Michigan Department of Community Health
837 Claims EDI Tutorial

March 20, 2003

Agenda

1. Welcome & Introductions
2. Status of HIPAA Regulations
3. Glossary
4. EDI Terminology
5. 837 Claim Transaction Overview
6. Common Problems
7. Envelope & 997
8. Q & A

Welcome

Status of HIPAA Regulations

Status of HIPAA Regulations

- Privacy Compliance Date is April 14, 2003.
- Transaction Compliance Date is October 16, 2003 (Note: this includes the Addenda.)
- Security Compliance Date is April 21, 2005
- The Final Rule on National Provider ID may be issued later this year.
- A Proposed Rule on Health Plan ID may be issued later this year.

Glossary

Glossary

HIPAA/Industry Term	Medicaid Term	Description
Claim	Invoice	A single paper form, or a collection of services by a single billing provider for a single patient, billed at one time.
Service Line	Claim Line	A single service generally associated with a procedure code.
Replacement	Adjustment	A billing provider's request to change a previously submitted claim.
Void/Cancel	Adjustment	A billing provider's request to void a previously submitted claim.
Health Care Claim Adjustment		The difference between the billing provider's usual charges and the paid amount. The reason for the difference is described through the use of Health Care Claim Adjustment Reason Codes.
Subscriber	Recipient/Beneficiary	The individual who is enrolled in Medicaid and receives services.
Billing/Pay-to Provider	Provider	A hospital, nursing facility, physician or dentist that submits claims to be reimbursed for care they provide to patients (subscribers).

EDI Terminology

HIPAA EDI Terminology

HIPAA ANSI X12 Term	Medicaid Term (if applicable)	Description
Transaction		The exchange of information between two parties to carry out financial or administrative activities related to health care.
Loop		A repeating section in an EDI transaction.
Segment		A group of related data elements within an EDI transaction.
Simple Data Element		The smallest unit of information in an EDI transaction.
Composite Data Element		A more complex unit containing two or more simple data elements.
Delimiter		A character used to separate data elements in an EDI transaction.
Qualifier		A data element that describes the type of information that is to follow in an EDI segment.

837 Claim Transaction Overview

HIPAA Transactions

Transactions prior to treatment

- Eligibility Verification (270/271)
- Authorization/Referral (278)

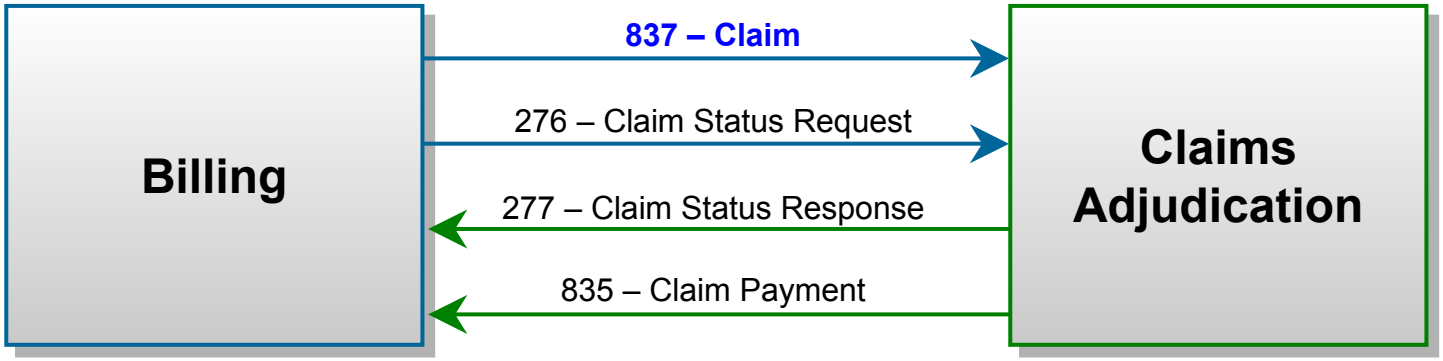
Claims and related transactions

- **Claims (837)**
- Remittances (835)
- Claim Status (276/277)

Managed care transactions

- Enrollment (834)
- Premium Payment (820)
- Encounter (837)

Claim-Related Transactions



The 837 Transaction

The HIPAA-mandated transaction to be used for the electronic transfer of health care claims or equivalent encounter information is the ASC X12N 837 Health Care Claim, Version 4010A1.

