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1 CAQH CORE Attachments Operating Rules: Background

1.1 CAQH CORE Overview

CAQH CORE is an industry-wide facilitator committed to the creation, and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, health plans, and patients. Guided by more than 100 participating organizations – including providers, health plans representing 75 percent of insured Americans, government entities, vendors, associations and standards development organizations – CAQH CORE Operating Rules drive a trusted, simple and sustainable healthcare information exchange that evolves and aligns with market needs.[1] CAQH CORE Operating Rules are developed using a consensus-based approach among industry stakeholders, and are designed to facilitate interoperability, improve utilization of administrative transactions, enhance efficiency and lower the cost of information exchange in healthcare. To date, this cross-industry commitment has resulted in operating rules that address many pain points of healthcare business transactions including eligibility and benefits verification, claims and claims status, claim payment and remittance, health plan premium payment enrollment and disenrollment, prior authorization, and aspects of value-based healthcare such as patient attribution.

1.2 Industry Interest in Attachments Operating Rules

Attachments refer to the exchange of patient-specific medical information or supplemental documentation to support an administrative healthcare transaction and are the bridge between clinical and administrative data. They provide health plans vital information for adjudication of a subset of claims, prior authorizations, referrals, post-adjudication appeals, audits and more. However, the attachments workflow is primarily manual and a source of significant administrative burden. According to the 2020 CAQH Index, only 22 percent of attachments are processed using a fully electronic method.[2] The Index also estimated that adoption of electronic attachment transactions could reduce healthcare industry per-transaction costs for exchange of attachments by over $377 million annually, $4.09 per transaction.[3]

Industry has waited for federal action on an attachments standard for many years. In 1996, HIPPA mandated the adoption of an electronic standard for attachments, along with many other administrative transactions. In most cases, the HIPAA-mandated standards have been federally adopted, and companion operating rules have been developed to support these transactions. The extended wait for a federal attachment standard has driven a sense of uncertainty, deterred vendor development of a standardized approach, and resulted in a range of standards and specifications to support the exchange of attachments.

[1] In 2012, CAQH CORE was designated by the Secretary of the Department of Health and Human Services (HHS) as the author for federally mandated operating rules under Section 1104 of the Patient Protection and Affordable Care Act (ACA).
[2] 2020 CAQH Index, CAQH.
[3] Ibid.

Since 2012, CAQH CORE has maintained a focus on attachments, collaborating with industry to provide education and gather insights on industry opportunities via operating rule development input, national webinars, and surveys. In 2019, CAQH CORE published the CAQH CORE Report on Attachments: Bridge to a Fully Automated Future to Share Medical Documentation, which examines the challenges associated with the exchange of medical information and supplemental documentation used for administrative transactions. The report identifies five areas to improve processes and accelerate the adoption of electronic attachments. These opportunity areas include workflows, data variability, exchange mechanisms, connectivity, security and infrastructure, and resources.

Building on the report findings, CAQH CORE launched a multi-stakeholder Attachments Advisory Group consisting of industry leaders representing health plans, providers, vendors government entities and advisors. The group evaluated pain points caused by the exchange of additional documentation across use cases, prioritizing a list of opportunity areas for operating rule development to reduce administrative burden for the Prior Authorization and Claims Attachments Use Cases.

2 Issues to be Addressed and Business Requirement Justification

2.1 Problem Space

Attachments uniquely combine data from two disparate systems – clinical and administrative. Due to limited administrative and clinical system integration, and the lack of a federally mandated electronic transaction standard for attachments by the Department of Health and Human Services (HHS), health plans, providers and vendors have been hesitant to develop standardized approaches to automate the exchange of attachments. This has led to varied and incomplete electronic solutions and work arounds.

The 2018 CAQH CORE Attachments Environmental Scan revealed that the majority of attachments today are submitted manually, as paper forms and records sent through the mail or by fax, presenting an incredible administrative burden to both health plans and providers. A regional health plan participating in the CAQH CORE Attachments Environmental Scan indicated that it takes 792 labor hours, the equivalent of nearly 20 people working full-time, to process the attachments it receives by mail, fax and web portal in the course of one week.

