Claim and Remittance

ACKNOWLEDGMENTS BEST PRACTICE

Prepared by the Minnesota Administrative Uniformity Committee (AUC)

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), Version 5010.

For more information, please see the AUC website, at:
http://www.health.state.mn.us/auc

Take aways

- Minnesota has requirements in law and rule for the standard, electronic exchange of several common health care administrative transactions
  - Includes acknowledgements
- This best practice is not required, but is highly encouraged to obtain the maximum value from acknowledgments
- This best practice:
  - Explains several important types of acknowledgments
  - Recommends how to use them in practice, according to a variety of scenarios
- Additional information is available at:
  - www.health.state.mn.us/auc
  - www.health.state.mn.us/asa

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I. BEST PRACTICE OVERVIEW

Best Practices are …

- …Important to help reduce health care administrative burdens and costs.
  - This best practice is one of a series published as part of Minnesota's initiative to reduce health care administrative costs by bringing about more standard, more automated exchanges of common health care business ("administrative") transactions.
- …Used in conjunction with other standards and Minnesota and federal regulations.
  - Adherence to Minnesota's best practices is not required, but is strongly encouraged.

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Best Practices are …

- …. Developed as consensus recommendations by the Minnesota Administrative Uniformity Committee (AUC).
  - The AUC is a large, voluntary, multi-stakeholder organization comprised of providers, payers, associations, and state agencies working together to reduce health care administrative costs and burdens.

For more information, including applicable state statutes and rules, the AUC, and other information, see www.health.state.mn.us/auc and www.health.state.mn.us/asa.

Summary of this Best Practice

Title	Claim and Remittance Acknowledgments Best Practice
Applies to:	Health care providers, group purchasers (payers), clearinghouses and other interested parties
Topic and focus:	Minnesota has enacted requirements for the standard, electronic exchange of acknowledgments when receiving health care claims or remittance advices. This best practice recommends which acknowledgments to use in a variety of situations.
Description:	This best practice illustrates the recommended exchange of acknowledgment transactions through a number of scenarios. The scenarios are not exhaustive, but illustrate many of the most common situations to be addressed.

II. Minnesota Regulations

Minnesota Statutes, Section 62J.536

- Minnesota requires the standard, electronic exchange of several health care business transactions, pursuant to Minnesota Statutes, section 62J.356 and related rules.
  - For more information see www.health.state.mn.us/asa
  - For additional summary information regarding requirements specific to acknowledgments, see the following two slides.

Requirements to provide acknowledgments

Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction.

Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

Requirements to provide acknowledgments (cont.)

The acknowledgment provided must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions or National Council for Prescription Drug Program (NCPDP) standards:

1) TA1;
2) 999; or
3) 277CA; or
4) the appropriate NCPDP response standard as the electronic acknowledgment. …

Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

Requirements for tracking mechanisms

Health care clearinghouses. (a) Beginning January 1, 2012, health care clearinghouses must use and make available suitable tracking mechanisms to allow health care providers and group purchasers to determine in a timely fashion that health care claims or equivalent encounter information transactions and health care payment and remittance advice transactions were delivered to their intended final destination. …

Minnesota Statutes, section 62J.536, Subd. 4
https://www.revisor.leg.state.mn.us/statutes/?id=62J.536

III. Acknowledgement Transactions

Sources

- The information in the following slides is based on ASC X12 TR3 Implementation Guides for Acknowledgments TA1, 999 and 277CA

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

Appendix B – “B.1.1.5.1 Interchange Acknowledgment, TA1” and

Appendix C – “TA1 – Interchange Acknowledgment”

Implementation Acknowledgment (999) 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

“1.3.2 Other Usage Limitations”

Implementation Acknowledgement (999), 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Sources (cont.)

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

"IK5 – Transaction Set Response Trailer" and "AK9 – Functional Group Response Trailer"

Implementation Acknowledgement (999), 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N.

"1.4 Business Usage"

Health Care Claim Acknowledgement (227), 005010X214.

Washington Publishing Company, January 2007

<http://www.wpc-edi.com>.

