Information:	2000F – MSG01 (MSG_1910)		

9.11 Proprietary payer report

For certain payers, such as Medicare DMERC regions B, C, and D, Availity passes a proprietary response directly from the payer to the provider. These response files have a .RPT extension and are a direct pass through without any mapping or editing by Availity.

10 270 transactions

A HIPAA term for the electronic submission of eligibility and benefits inquiries. Use a 270 ("two-seventy") transaction to request information from a health plan about what services are covered for a particular patient and any required copay or coinsurance.

11 271 transactions

A HIPAA term for electronic responses from health plans to eligibility and benefits inquiries (270). A 271 ("two-seventy-one") response includes information about what services are covered for a particular patient and any required copay or coinsurance.

12 276 transactions

A HIPAA term for the electronic submission of claim status inquiries. Use a 276 (" two-seventy-six") transaction to check the status of claims or find out information about a denial or a delay.

13 277 transactions

A HIPAA term for electronic responses from health plans to claim status inquiries (276). A 277 ("two-seventy-seven") response includes the status of a claim or information behind a denial or a delay.

14 277RFAI transactions

A HIPAA term for a payer's request for additional information to support a health care claim ("two-seventy-seven RFAI").

15 278 transactions

A HIPAA term for electronic requests to, and responses from, health plans related to authorizations and referrals. Use a 278 ("two-seventy-eight") transaction to do the following:

- Request authorization for a procedure, service, or supply
- Inquire about a previously submitted authorization request
- Request approval for a referral to another physician, specialist, or facility
- Inquire about a previously submitted referral request

16 5010

A specification for all electronic health care transactions governed under HIPAA. Legislative mandate required an industry-wide migration from ASC X12 Version 4010/4010A to Version 5010 by the beginning of 2012.

17 835 transactions

A HIPAA term for electronic remittance advice (ERA) sent by health plans. Use an 835 ("eight-thirty-five") transaction to view adjudication results and payment information for submitted claims.

18 837 transactions

A HIPAA term for the electronic submission of healthcare claim information to health plans. The 837 ("eight-thirty-seven") transaction set is divided into three groups: 837P for professional claims, 837I for institutional claims, and 837D for dental claims.

19 administrator

The person responsible for setting up and maintaining user accounts, maintaining organization information, and performing other administrator tasks in Availity Essentials. The administrator must have legal authority to sign agreements for the organization.

20 admitting diagnosis

The initial diagnosis made when the patient is first admitted to the hospital.

(Adapted from: http://www.cms.gov/apps/glossary/)

21 advice number

A field that displays in the claim status inquiry results for some payers that providers can use when researching claim remittance.

22 ANSI

American National Standards Institute (ANSI). An organization that administers and coordinates various standards and standards systems in the U.S., such as X12.

American National Standards Institute (ANSI)

ANSI

23 attest

To affirm to be true or genuine; *specifically*: to authenticate by signing as a witness.

When requesting a patient care summary for Florida Medicaid, the physician or physician's designee must attest that a signed patient consent form is on file or that the physician needs emergency access and the patient is unable to sign a consent form.

24 atypical providers

Non-health care providers who might or might not have a National Provider Identifier (NPI). Atypical providers are providers that do not provide healthcare services as defined under HIPAA in Federal regulations at 45 CFR § 160.103, such as taxi, meal delivery, and respites services, and contractors who build wheelchair accessible ramps..

25 authorizations

A type of health care service review. Authorizations can be one of these types.

- **Inpatient** – Payers typically require an inpatient authorization before a patient is admitted to a facility as inpatient. This type of authorization is sometimes called an "admission review" or "pre-certification."
- **Outpatient** – Payers typically require an outpatient authorization for outpatient treatments at a facility, such as for diagnostic, invasive, or surgical procedures; observations; and therapies. Also, they often require outpatient authorizations for durable medical equipment (DME) and home health services. This type of authorization is sometimes called a "health services review."