In late 2019, CAQH CORE conducted an industry-wide survey to further inform the development of operating rules to support a more standardized workflow. Surveys were received from over 340 organizations across three stakeholder types: providers, health plans and vendors/clearinghouses. The results, which showed wide variability in how attachments are exchanged, highlighted the prevalence of mail and fax with nearly 60% of organizations using mail and fax to exchange prior authorization and claims attachments.[4]

Health plans and providers participating in CAQH CORE attachments research identified multiple pain points throughout the attachments workflow. For example, providers are often unaware of the clinical documentation required by the health plan to complete a prior authorization or claim submission and frequently send unsolicited attachments with too much, too little or incorrect information to health plans based on past experience with the provision of a specific service. Health plans must sort through

[4] CAQH CORE Attachments Survey Issue Brief.

the clinical information sent by the provider and establish what is required to complete the prior authorization or claim submission, and what is incorrect or missing from the submission. Once all the necessary clinical documentation is received from the provider, which may require multiple communications back and forth between provider and health plan, the health plan must spend additional time linking the original submission with the relevant attachments. Throughout this process, providers are often not aware whether an attachment was received by the health plan, resulting in further unnecessary duplicate attachments sent to the health plan and manual follow up by providers who want to confirm if the additional documentation was received successfully.

Clearly defined exchange standards, accurate data and supporting infrastructure requirements are needed to ensure attachments flow seamlessly through the healthcare system. During the development of the CAQH CORE Attachments Operating Rules, the following priorities rose to the top:

- Enhance attachments workflow process via electronic methods for identifying attachment-specific data to support adjudication of a claim or prior authorization.
- Establish standard codes for providers to communicate when additional documentation is being sent to a health plan.
- Streamline attachment documentation requests and reassociation of attachments.
- Establish requirements for acknowledgements, data errors and response times by health plans when attachments are sent electronically.
- Develop data file format requirements for quality, readability and size efficiency.

2.2 Business Requirement Justification and Focus of the CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule

The purpose of this operating rule is to identify and standardize the data used for exchanging attachments to support X12 00510X217 278 Prior Authorization Requests (hereafter referred to as the X12 v5010X217 278).

When attachments are not submitted in parallel with the original X12 v5010X217 278 Prior Authorization Request, the attachment and Request must be linked, or reassociated. This reflects one of the most significant problem areas in the attachments workflow. The requirements in this operating rule address these issues by reducing the unnecessary back and forth between providers and health plans, enable shorter adjudication timeframes and reduce staff resources spent on manual follow up.

The following requirements included in the rule address data content of attachments and additional documentation to support an X12 v5010X217 278 Prior Authorization Requests:

- Additional guidance for the use of the **X12 824 transaction to communicate data and processing errors**, allowing for more specificity when providers adjust the submission due to errors.
- Streamline the reassociation and identification process with use of **Code EL** on the X12 v5010X217 278 Request and Response and **Common Reference Data** on the X12 v6020X316 275 attachment.
- Use of **Common CORE Connectivity Headers** and **Common CORE Data Elements** when sending additional documentation with the X12 275 transaction.

Additionally, given attachments serve as the bridge between clinical and administrative data, CAQH CORE Attachments Subgroup participants decided to scope this operating rule for attachments sent using the X12 v6020X316 275 transaction and additional documentation sent without using the X12 v6020X316 275 transaction (i.e., using CORE Connectivity as the exchange method and any non-X12 payload including, HL7 FHIR Resources, HL7 C-CDA, .PDF, etc.) to support the convergence of clinical and administrative data as the healthcare industry continues to move towards a more interoperable ecosystem.

3 Scope

3.1 What the Rule Applies To

This CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule applies to the exchange of patient-specific information or supplemental documentation sent to support prior authorizations sent via the X12 005010X217 278 Health Care Services Review – Request for Review and Response Technical Report Type 3 and associated errata (hereafter referenced as X12 v5010X217 278).