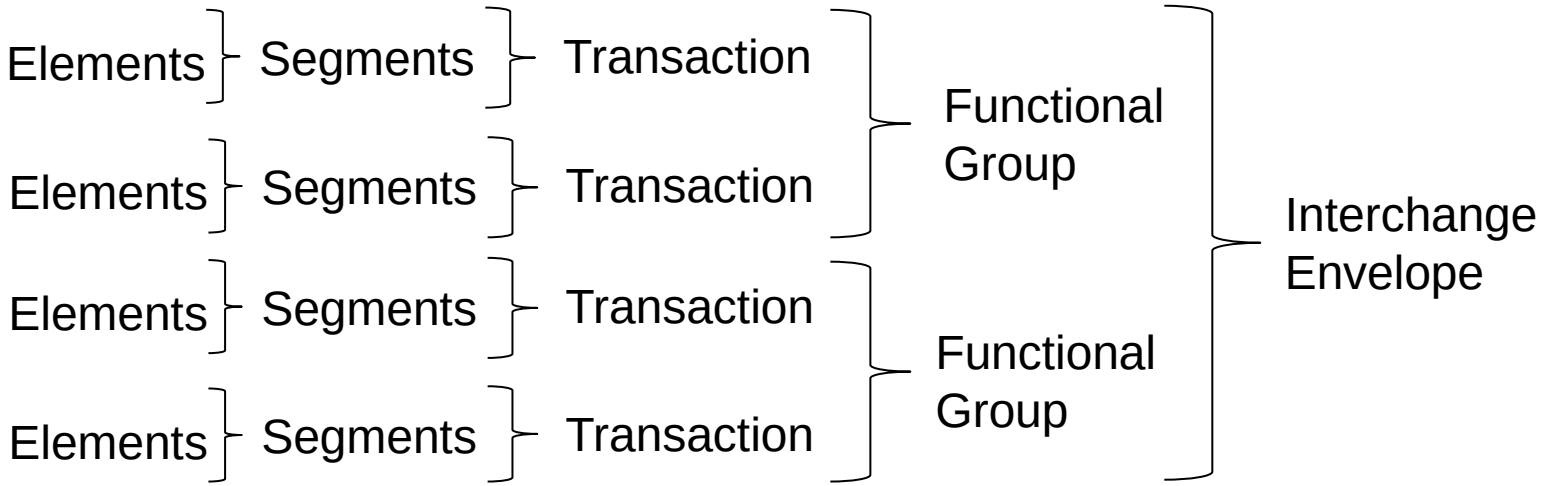
This information is cited by using an abbreviated version of the information source(s) where applicable, and a list of the works cited in their complete, more detailed form at the end of this slide presentation.

Business Purpose

Acknowledgements are used in the exchange of transactions to:

- ❑Report Syntax Errors
- ❑Report HIPAA TR3 (Guide) Errors
- ❑Acknowledge Receipt
- ❑Accept or Reject

Reminder -- Nomenclature



Different acknowledgments are used to provide different levels of information.

Types of Acknowledgements per Minnesota requirements

Type	Name	Purpose
Delivery Acknowledgement	**TA1** (Interchange Acknowledgment)	• Explains Envelope Compliance and Acknowledgement Click TA1 details for TA1 description.
Syntax and HIPAA TR3 Response Acknowledgement	**999** (Implementation Acknowledgment)	• X12 Standard Compliance • Implementation Guide Compliance (HIPAA TR3) Click 999 details for 999 description.
Business Application Acknowledgement	**277CA** (Claims Acknowledgement)	• Pre-Adjudication Only Click 277CA details for 277CA description