26 Availity trading partner

An Availity trading partner is a submitter that aggregates on behalf of their providers, payers, and/or members to Availity.

Examples: Practice Management System (PMS)/Electronic Medical Record (EMR), Health Information System (HIS), billing services, Revenue Cycle Management (RCM), and Durable Medical Equipment (DME).

27 batch ID

A unique, 16-digit date-timestamp that Availity assigns to an EDI transmission file when you upload and submit it through Availity. The ID takes the format YYYYMMDDHHMMSSSS.

28 bilateral trading partner (clearinghouse)

A bilateral trading partner, also known as a clearinghouse, is a submitter and/or receiver that can send volume to partners to access their payers. Those partners can also send volume to Availity to access our payer partners.

29 CBSA code

Core-based statistical area (CBSA) code. Code that identifies the location where routine or continuous home care service is provided or the facility where inpatient care is delivered.

core-based statistical area (CBSA) code

CBSA code

30 claim

A formal request to receive payment from a payer for health care services rendered by a health care provider. The request includes information about the services provided, diagnosis, and other relevant information.

31 claim adjustment reason codes

Codes that communicate why the payer paid a claim or claim line differently from how the provider billed it. If no adjustment was made to a claim or line, no adjustment reason code displays.

You can find code lists for this and other types of codes at https://x12.org/codes.

32 claim status category codes

Claim status category codes indicate the general category of the status of the claim or claim line, which is then further detailed in any claim status codes . Statuses may include accepted, rejected, additional information requested, and so on.

You can find code lists for this and other types of codes at http://www.wpc-edi.com/content/view/711/401/.

33 claim status codes

Codes that convey the status of an entire claim or a specific claim line. Also known as "health care claim status codes."

You can find code lists for this and other types of codes at http://www.wpc-edi.com/content/view/711/401/.

34 condition codes

Codes that describe the patient's condition at the time of treatment. These codes are necessary to adjudicate Medicare and Medicaid claims and are part of Code Source 132 National Uniform Billing Committee (NUBC) codes.

35 CPT

Current Procedural Terminology (CPT). A procedure coding list created and maintained by the American Medical Association (AMA)

.

Current Procedural Terminology (CPT)

CPT

36 credentialing

The process of collecting and supplying credentials, such as academic, licensing, and related information, about physicians and other health practitioners to insurance carriers, hospitals, and government agencies.

37 CSV file

Comma-separated values (CSV) file. A file that stores tabular data. In a CSV file, each record (or row) is usually separated by a line break. Within each record, each field is separated by a comma. For example:

```
record1_field1,record1_field2
record2_field1,record2_field2
record3_field1,record3_field2
```

Many features in Availity Essentials can export data to and import data from a CSV file. You can open a CSV using most spreadsheet programs such as Microsoft Excel. You can also use Notepad to open a CSV file.

comma-separated values (CSV) file

CSV file

38 customer ID

A unique number at least four digits in length that Availity uses to identify your organization. The official term is "customer ID," although you may occasionally see the terms "organization ID" or "genkey" on some Availity pages.

When an organization submits an EDI transmission file, the customer ID is appended to the front of the interchange control number in the Availity batch ID.

customer ID

39 DPR file

Delayed payer report (DPR) file. A file that Availity creates in response to EDI claims in these cases:

- If the payer processes claims on a batch schedule, rather than in real time
- If the payer uses other non-real-time adjudication processes
- If the payer sends additional information about the claim after Availity has sent the electronic batch report (EBR) file to the provider
- If the payer is non-direct, or accepts batch claims through another clearinghouse

delayed payer report (DPR) file

DPR file

40 DRG codes

Diagnosis-related group (DRG) codes. Codes and categories that hospitals use on discharge claims. According to the Centers for Medicare & Medicaid Services (CMS), the DRG coding system is "a classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual."

(Adapted from: http://www.cms.gov/apps/glossary/)

diagnosis-related group (DRG) codes

DRG codes

41 E codes

External causes of injury and poisoning (E) codes. Codes that supply supplemental information about the event during which an injury or illness took place and about the individuals affected.