To support the efficient exchange of additional information or documentation to support a prior authorization sent in either Batch or Real Time Processing Mode, the rule also applies to the conduct of the following X12 transactions:

- X12 v6020X290 999 Implementation Acknowledgement for Health Care Insurance Technical Report Type 3 (hereafter referred to as X12 v6020X290 999).
- X12 v6020X257 824 Application Advice Technical Report Type 3 (hereafter referred to as X12 v6020X257 824).

In addition, the rule applies across the following electronic attachment submission methods:

X12 Attachment Submission Method:

- X12 006020X316 275 Additional Information to Support a Health Care Services Review Technical Report Type 3 (hereafter referred to as X12 v6020X316 275).[5,6]

Electronic Non-X12 Additional Documentation Payload Format and Submission Methods:

- Other payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity.

[5] Given the X12 attachment standards have not been mandated under HIPAA, health plans, providers and vendors and their agents are not federally required to support the X12 6020X315 275 transaction.

[6] Stakeholders and their agents may choose to implement higher versions of the X12 X316 275 transaction but must also continue to support X12 v6020X316 275 in accordance with this rule.

3.2 When the Rule Applies

This CAQH CORE Attachments (275/278) Prior Authorization Data Content Rule applies when:

- A provider and its agent electronically send patient-specific information or supplemental documentation (solicited or unsolicited) to a health plan to support a X12 v5010X217 278 Prior Authorization Request.

And

- A health plan and its agent electronically process patient-specific information or supplemental documentation and respond to a provider to support a X12 v5010X217 278 Prior Authorization Response.

3.3 What the Rule Does Not Require

While the rule requirements address the optional use of non-X12 additional documentation submission format methods, the rule does not require any entity or its agent to:

- Exchange documentation using an electronic, non-X12 additional documentation submission format method (e.g., HL7 C-CDA, .pdf, .doc, etc.) exchanged via CORE Connectivity.

3.4 Maintenance of This Rule

Any updates to change rule requirements will be made in alignment with CAQH CORE processes for updating versions of the operating rules, as determined by industry need, or CAQH CORE Participants.

3.5 Assumptions

A goal of this rule is to adhere to the principles of electronic data interchange (EDI) in assuring that clinical information sent is accurately received and to facilitate correction of errors for electronically submitted additional documentation requests.

The following assumptions apply to this rule:

- A successful communication connection has been established.
- This rule is a component of the larger set of CAQH CORE Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules.
- This rule is not a comprehensive companion document addressing any content requirements of the X12 5010X217 278, X12 6020X316 275, X12 6020X290 999, X12 6020X257 824 or HL7 C-CDA.
- Compliance with all CAQH CORE Operating Rules is a minimum requirement; any HIPAA-covered entity is free to offer more than what is required in the rule.

4 Data Content Rule Requirements for Attachments using the X12 275 Transaction

The rule requirements in this section apply only when an entity and their agent use an X12 attachment method listed in §3.1.

4.1 Reassociation Requirements

To speed up the adjudication of an X12 v5010X217 278 Request, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010X217 278 transaction, typically referred to as an unsolicited attachment, to support the Request.[7]

There are two submission methods a provider can use to deliver an ~~unsolicited~~ attachment that are addressed in this rule:

1. Using the X12 v6020X316 275 transaction to provide additional documentation.
2. Using ~~a non-X12 method (e.g.,~~ CORE Connectivity[8] as the payload exchange method without an X12 payload format, ~~FHIR, DIRECT messaging, web portals, etc.) to provide additional documentation~~.

The following requirements address the X12 submission method~~s~~ for the reassociation of solicited and unsolicited attachments sent to support a X12 v5010X217 278 Request.