TA1

Source: Slides 19 through 22 based on or adapted from 005010X231 3

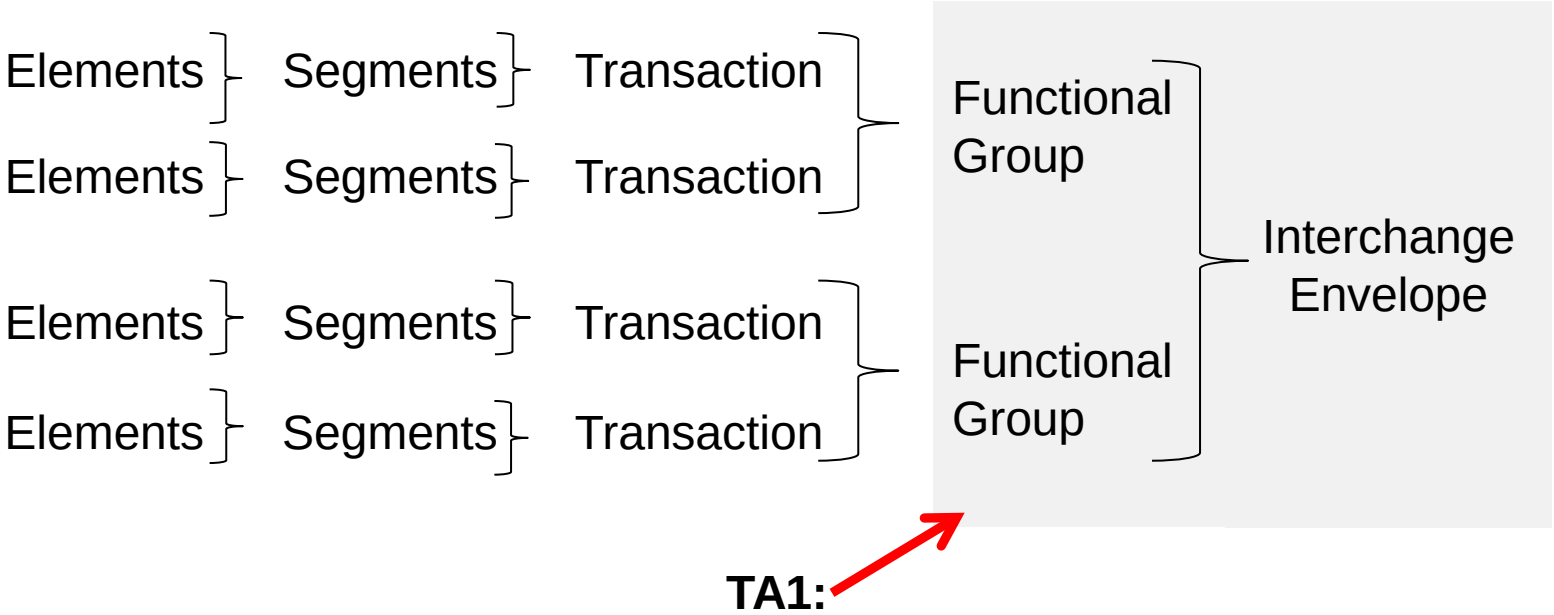
- *Interchange Business Purpose*
  - The TA1 verifies the envelopes only (whether the envelope was received).
    - The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure.
    - The TA1 will be used to report the status of processing a received interchange header and trailer (ISA-IEA). It will either indicate that the interchange is accepted or rejected.
  - When a TA1 is received and it rejects:
    - You will need to correct and resubmit the entire ISA –IEA Interchange

TA1 – 1.1

- Interchange Business Purpose (cont.)
  - The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure.
  - A TA1 can be included in an interchange with other functional groups and transactions.
  - The X12 Implementation Guide (TR3) states that the TA1 is required to be sent when requested by the sender (as indicated in the ISA14 of the submitted interchange), or when an interchange is rejected.

Return to Table

TA1 - 1.2



- Indicates whether an envelope (functional group or interchange level) was received and any errors.
- Reports on whether envelope data such as the interchange control number, interchange date and time stamp, and other summary data are consistent and correct.
- Does not provide information at the transaction, segment, and element levels.

TA1 – 1.3

- Usage Recommendations:
  - This best practice recommends that the **receivers only send the TA1 when the interchange is noncompliant and is rejected**.
  - It is recommended that **senders of transactions set the ISA14 to zero** knowing that a TA1 will arrive if the Interchange is rejected.
    - When the Interchange is valid the sender will receive an appropriate acknowledgment (999 and/or 277CA) to verify receipt.