- Professional
- Institutional
- Dental

Business Uses

Provides standard format for electronic transfer of:

- Claims data
- Claim replacements and voids
- Encounter data

To be used by:

Professional

- Practitioners
- Ambulance service
- Clinical labs
- Medical suppliers
- DME suppliers
- Hearing aid dealers
- Oxygen suppliers
- Hearing and speech
- Orthotists/prosthetists

Institutional

- Inpatient hospitals
- Outpatient hospitals
- Long-term care facilities
- Home health agencies
- Hospices

Dental

- Dentists (including all subspecialties)
- Dental clinics

HIPAA's Impact on Payers
General

- All payers are required by law to have the capability to receive all HIPAA transactions by 10/2003.
- The payer, in accordance with policy and contractual agreements, can ignore data within the 837 data set.
- Payers can specify which data they require or would prefer in order to efficiently adjudicate a claim.
- When conducting the 837 transaction, covered entities must use the medical and non-medical data code sets specified in the implementation guide.

The Good News for Providers

The standard 837 transaction:

Lets providers use a standard format for all payers.

- Administrative Simplification
- Cost savings

Interactions with Other Transactions

- Providers can supply certain information on the claim in order to match it with the Remittance Advice.
- If this information is supplied in the 837 transaction, it must be echoed on the 835 Remittance Advice.
  - Includes:
    Patient Control Number
    Patient Account Number
    Medical Record Number

Data Overview

Six important types of information in the 837 transaction:

- Submitter/Receiver
- Provider
- Subscriber/Patient
- Claim
- Service Line
- Coordination of Benefits (COB)

Submitter/Receiver Information

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
56	005	ST	Transaction Set Header	R	1	
57	010	BHT	Beginning of Hierarchical Transaction	R	1	
60	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
61	020	NM1	Submitter Name	R	1	
64	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
67	020	NM1	Receiver Name	R	1	

Submitter

- Entity Name
- ETIN/Primary ID Number
- Contact Name
- Contact Communication Information

Receiver

- Name
- Receiver ID

Submitter/Receiver Information Example

```
NM1*41*2*SUBMITTER CLEARINGHOUSE CORP*****46*0079~
PER*IC*SALLY SMITH*TE*2484890000~
NM1*40*2*MDCH MEDICAID FFS*****46*D00111~
```

Billing Provider Information

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
69	001	HL	Billing/Pay-To Provider Hierarchical Level	R	1	
71	003	PRV	Billing/Pay-To Provider Specialty Information	S	1	
73	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
76	015	NM1	Billing Provider Name	R	1	
79	025	N3	Billing Provider Address	R	1	
80	030	N4	Billing Provider City/State/ZIP Code	R	1	
82	035	REF	Billing Provider Secondary Identification	S	8	
85	035	REF	Credit/Debit Card Billing Information	S	8	
87	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
91	015	NM1	Pay-To Provider Name	S	1	
94	025	N3	Pay-To Provider Address	R	1	
95	030	N4	Pay-To Provider City/State/ZIP Code	R	1	
97	035	REF	Pay-To Provider Secondary Identification	S	5	