4.1.1 Reassociation of an Unsolicited X12 275 to an X12 278 Request[9]

When a HIPAA-covered provider and its agent send an unsolicited X12 v6020X316 275 in support of an X12 v5010X217 278, PWK02 Code EL in Loop 2000E/Loop 2000F in the X12 v5010X217 278 Request must be used to notify a HIPAA-covered health plan and its agent that additional documentation is being transmitted electronically using the Binary Data Segment (BDS) in X12 v6020X316 275.[10,11]

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[7] Given the X12 attachments standards have not been mandated under HIPAA, providers and their agents are not federally required to send additional documentation via the X12 v6020X316 275 attachment transaction; however, if a provider and its agent send an X12 v6020X316 275 attachment to a health plan and its agent, the health plan and its agent must follow the reassociation requirements for the X12 v5010X217 278 and X12 v6020X314 275 specified in this rule.

[8] ~~The~~ CORE Connectivity ~~Rule~~ specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content ~~they are serving~~ being transmitted.

[9] This rule does not require providers and their agent to send an unsolicited X12 v6020X316 275 attachment in support of a prior authorization Request. However, if an unsolicited X12 v6020X316 275 attachment is sent by a provider or its agent, the rule requirement must be followed.

[10] While this requirement does not prohibit providers and their agents from using alternative methods to submit the unsolicited additional documentation (e.g., ~~CORE Connectivity,~~ FHIR, DIRECT messaging, web portals, etc.), it specifies the use of PWK02 Code EL if the additional documentation is sent via a X12 v6020X316 275 transaction.

[11] PWK values may be used for other scenarios as defined in specific companion guides and agreed upon by trading partners.

4.1.1.1 Common Reference Data Used to Reassociate a X12 275 and an X12 278 Request

When a provider sends a X12 v6020X316 275 to support an X12 v5010X217 278 Prior Authorization Request, CAQH CORE recommends the use of the following common reference data to be included on the X12 v6020X316 275 for patient identification and reassociation purposes.

This list of recommendations is not intended to be either exhaustive or prohibitive. The terms included in the list below are defined in Appendix §6.1: X12 TR3 Data Element and Common Reference Data Mapping.

- ACN
- Case reference/ID #
- Date of Birth (DOB)
- Date of Service (DOS)
- Internal Medical Facility #
- Member ID
- Member Name
- Prior Authorization Tracking #

4.1.2 Reassociation of a Solicited X12 275 to an X12 278 Request

A HIPAA-covered health plan and its agent must use PWK02 Code EL in Loop 2000E/Loop 2000F in a pended X12 5010X217 278 Response to request the electronic submission of additional documentation supporting medical necessity in the X12 v6020X316 275~~[12]~~.

5 Data Content Rule Requirements for Attachments using the Non-X12 Method

The rule requirements in this section apply only when an entity and their agent use CORE Connectivity without an X12 payload format, ~~a non-X12 attachment method~~ such as those listed in §3.1 to exchange an electronic attachment. ~~*When the Rule Applies*~~.

5.1 Reassociation Requirements

To speed up the adjudication of an X12 v5010X217 278 Request, a provider and its agent may submit the necessary additional documentation or attachment along with the initial submission of the X12 v5010X217 278 transaction, typically referred to as an unsolicited attachment to support the Request. There are two submission methods a provider can use to deliver an unsolicited attachment that are addressed in this rule:

~~[12] Given the X12 attachments standards have not been mandated under HIPAA, providers and their agents are not federally required to send additional documentation via the X12 v6020X316 275 attachment transaction. However, if a provider and its agent send an X12 v6020X316 275 attachment to a health plant and its agent, the health plan and its agent must follow the reassociation requirements for the X12 v5010X217 278 and X12 v6020X316 275 specified in this rule.~~

1. Using the X12 v6020X316 275 transaction to provide additional documentation.
2. ~~2.~~ Using ~~a non-X12 method (e.g.,~~ CORE Connectivity[13] as the payload exchange method without an X12 payload format.~~, FHIR, DIRECT messaging, web portals, etc.) to provide additional documentation.~~

The following requirements address non-X12 submission method~~s~~ for the reassociation of solicited and unsolicited attachments sent to support an X12 v5010X217 278 Request.