See the information on the CMS website for information about when you should use E codes: http://www.cms.hhs.gov

42 eBill

Electronic medical bill (eBill). A term used in workers' compensation to refer to an electronic claim. The charge for each episode of care or encounter with an injured employee is considered a "bill."

eBill Agent

An "eBill agent" facilitates the processing of the workers' compensation eBills between health care providers and payers, much the same way a group health clearinghouse facilitates commercial claims. It can also establish electronic connectivity between the various parties to the transaction.

eBill Attachments

In workers' compensation, the majority of eBills require additional information, or attachments, before the payer can adjudicate. An electronic tracking number (attachment control number) provides the link between the eBill and the attachment.

(Content sourced from Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP), Electronic Medical Billing White Paper, 2010.)

electronic medical bill (eBill)

eBill

43 EBR file

Electronic batch report (EBR) file. A file that Availity sends in response to submitted EDI claims. The EBR contains claim-level information and indicates whether the payer accepts or rejects each claim based on its own HIPAA compliance and payer-specific edits.

The EBR includes any pre-adjudication and real-time adjudication responses. It might include pre-payment or payer acknowledgements, depending on reporting preferences.

Availity also sends EBRs for health care services review, or authorizations and referrals.

electronic batch report (EBR) file

EBR file

44 EDI

Electronic data interchange. A data transfer protocol, or set of rules and standards, used to route standard-formatted data electronically, such as claims, inquiries, requests, and other business data.

electronic data interchange (EDI)

EDI

45 EDI transmission file

Electronic data interchange (EDI) transmission file. An ANSI X12 file containing individual transactions, such as professional claims. X12 transmission files can contain different types of transactions, each of which must be grouped in unique functional groups and transaction sets devoted to that transaction type. The first segment in a transmission file is an ISA segment and the last segment is an IEA segment.

46 EFT

Electronic funds transfer (EFT). A data transfer protocol, or set of rules and standards, used to route funds electronically. In the health care industry, this protocol is used to route payment checks electronically to providers.

electronic funds transfer (EFT)

EFT

47 encounter

Filed for services rendered under a risk-sharing HMO plan. Similar to a claim, an encounter reports the context and purpose of services performed under the contract. However, the encounter is not reimbursable like a traditional claim. The payer uses encounter data to determine the risk status of the population enrolled in the HMO. It then modifies the contract fees it pays to the provider accordingly.

48 EPA

Electronic provider access (EPA). Gives participating out-of-area providers the same access to electronic pre-service review capabilities as local providers, enabling them to conduct online pre-service review.

The out-of-area provider has access to all electronic pre-service review capabilities, including those provided by vendors, through the health plan portal via Availity Essentials, with routing performed by the Blue Cross Blue Shield Association. The routing is based on the prefix of the member ID. After accessing the health plan portal, providers can conduct pre-service reviews as if they were local providers.

electronic provider access (EPA)

EPA

49 EOB

Explanation of benefits (EOB). A statement sent by a health plan with details of the claims associated with a payment (check or EFT) sent to a provider.

An EOB is also sometimes referred to as one of the following in the healthcare industry:

- **EOP** – Explanation of payment
- **NOP** – Notice of payment

EOB (explanation of benefits)

EOB

50 Fast Path

A service that enables you to get priority customer service from the payer for questions about a patient's eligibility and benefits or about authorization or referral requests. For payers who provide this service, the eligibility and benefits results, or authorization or referral request response, displays the Fast Path information you need when contacting the payer.

The Fast Path service for questions about a patient's eligibility and benefits is currently available for the following payers:

- BlueCross BlueShield of Tennessee
- Florida Blue

The Fast Path service for questions about authorization or referral requests is currently available only for Florida Blue.

51 fee-for-service plan

An HMO, PPO, or other plan type where the payer pays a fee to the provider for individual services as they are performed. A claim is required for providers to receive payment under this type of plan.