- Name
- Address
- Telephone Number
- SSN or EIN
- Medicaid Provider ID

Billing Provider - Professional

25. FEDERAL TAX I.D. NUMBER SSN EIN
987654321 X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

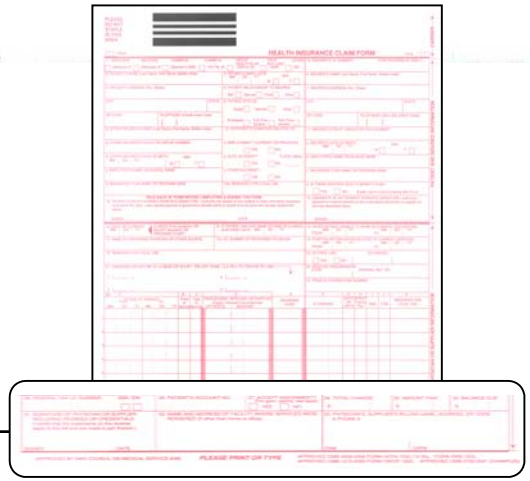
30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Margaret Sanger
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
MARGARET SANGER MD
456 DOCTORS WAY
BIG CITY MI 48765 2488471212
PIN# 101234567 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



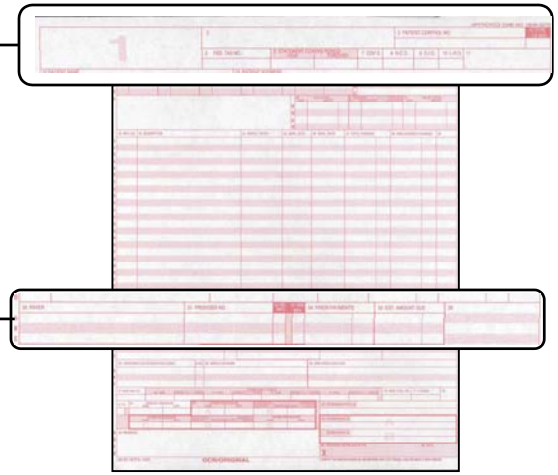
```
NM1*85*1*SANGER*MARGARET****34*987654321~
N3*456 DOCTORS WAY~
N4*BIG CITY*MI*48765~
REF*1D*101234567~
PER*IC**TE*2488471212~
```

Billing Provider - Institutional

APPROVED OMB NO. 0938-0279

MILLER NURSING FACILITY 123 MAIN STREET ANYTOWN MI 48000 (999)555-1234	2			3 PATIENT CONTROL NO.				4 TYPE OF BILL
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C'D.	9 C-I'D.	10 L-R'D.	11
	987654321							

	50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	D111 MEDICAID	60 1234567					
B							



```
NM1*85*2*MILLER NURSING FACILITY*****24*987654321~
N3*123 MAIN STREET~
N4*ANYTOWN*MI*48000~
REF*1D*601234567~
PER*IC*MILLER NURSING FACILITY*TE*9995551234~
```

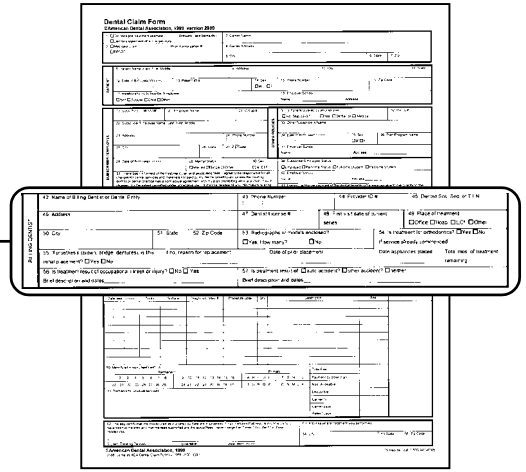
Billing Provider - Dental

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity	43. Phone Number	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
HERBIE ELFKIN	( )	121234567	

46. Address	47. Dentist License #

50. City	51. State	52. Zip Code



```
NM1*85*1*ELFKIN*HERBIE****34*456789123~
N3*123 MAIN~
N4*NORTH POLE*MI*48122~
REF*1D*121234567~
```