5.1.1 Use of CORE Connectivity Headers to Reassociate Additional Documentation using the Non-X12 Method

Reassociation of additional documentation sent via a non-X12 format for the original X12 v5010X217 278 Prior Authorization Request varies greatly depending on the submission mode of the additional documentation method. CORE Connectivity includes requirements for the exchange of messages using SOAP and REST that is payload agnostic, meaning the SOAP and REST services are not aware of the content. HIPAA-covered providers and their agents using the most recent version of CORE Connectivity to transmit a non-X12 payload must follow the appropriate header requirements to notify health plans and their agents that additional documentation is being transmitted electronically.

In the unsolicited non-X12 scenario using CORE Connectivity as the submission method, a provider and its agent can indicate using SOAP or REST headers that an attachment was sent and specify the attachment body type (e.g., .pdf or HL7 C-CDA, etc.).

When sending a non-X12 unsolicited attachment using CORE SOAP Connectivity Requirements §4.4.3 *<SDO>_<PayloadType>_<Version>_<Sub-version>* the provider and its agent may identify the <PayloadType> from the following list:

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg
- Additional formats are acceptable

When sending a non-X12 unsolicited attachment using CORE REST Connectivity Requirements §5.3.2 Specifications for REST API URI Path Endpoints for Payload Types the provider and its agent may identify the REST API URI Path Endpoint from the following list:

[13] CORE Connectivity specifies requirements for the exchange of messages using SOAP and REST. Additionally, CORE Connectivity is payload agnostic, meaning the SOAP and REST Services are not aware of the content being transmitted.

- HL7 C-CDA
- .pdf
- .doc
- .docx
- .txt
- .jpg
- Additional formats are acceptable

As the industry continues to evolve, this rule may be updated to include requirements for additional non-X12 submission methods and attachment types.

5.1.1.1 Attachment Data Elements of Unsolicited Additional Documentation using the Non-X12 Method

For health plans to effectively match attachment payloads (e.g., HL7 C-CDA, .pdf, .doc, etc.) to the correct administrative transaction the need for a uniform identifier data set is required to facilitate reassociation.

~~The *Attachment Data Elements* as defined in~~ *Table 1. Attachment Data Elements* identifies the data elements necessary for successful reassociation of the non-X12 attachment payload and the X12 v5010X217 278. A provider and its agent must include all available Attachment Data Elements as part of the attachment payload when sending additional information to facilitate reassociation to a prior authorization transaction. Available data elements can be included in some fashion (e.g., a separate document along with the payload or included in the payload document itself) as part of the attachment payload.

This rule does not prohibit a provider and its agent and a health plan and its agent from mutually agreeing to exchange more data in addition to the required minimum data needed for reassociation.

NOTE: Data elements included in Table 1 are only required if available to the provider at time of submission of the attachment. The provider should return as many elements as possible to ensure reassociation with the prior authorization.

Table 1. Attachment Data Elements for Reassociation using Non-X12 Attachment Methods

#	Element	CAQH CORE Element Definition
1	**Auth #**	An *authorization ID* is a character string that is associated with a process that is checked to determine the authority to perform a specified operation. Authorization ID concept/wording is not used in the X12 v5010X217 278 TR3.
2	**Date of Birth (DOB)**	Date of Birth
3	**Date of Service (DOS)**	The date of service is the specific date at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record.

#	Element	CAQH CORE Element Definition
4	**Member ID**	Identifier assigned to the patient by the health plan. Health plans may assign • a unique identifier to all individuals covered by the contract or • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.
5	**NPI**	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identifier for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
6	**Patient ID**	The glossary of the accreditation manual defines a **patient identifier** as "Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended."
7	**Patient Last Name**	Patient name includes a set of words by which a person is known, i.e. First, Middle, and Last or Family Name. A legal name identifies a person for administrative and other official purposes, like insurance payments. It is generally the name that appears on a person's birth certificate but may change over time, as individuals adopt nicknames. Last name/surname: Generational titles such as Jr, Sr, III are considered part of the last name, and should be included in this field.
8	**Prior Authorization "Tracking" #**	Sometimes ~~insurance companies~~ health plans provide a set number of services that they will cover, or they provide a certain time period during which they will cover services for a client. They use **prior authorization numbers** that need to be included in the claims submitted for those services.
9	**Procedure**	A **medical procedure** is a course of action intended to achieve a result in the delivery of healthcare. A *medical procedure* with the intention of determining, measuring, or diagnosing a patient condition or parameter is also called a *medical* test.
10	**Subscriber/Dependent First & Last Name**	The X12 ASC[14] standard describes subscriber and dependent as follows: • The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient.