52 file ID

A unique number assigned to EDI files received by Availity. Displays in response files in the following format: 1-123456789.

53 functional group

A term used in EDI to describe the highest structural level in an X12 file, such as a transmission file or implementation acknowledgement file. The boundaries of a functional group are denoted by a GS segment at the beginning and a GE segment at the end.

54 HCPCS

Health Care Financing Administration Common Procedural Coding System (HCPCS). A procedure coding list created and maintained by the Centers for Medicare & Medicaid Services (CMS). The acronym is commonly pronounced "hick-picks." Availity does not support HCPCS codes from before 2002.

You can access up-to-date lists at https://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp.

Health Care Financing Administration Common Procedural Coding System (HCPCS)

HCPCS

55 HCSR

Health care services review (HCSR). The official HIPAA term for authorizations and referrals.

health care services review (HCSR)

HCSR

56 header information

Information on payer responses, or transaction results, that includes patient demographic information, such as name, date of birth, and member information; payer demographics; and plan information. Header information can vary depending on the transaction type and the payer. Header information can also vary among payers.

57 hierarchical condition category

A clinical coding information category that The Centers for Medicare & Medicaid Services (CMS) assigns and uses to calculate risk premiums for Medicare managed care organizations (MCOs). If assigned by CMS, Availity displays this coding information in the **Patient Care Summary Diagnosis** panel | **HCC** column for CarePlus and Humana.

58 HIPAA

Health Insurance Portability and Accountability Act of 1996. A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships.

Title II, Subtitle F, of HIPAA gives the U.S. Department of Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

HIPAA

59 HIPPS

Health Insurance Prospective Payment System (HIPPS). Also known as Resource Utilization Group (RUG). A set of payment codes created and maintained by the Centers for Medicare & Medicaid Services (CMS). Using HIPPS, Medicare payment is derived from the classification system for the service, such as DRGs for inpatient hospital services.

CMS maintains separate HIPPS code sets for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

You can access up-to-date lists at http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp

Health Insurance Prospective Payment System (HIPPS)

HIPPS

60 HIS

Hospital information system (HIS). A computer system that hospitals use to manage their administrative tasks, such as admissions, billing, and scheduling.

hospital information system (HIS)

HIS

61 HL7

Health Level Seven International (HL7). The clinical file format used to electronically transmit health-related information between medical applications. Supporting these transactions allows Availity to assist hospital teams and lab facilities in monitoring high risk patients. This may include:

- Following the patient's progress.
- Setting up patient care plans to be used after discharge to prevent readmissions
- Identifying where patients go after discharge and direct them to preferred facilities as needed.
- Helping hospitals better manage authorizations for emergency room patients.

(Adapted from: http://www.hl7.org/)

Health Level Seven International (HL7)

HL7

62 HMO

Health maintenance organization (HMO). A type of health insurance plan based on a gate-keeper model, where the patient's primary care physician (PCP) requests referrals and authorizations from the payer for treatment with other physicians and specialists.

Payers negotiate fee schedules with its network of providers. Patients typically pay copayments for services. The provider usually files an encounter instead of a claim.

health maintenance organization (HMO)

HMO

63 IBR file

Immediate batch response (IBR) file. A file Availity sends in response to submitted EDI claims that passed file format and structure validation. The IBR contains claim counts and charges at the claim-level, including accepted claims, and it lists any HIPAA compliance errors and payer-specific errors returned by Availity on behalf of the payer.

immediate batch response (IBR) file

IBR file

64 ICD-10

International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10). A medical classification list by the World Health Organization (WHO). ICD-10 contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

In the United States, there are two modifications of ICD-10: ICD-10 Clinical Modification (ICD-10-CM) for diagnosis codes and ICD-10 Procedure Coding System (ICD-10-PCS) for procedure codes.

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. governmental agencies responsible for overseeing all changes to ICD-10-CM and ICD-10-PCS. On October 1, 2015, CMS replaced ICD-9-CM with the ICD-10 revisions.