Billing Provider Similarities

NM1: Name

N3, N4: Address

REF: Secondary Identifier

PER: Contact Information

“Reading” EDI

“85” = Billing Provider

“2” = Non-person entity

“24” = EIN to follow

EIN

```
NM1*85*2*MILLER NURSING FACILITY*****24*987654321~
N3*123 MAIN STREET~
N4*ANYTOWN*MI*48000~
REF*1D*601234567~
PER*IC*MILLER NURSING FACILITY*TE*9995551234~
```

Medicaid Provider ID

“1D” = Medicaid Provider ID to follow

Subscriber/Patient Information

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
99	001	HL	Subscriber Hierarchical Level	R	1	
101	005	SBR	Subscriber Information	R	1	
106	007	PAT	Patient Information	S	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
108	015	NM1	Subscriber Name	R	1	
112	025	N3	Subscriber Address	S	1	
113	030	N4	Subscriber City/State/ZIP Code	S	1	
115	032	DMG	Subscriber Demographic Information	S	1	
117	035	REF	Subscriber Secondary Identification	S	4	
119	035	REF	Property and Casualty Claim Number	S	1	

- Name
- Address
- Beneficiary ID
- Gender
- Date of Birth

Subscriber/Patient Similarities

Identical across all claim types

- **NM1**: Name; includes Beneficiary ID
- **Nx** (N3, N4): Address
- **DMG**: Demographic Info; Date of Birth, Gender

Subscriber/Patient Information Example

12 PATIENT NAME: DOE JOHN

13 PATIENT ADDRESS: 456 PERSIAN STREET LANSING MI 49999

14 BIRTHDATE: 09111911 | 15 SEX: M | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
DOE JOHN		13174298		

"MI" = Member ID to follow

Medicaid ID

```
NM1*IL*1*DOE*JOHN****MI*13174298~
N3*456 PERSIAN STREET~
N4*LANSING*MI*49999~
DMG*D8*19110911*M~
```

Gender

Date of Birth

Claim Level Information

Similarities

- **CLM:** Claim Information; Patient Control Number, Total Claim Charges, Claim Frequency Type
- **REF:** Medical Record Number

Differences

- **DTP:** Date; Different “type”
- Various…

Claim Level Information

Professional

- Patient Account Number
- Diagnoses
- Total Charge

Institutional

- Patient Control Number
- Type of Bill
- Statement Dates
- Patient Status
- Medical Record Number
- Principal Procedure
- Condition Codes
- Occurrence Codes and Dates
- Value Codes
- Total Charge
- Diagnosis
- Attending Provider

Dental

- Place of Service/Treatment
- Orthodontic Total Months of Treatment
- Tooth Status Code
- Patient Account Number
- Total Charge
- Prior Authorization Number
- Date of Service

Claim Level Information Example

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
		CAIDNF4	213

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	110102	113002					

12 PATIENT NAME	13 PATIENT ADDRESS
	456 PERSIAN STREET LANSING MI 49999

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
			060102			4		30									

22									22
23	0001	TOTAL CHARGES				300000			23

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
436											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
			A		B		2088004 SMITH JOHN	a b

```
CLM*CAIDNF4*3000***21:A:3*Y**Y*A*********N~
DTP*434*RD8*20021101-20021130~
DTP*435*DT*20020601~
CL1**4*30~
HI*BK:436~
HI*BE:D3:::200~
QTY*CA*30*DA~
NM1*71*1*SMITH*JOHN****34*897911995~
PRV*AT*ZZ*203BG0000X~
REF*1D*102088004~
```

Claim Level Information

```
CLM*CAIDNF4*3000***21:A:3*Y**Y*A*********N~
DTP*434*RD8*20021101-20021130~
DTP*435*DT*20020601~
CL1**4*30~
HI*BK:436~
HI*BE:D3:::200~
QTY*CA*30*DA~
NM1*71*1*SMITH*JOHN****34*897911995~
PRV*AT*ZZ*203BG0000X~
REF*1D*102088004~
```