[14] X12, chartered by the American National Standards Institute, develops and maintains EDI standards which drive business processes globally.

#	Element	CAQH CORE Element Definition
		• The dependent is a person who cannot be uniquely identified to an information source by a unique Member Identification Number but can be identified by an information source when associated with a subscriber. • First and last names are generally the name that appears on a person's birth certificate but may change over time, and as individuals adopt nicknames.
11	**TIN**	The federal taxpayer identification number (**TIN**) that identifies the physician/practice/supplier to whom payment is made for the line-item service. This number may be an employer identification number (EIN) or social security number (SSN).

6 *Appendix*

The terms defined below were selected by CAQH CORE Participants as data elements that most commonly assist with patient identification and reassociation when used by a provider to send a X12 v6020X316 275 attachment to support an X12 v5010 278 Prior Authorization. The data elements are referenced in §4.1.1.1 of this rule.

This list is based on the X12 transaction implementation guides for the identified transactions used to address the provider/health plan exchange of additional documentation to support a prior authorization request. It is informational only. Implementers should rely on the published X12 transaction specifications. The list is not intended to be either exhaustive or prohibitive.

Table 6.1 X12 TR3 Data Element and Reference Identification Mapping

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
1	**ACN (Attachment Control Number)** *Also known as Payer's Auth Control Number or Provider's Attachment Control Trace Number.*	An alphanumeric value used to associate documentation exchanged electronically between trading partners to a specific transaction	Loop 2000E Patient Event/2000F Service Level Segment PWK05 66 Identification Code Qualifier AC Attachment Control Number Segment PWK06 67 Identification Code – Designated Implementation Name = Attachment Control Number • Data Element PWK06 Code AC Attachment Control Number *(Means of associating electronic claim with documentation forwarded by other means)* 67 - Identification Code is an alphanumeric data element in X12 base standard • Required in Patient Event Loop when provider has additional documentation associated with this health care services review. • Required in Service Level Loop when provider has additional documentation	Loop 2000E Patient Event/2000F Service Level Segment PWK05 66 Identification Code Qualifier AC Attachment Control Number Segment PWK06 67 Identification Code – Designated Implementation Name = Attachment Control Number • Data Element PWK06 Code AC Attachment Control Number *(Means of associating electronic claim with documentation forwarded by other means)* 67 - Identification Code is an alphanumeric data element in X12 base standard • Required in Patient Event Loop when the health plan requests additional patient information.	LOOP 2000A TRN Segment Attachment Control Number -required use segment. • Unsolicited 275 requires provider PWK06 ACN from 278 PWC06 request. • Solicited 275 requires health plan PWL06 ACN from 278 PWK06 response.