You can access information at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.

(Adapted from: https://en.wikipedia.org/wiki/International_Statistical_Classification_of_Diseases_and_Related_Health_Problems)

International Classification of Diseases, 10th revision (ICD-10)

ICD-10

65 ICD-9

International Statistical Classification of Diseases and Related Health Problems, 9th revision (ICD-9). A medical classification list by the World Health Organization (WHO).

International Classification of Diseases, Clinical Modification (ICD-9-CM) is an adaptation of ICD-9 used for assigning diagnostic and procedure codes associated with inpatient, outpatient, and physician office use in the United States. ICD-9-CM is based on ICD-9, but provides additional morbidity detail.

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. governmental agencies responsible for overseeing all changes to ICD-9-CM. On October 1, 2015, CMS replaced ICD-9-CM with ICD-10 revisions.

You can access information at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.

(Adapted from: https://en.wikipedia.org/wiki/International_Statistical_Classification_of_Diseases_and_Related_Health_Problems)

International Classification of Diseases, 9th revision (ICD-9)

ICD-9

66 Interchange control number

Interchange control number. A unique nine-digit number generated by a provider's practice management system (PMS), hospital information system (HIS), or other EDI transaction system. It identifies the EDI transmission file uploaded or routed to Availity. The interchange control number displays in the ISA13 and the IEA02 segments (positions) of submitted files. It is sometimes referred to as the "batch control number" or the "file control number." However, it is not the same as the Availity batch ID, which is a number that Availity generates.

interchange control number

67 ICN / DCN

Internal control number / document control number (ICN / DCN). A control number used by payers.

internal control number / document control number (ICN / DCN)

ICN / DCN

68 legacy identifier

Any identifier that payers used prior to the NPI manadate to identify health care providers. Legacy identifiers include OSCAR, NSC, PINs, UPINs, Blue Cross provider numbers, and other payer-designated identifiers. Since the NPI mandate compliance date (May 23, 2008), providers must use NPI to identify themselves as health care providers in HIPAA-standard transactions. However, payers can still assign legacy identifiers to providers and use them as secondary identifiers.

Note: A tax ID is required for tax purposes when the provider is identified as the billing provider or pay-to provider on claims. However, in compliance with the NPI mandate, the tax ID is not allowed to identify rendering providers.

69 LOINC

Logical Observations Identifiers, Names, Codes (LOINC). A clinical terminology important for laboratory test orders and results, produced by the Regenstrief Institute.

LOINC is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information. LOINC is likely to become a HIPAA standard for some segments of the Claims Attachment transaction. In 1999, it was identified by the HL7 Standards Development Organization as a preferred code set for laboratory test names in transactions between health care facilities, laboratories, laboratory testing devices, and public health authorities.

(Source: National Library of Medicine.

Logical Observations Identifiers, Names, Codes (LOINC)

LOINC

70 LPI

Local provider identifer (LPI). An internal identifier created and used by facilities to designate a provider within that organization. You can assign this identifier to a provider in Availity Essentials using the Manage My Organization – Manage Providers feature on the Manage My Organization.

local provider identifier (LPI)

LPI

71 Medicaid intermediary

A third-party agency, company, or other organization that is contracted to process Medicaid claims and other transactions on behalf of the state agency that administers the Medicaid program.

72 Medicare intermediary

A third-party agency, company, or other organization that is contracted to process Medicare claims and other transactions on behalf of the Centers for Medicare & Medicaid Services (CMS).

73 medication reconciliation

A process of improving transitional care by preventing medication errors after hospital discharge. Medication reconcilation seeks to avoid inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care. Transitions in care include changes in setting, service, practitioner or level of care.

(Adapted from: https://psnet.ahrq.gov/primers/primer/1)

74 national drug code (NDC)

A national drug code (NDC) is a 10-digit number issued by the Food and Drug Adminstration (FDA) for reporting prescribed drugs and biologicals when required by government regulation. Providers can also report NDCs to enhance claim adjudication processes.