Service Line Information

Similarities

- Structure
  - Quantity
  - Charges
  - Service code
  - Date of Service

Differences

- SV1, SV2, SV3
- Line Item Control Number

Service Line Information

Professional

- Procedure Information (HCPCS/CPT code, quantity, charge)
- Date of Service
- Place of Service Code
- Diagnosis Pointer
- Emergency Indicator
- Other Provider Information
- Other Payer Prior Authorization or Referral Number
- Other Payer Line Adjudication Information

Institutional

- Revenue Code
- HCPCS (if applicable)
- Date of Service (if applicable)
- Service Units (Quantity)
- Procedure Charges
- Other Provider Information
- Other Payer Line Adjudication Information

Dental

- CDT-3 code
- Tooth number and surface
- Quantity
- Date of Service
- Charge
- Other Provider Information
- Other Payer Prior Authorization or Referral Number
- Other Payer Line Adjudication Information

Service Line - Professional

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 0815 2001	08152001	11		99201		1	5000	1		Y		
2 0822 2001	08222001	11		99213		2	10000	1		N		

PLIER INFORMATION

```
LX*1~
SV1*HC:99201*50*UN*1*11**1**Y~
DTP*472*RD8*20010815-20010815~

LX*2~
SV1*HC:99213*100*UN*1*11**2**N~
DTP*472*RD8*20010822-20010822~
```

Service Line - Institutional

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0120	ROOM & BOARD	10000		30	300000			1
2									2
3									3
4									4
5									5

Example 1:

LX*1~

SV2*01203000*DA*30*100~**

Example 2:

LX*1~

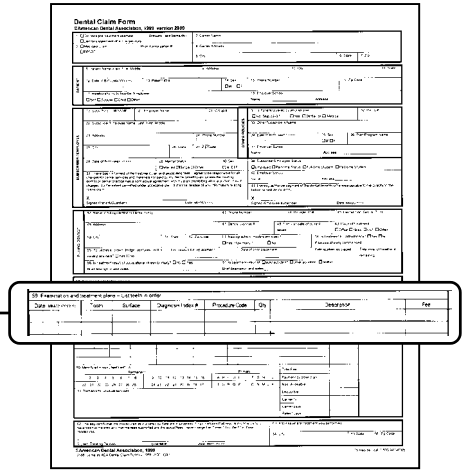
SV2*0420*HC:97016*100*UN*2~

Service Line - Dental

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
02152002	30	O		D2140	1		2900



LX*1~

SV3*AD:D2140*29****1~

TOO*JP*30*O~

Coordination of Benefits

Claim Level

- Claim level adjustments
- Insured's name, sex, DOB
- Amounts
- Other payer name, ID
- Assignment of benefits
- Patient signature indicator

Service Line Level

- ID of payer who adjudicated the service line
- Adjudication date
- Amount paid for the service line
- Procedure code used for adjudication
- Paid units
- Service line adjustment(s)

Common Problems

Submitter vs Provider

MDCH as the Destination Payer

- **MDCH Data Clarification Documents**
  - What Are They?
  - Identifiers
  - Business Rules
  - Important Tips
  - Maximums and Limitations
  - Transaction Structure
  - Coordination of Benefits

MDCH Direct Submitters

- **Envelope Specifications**
- **997 Functional Acknowledgement**

MDCH as the Destination Payer

"The following information applies to all claims where MDCH is the destination payer, regardless of whether you submit directly to MDCH or through Blue Cross or any other clearinghouse."

Data Clarification Documents

Data clarification documents were created by MDCH as a companion to the National Electronic Data Interchange Transaction Set Implementation Guides.

- Institutional Claim, ASC X12N 837 (004010X096)
- Professional Claim, ASC X12N 837 (004010X098)
- Dental Claim, ASC X12N 837 (004010X097)

Addenda to these documents will be supported as specified in the 2/20/03 Federal Register's Final Rule. The timetable for B2B testing will be announced soon.