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
			associated with this health care services review that applies to the service(s) requested in this loop	• Required in Service Level Loop when the health plan needs to request additional information that applies to the service(s) requested in this Service loop	
2	**Case Reference/ ID #**	~~N/A~~ An identifier assigned by the payer to link related attachment requests which may involve single or multiple patients and/or providers.	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level • UM01 1525 Request Category Code • UM02 1322 Certification Type Code • UM03 1365 Service Type Code	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level • UM01 1525 Request Category Code • UM02 1322 Certification Type Code • UM03 1365 Service Type Code	Loop 2000A Service Trace Number *(Required when additional information pertains to specific services, etc. originally referenced in 278 and 278 contains a Service Trace Number in associated Services loop)*
3	**DOB (Date of Birth)**	Patient date of birth	Loop 2010C DMG01/DMG02 Birth Date – use is Situational. • Required when birth date is needed to identify the patient. • If not required, do not send	Loop 2010C DMG01/DMG02 Birth Date • Required when used by the health plan to determine medical necessity. • If not required, do not send	N/A
4	**DOS (Date of Service)**	The date of service is the specific time at which a patient has been given medical treatment. It is recorded for billing purposes and as an item in a patient's medical record. It also matters for insurance purposes, since health insurers base their reimbursement or payment on the date of service, along with other billing factors. Also known as Event Date – meaning the proposed or actual date or range of dates services will be provided to a patient.	Loop 2000E Patient Event DTP Event Date • Required when the proposed or actual date or range of dates of this patient event are known Loop 2000F Service DTP Service Date • Required when proposed or actual date or range of dates of service is different from the Patient Event Date	Loop 2000E Patient Event DTP Event Date/Loop 2000F Service DTP Service Date • Required when the health plan authorizes service for a specific date or date range. • If not required, do not send	N/A
5	**Internal Medical Facility #**	N/A	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level UM04 C023 Health Care Service Location Information	Loop 2000E — UM Segment Health Care Services Review Information Patient Event Level UM04 C023 Health Care Service Location Information	N/A

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
6	**Member ID**	Identifier assigned to the patient by the health plan. Health plans may assign • a unique identifier to all individuals covered by the contract. or • a high-level identifier to the contract subscriber which is used to identify the dependent by adding a suffix. There is no adopted standard to identify patients. A common practice is for each provider and plan to use different identifiers for the same individual.	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of the subscriber who may also be the patient NM108/NM109 Member Identification Number in Loop 2010C; NM108/NM109 Member Identification Number not used in Loop 2010D • One subscriber Loop 2010C if the subscriber is the patient. • One subscriber Loop 2010C if the dependent is the patient and has a unique member ID. • One subscriber Loop 2010C and one dependent Loop 2010D if the dependent is the patient and the dependent does not have a unique identifier different from the subscriber member ID	Loop 2010C Subscriber/2010D Dependent NM108/NM109 Member Identification Number in Loop 2010C; NM108/NM109 Member Identification Number not used in Loop 2010D • One subscriber Loop 2010C if the subscriber is the patient. • One subscriber Loop 2010C if the dependent is the patient and has a unique member ID. • One subscriber Loop 2010C and one dependent Loop 2010D if the dependent is the patient and the dependent does not have a unique identifier different from the subscriber member ID	Loop 1000C Patient Name *(Required to identify the patient as identified in the corresponding 278)*
7	**Member Name**	Name of patient; patient could be either the health plan subscriber or a dependent of the subscriber.	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of the subscriber who may also be the patient • NM103 Last Name • NM104 First Name	Loop 2010C Subscriber/2010D Dependent NM1 Segment is Required Segment and conveys name and identification number of the subscriber who may also be the patient • NM103 Last Name • NM104 First Name	Loop 1000A Information Source Name *(Required to identify creator and sender of 275)* Loop 1000B Information Receiver Name *(Required to identify receiver of 275)* Loop 1000C Patient Name *(Required to identify the patient as identified in the corresponding 278)*
8	**PA Tracking #**	An identifier assigned by the provider to the prior authorization request it is submitting to the health plan. An identifier assigned by the health plan to the prior authorization response it is returning to the provider.	Loop 2000E TRN Segment Patient Event Tracking Number/Loop 2000F Service Level Tracking Number – use is Situational in both loops. • Segment can repeat 2 times. • If a second clearinghouse needs to assign their own TRN segment, they must replace the TRN from the first clearinghouse and retain it to	Loop 2000E TRN Segment Patient Event Tracking Number/Loop 2000F Service Level Tracking Number. • Segment can repeat 3 times • Health plan must return TRNs received in request. • Health plan must return TRN when it assigns a trace number to this patient	Loop 1000C Patient Name – REF Segment Patient Event Trace Number – Use in both solicited and unsolicited 275 *(Required when Patient Event Tracking Number appears in TRN segment of associated 278)*

#	Reference Metadata	Description	X12 v5010217 278 Request	X12 v5010X217 278 Response	X12 v6020X316 275
			be returned in the 278 response.	event in the response for tracking purposes	