Each national drug code consists of three segments separated by a hyphen.

- The first segment identifies the labeler or vendor (labeler code).
- The second segment identifies a specific strength, dosage form, or formulation (product code).
- The third segment identifies package sizes (package code).

75 NPI

National Provider Identifier (NPI). A 10-digit identification number issued to covered health care providers in the United States. Covered health care providers, health plans, and health care clearinghouses use NPI in administrative and financial transactions adopted under HIPAA.

The NPI is intelligence-free, meaning that none of the digits identify anything about the provider. The NPI replaces all other provider plan IDs and must be used instead of legacy identifiers in the HIPAA standard transactions.

National Provider Identifier (NPI)

NPI

76 NUBC

National Uniform Billing Committee (NUBC). A committee, established by the American Hospital Association (AHA), that creates and maintains the NUBC billing code list.

For more information, visit their website at http://www.nubc.org/.

National Uniform Billing Committee (NUBC)

NUBC

77 occurrence codes

Codes that define a significant event related to a claim that might affect claim processing.

78 occurrence span codes

Codes that identify an event relating to a claim that occurred over multiple days.

79 other blue plans

If Blue plans in your region (area) have partnered with Availity to accept transactions, the option **Other Blue Plans** might display in the **Payer** field on many transaction pages, along with the option for the in-state Blue plan.

The **Other Blue Plans** option refers to Blue Cross Blue Shield plans outside of the region (area) in which the provider is located. When you select this option, the transaction is submitted to the in-state Blue plan, which routes the transaction to the Blue Exchange network and, ultimately, to the other Blue plan.

80 payer

The health plan, insurance company, or carrier responsible for paying providers and facilities for health care services rendered.

81 PCP

Primary care physician (PCP). Typically a general or family practitioner, this physician provides basic health care services to patients. Under HMO plans, the PCP also acts as a gate keeper by requesting referrals and treatment authorizations from payers when the patient must visit other physicians, specialists, and facilities.

primary care physician (PCP)

PCP

82 PMS

Practice management system (PMS). A computer system that professional provider offices use to manage their business, which may include billing, scheduling, and other administrative tasks.

practice management system (PMS)

PMS

83 POS

Point of service (POS). A type of health insurance plan that combines elements of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Depending on the specific plan guidelines, the patient might have a primary care physician (PCP), who coordinates health care under HMO-like guidelines, or the patient might be able to access providers under PPO-like guidelines.

point of service (POS)

POS

84 principal diagnosis

The diagnosis or medical condition primarily responsible for requiring a patient's visit to a provider or admission to a hospital.

(Adapted from the CMS website)

85 PTAN

Provider transaction access number (PTAN). An identifier used by Medicare containing five to ten alphanumeric characters. It is also known as the provider number, Medicare PIN, or Medicare ID number. It is not the same as NPI, Tax ID, or Medicare UPIN.

Where can a provider find the PTAN?

- On the Medicare contract
- In the NPPES registry, listed as Medicare PIN for some providers
- On the CMS HCFA paper form in box 24J

provider transaction access number (PTAN)

86 RARC

Remittance advice remark codes (RARC). Codes that convey information about remittance processing or provide a supplemental explanation for an adjustment already described by a claim adjustment reason code (CARC). Each remittance advice remark code includes a specific message.

You can find code lists for this and other types of codes at http://www.wpc-edi.com/content/view/711/401/.

remittance advice remark codes (RARC)

RARC

87 referrals

A type of health care service review sometimes known as a "specialty care review." Payers, particularly under health maintenance organization (HMO) plans, often require patients to get a referral from a primary care physician (PCP) in order to see a specialist for additional health care services.

Note: Referrals differ from outpatient authorizations, which involve facilities.

88 revenue codes

Four-digit codes beginning with zero that are required on facility claim lines for accounting purposes. Revenue codes are usually associated with specific procedure codes. They describe a specific accommodation, ancillary service, or billing calculation.