Data Clarification Documents can be found on the MDCH web site at:

www.Michigan.gov/mdch, under Providers >> HIPAA Implementation Materials >> HIPAA Data Clarification Documents

Data Clarification
Identifiers

- MDCH requires the REF (Provider Secondary Identification) for all Medicaid providers included on the 837 claim.
  - REF01 = 1D (Medicaid Provider Number)
  - REF02 = 9-digit unique Medicaid assigned provider identifier (2-digit provider type followed by 7-digit Medicaid assigned identifier)
- Billing Provider Primary Identifier must include the EIN or SSN value.
- Subscriber Primary Identifier must include the 8-digit member ID assigned by MDCH.
- Destination Payer Primary Identifier should include the PI (Payer Identification) qualifier and “DØØ111” for MDCH.

Data Clarification
Business Rules

- The Patient is always the subscriber
  - 2000C (Patient Hierarchical Level) not used
  - 2010CA (Patient Name) not used
- Billing Provider information is used for payment, Pay-to Provider information may be sent but is not used.

Data Clarification
Important Tips

- Clearinghouses must still send HIPAA-compliant claims even if their clients do not provide all the necessary data.
- Several documents are needed to prepare claims efficiently.

Programmers need:	**Billers need:**
Implementation Guide	*Michigan Uniform Billing (UB-92) Manual*; *UB-92 National Uniform Billing Data Element Specifications Manual*
Data Clarification Documents	*Health Care Finance Administration Common Procedural Coding System (HCPCS)*
Electronic Submission Manual	*Current Dental Terminology (CDT) manual*
	External codes
	Chapter IV of MDCH policy manuals

- Providers must send all situationally required elements
  - For example, the situational REF, Provider Secondary Identification, segments that are “Required when a secondary identification number is necessary to identify the entity.”

Data Clarification
Maximums and Limitations

- MDCH recommends a maximum of 5,000 CLM segments in a single transaction (ST-SE). [Implementation Guide *recommendation*]
- MDCH accepts a maximum of 100 repetitions of the 2300 CLM loop within each patient/subscriber loop. [Implementation Guide *requirement*]
- MDCH accepts a maximum of 50 services line for Professional and Dental claims. [Implementation Guide *requirement*]
- MDCH recommends submitting 50 or fewer service lines for each Institutional claim to avoid processing delays.

Transaction Structure

ST 837

2000A — Billing Provider

2000B — Subscriber

2300 — Claim

2400 — Svc Line

2400 — Svc Line

…

2300 — Claim

2400 — Svc Line

…

2000B — Subscriber

2300 — Claim

2400 — Svc Line

2000A — Billing Provider

2000B — Subscriber

2300 — Claim

2400 — Svc Line

…

SE 837

Recommended max. 5000 claims per transaction

Max. 100 claims per subscriber

837 Professional - Max. 50 svc lines per claim *

* 837 Institutional - Recommended 50 svc lines per claim

Data Clarification
Coordination of Benefits

- The 837 claim contains much more COB information than paper or other electronic claims and billers should prepare accordingly.
- HIPAA requires information about all other payers if they are potentially involved in paying part of the claim.
- Prior payer's adjudication information must be shown in the claim.
- Providers with an 835 can easily transfer prior payer adjudication information to the 837.
- Providers without an 835 must still meet compliance rules, including balancing.
- Tip: Indicate appropriate Payer Sequence Code for each known payer on the claim.

MDCH Direct Submitters

"The following envelope and 997 information ONLY applies if you are submitting claims DIRECTLY to MDCH. If you are submitting claims through Blue Cross or any other clearinghouse, use the envelope and 997 information provided to you by that clearinghouse; IGNORE the following slides."

Envelope Specifications

- MDCH includes envelope and 997 specifications in the *MDCH Electronic Submission Manual*.
  - MDCH specifications generally follow the HIPAA Implementation Guide, Appendix B
- Guidelines:
  - Interchange Control Header/Trailer (ISA/IEA)
    - ISA06 (Interchange Sender ID) = Billing Agent ID
    - ISA15 (Usage Indicator) = P (Production claims) or T (Test Data)
  - Functional Group Header/Trailer (GS/GE)
    - GS02 (Application Sender's Code) = Billing Agent ID
    - GS03 (Application Receiver's Code) = D00111 for Medicaid
    - GS08 (Version / Release / Industry Identifier Code)
      - » "004010X096" Institutional – PRODUCTION CLAIMS ("00410X096A1" for the addenda version)
      - » "004010X098" Professional – PRODUCTION CLAIMS ("00410X098A1" for the addenda version)
      - » "004010X097" Dental – PRODUCTION CLAIMS ("00410X097A1" for the addenda version)

997 Functional Acknowledgement

- MDCH allows multiple 837 transactions (ST-SE) in each functional group (GS-GE).
- All the transactions in a single functional group must be a single type (professional, institutional, and dental claims).
- MDCH allows multiple functional groups in an interchange (ISA-IEA).
- A 997 Functional Acknowledgement is generated for each functional group in an interchange.
  - 997 Functional Acknowledgements include Data Segment (AK3) or Data Element (AK4) information when appropriate for rejections

997 - Accepted

```
ISA*00**00**ZZ*D00111*ZZ*
0079*020627*1511*U*00401*000000212*0*P*:~
GS*FA*D00111*0079*20020627*151119*2120001*X*00401
0~
ST*997*0001~
AK2*837*v0194t003~
AK5*A~
AK9*P*1*1*1~
SE*18*0001~
GE*1*2120001~
IEA*1*000000212~
```

BASICS to deciphering the Weakest Link in data chain:

AK2 … AK5***A~ = Good**

"Received and no errors detected"

997 - Rejected

```
ISA*00**00**ZZ*D00111*ZZ*
0079*020627*1511*U*00401*000000212*0*P*:~
GS*FA*D00111*0079*20020627*151119*2120001*X*004010~
ST*997*0001~
AK1*HC*681019490~
AK2*837*v0194t002~
AK3*SV2*48*2400~
AK4*6*1371*6*1One~
AK3*SV2*57*2400~
AK4*6*1371*6*Two2~
AK5*R~
AK9*P*1*1*1~
SE*18*0001~
GE*1*2120001~
IEA*1*000000212~
```

AK2…AK5***R~ = Bad "Rejected"** and detail on the specific error is outlined in AK3 or AK4 segments.

DETAIL Refer to 837-I Implementation Guide, Appendix B.2 for how to decipher each AK segment.

- AK3: Segment ID where error occurs
- AK4: Specific element within the data segment named in AK3.

997 – Deciphering Rejections

```
ISA*00**00**ZZ*D00111*ZZ*
0079*020627*1511*U*00401*000000212*0*P*:~
GS*FA*D00111*0079*20020627*151119*2120001*X*004010~
ST*997*0001~
AK1*HC*681019490~
AK2*837*v0194t002~
AK3*SV2*48*2400~
AK4*6*1371*6*1One~
AK3*SV2*57*2400~
AK4*6*1371*6*Two2~
AK5*R~
AK9*P*1*1*1~
SE*18*0001~
GE*1*2120001~
IEA*1*000000212~
```

Example:

AK3*SV2*48*2400~

Error identified in SV2 segment of the 2400 loop; the 48th segment in this transaction.

AK4*6*1371*6*1One~

Error in the 6th element of the segment identified in the preceding AK3. X12 calls this element "1371" and that specific element is "Service Line Rate". It "contains an invalid character" as denoted by (the second) "6" and that invalid character is "1One".

837 Transaction Recap

Q & A