Revenue codes are part of Code Source 132 National Uniform Billing Committee (NUBC) codes (http://www.nubc.org/).

89 risk-sharing HMO

A health maintenance organization (HMO) plan where the payer pays the provider a monthly or quarterly, per-member contract fee in exchange for the provider's agreement to provide services to patients who are members of the payer's risk-sharing HMO plan. Under this plan, the provider files an encounter instead of a claim.

90 RUG

Resource utilization group (RUG). Classifications into which nursing home patients may be assigned according to their activity levels underlying illnesses, the complexity of care they need, their cognitive status, and other variables affecting their care.The primary use is for insurance reimbursement calculations.

(Medical Dictionary. S.v. "resource utilization group." Retrieved December 22 2016 from http://medical-dictionary.thefreedictionary.com/resource+utilization+group)

resource utilization group (RUG)

RUG

91 secondary diagnosis

A diagnosis or medical condition that is not the principal diagnosis, but nevertheless influences the services or treatment rendered by the provider or the length of stay in the hospital.

(Adapted from the CMS website)

92 subscriber

Also known as "member." The individual who holds the health insurance policy. A dependent, on the other hand, is an individual who is covered on the subscriber's policy.

Example: Jane Doe has health insurance coverage through her employer, and her husband and children are covered on her policy. Jane is the subscriber on her policy, while her husband and children are dependents on her policy.

93 syntax

The standardized structure and organization of information or data. This means data in an electronic file is organized and structured according to a set of industry-accepted standards and rules to ensure the computer systems sending and receiving the data can interpret it. In simpler terms, everyone in the industry agrees to organize and structure the data in a certain way so that all computer systems involved can read and understand it.

94 traditional indemnity plan

A fee-for-service health insurance plan where the patient chooses providers at will. Payers negotiate usual, customary, and reasonable (UCR) fees with in-network providers, which the providers charge as maximum payment for services. Providers file claims under this type of plan.

The patient pays an annual deductible and co-payments for services. If a patient visits an out-of-network provider, the provider might charge more than the UCR fees, and the patient must pay the difference.

95 transaction

A term for the transmission of information between two parties to carry out administrative or financial activities. For example, you carry out a transaction when you deposit or withdraw funds from a bank account, either in person or through an ATM.

In the health care and health insurance industries, "transaction" refers to any electronic claim, inquiry, or request submitted to payers, as well as the corresponding response from the payer.

At Availity, you can submit these transactions electronically if Availity and the payer are partnered to support them.

96 transaction ID

A unique, Availity-generated number that identifies an online transaction to a payer. If you contact Availity Client Services for assistance with a transaction you submitted on Availity Essentials, have the transaction ID ready. You can determine the transaction ID using the transaction log feature in Availity Essentials.

97 transaction set

A term used in EDI to describe the second-highest structural level in an X12 file, such as a transmission file or acknowledgement file. The boundaries of a transaction set are denoted by a beginning ST segment and an ending SE segment.

98 treatment codes

Codes that describe home health treatment. They are required to adjudicate home health claims. The source for these codes is Code Source 359.

99 unit

Any division of quantity accepted as a standard of measurement. For example, minutes, hours, and days are units of time.

100 urgent

Care for an illness or injury that is not a medical emergency but requires immediate medical attention. When you file a claim for emergency or urgent services, most payers require you to identify the condition as either an emergency or an urgent condition.

(Adapted from: https://www.oxhp.com/press/glossary_of_terms.html)

101 value codes

Codes that relate amounts or values to identified data elements needed to process a claim, especially for Medicare and Medicaid. The payer qualifies these codes, which are part of Code Source 132 National Uniform Billing Committee (NUBC) codes.

102 X12

A nationally recognized standard for exchanging electronic data that is maintained by the American Standards Institute (ANSI). It allows organizations with varied computer systems to exchange data electronically in a consistent and standard format.