999

Source: Slides 23 through 27 based on or adapted from 005010X231 2

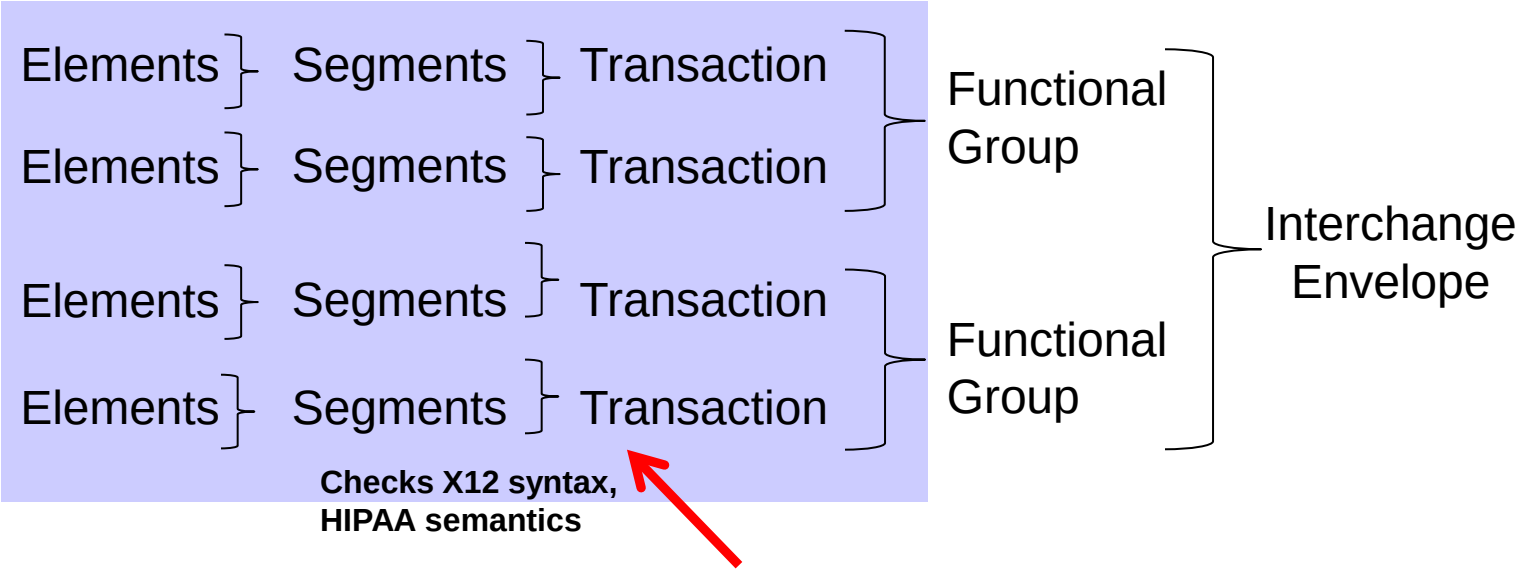
- Business Purpose
  - The 999 reports the results of the X12 syntactical analysis, plus the results of the HIPAA TR3 semantic analysis
  - The 999 replaces the 997 transaction.
    - It is not compliant to use a 997 to acknowledge HIPAA TR3s
      - See formal interpretation from X12 at: http://www.x12.org/subcommittees/x12rfi.cfm
    - Minnesota law requires use of the 999
      - Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

999 - 1.1

- Business Purpose (cont.)
  - This 999 implementation guide can NOT be used for any application level validations.
  - The ASC X12 999 transaction set is designed to respond to one and only one functional group (i.e. GS/GE), but will respond to all transaction sets (i.e. ST/SE) within that functional group.
  - When a 999 has a disposition of “accepted” this means the submitted file has completed syntactical and semantic edits only.
    - It does <u>not</u> mean that the file or units of work were accepted for processing.

Return to Table

999 - 1.2



999:

- Indicates whether information in an envelope meets the X12 Implementation Guide requirements (“syntax requirements”, “semantic requirements”)
- Checks for 13 types of errors at the segment level:
  - E.g., *“Required Segment Missing”; “Segment Not in Proper Sequence”; “Segment Has Data Element Errors”, and others*
- Checks for 18 types of errors at the data element level:
  - *E.g., “Required Data Element Missing”; “Invalid Character In Data Element”; “Too Many Data Elements”; and others*

999 - 1.3

Types of 999s	
A = Accepted	This code value can only be used if there are no AK2 loops or all AK501 values = ‘A’.
E = Accepted with Errors	The transaction set is accepted but there are errors which are reported in the AK2 loop of the 999. • The AK2 loop will identify which transaction within a functional group contained errors, but were forwarded for further processing.
P = Partially accepted	Partially accepted, at least one transaction set was rejected
R = Rejected	The transaction set is not accepted and the errors will be reported in the AK2 loop of the 999. • This loop will identify which transactions within a functional group contained errors, and will NOT be forwarded for further processing. • Corrections will need to be made and the transaction resubmitted.

The table above presents 999 acknowledgment codes illustrating accept or reject conditions based on the syntax editing of the transaction set or functional group (005010X231).

999 – 1.4

- Usage Recommendations:
  - A 999 will be sent from a receiver to a sender only if the sender uses a v5010 X12 transaction format.
    - There is no way to send a 999 from a CH to a sender if the sender submits another format.

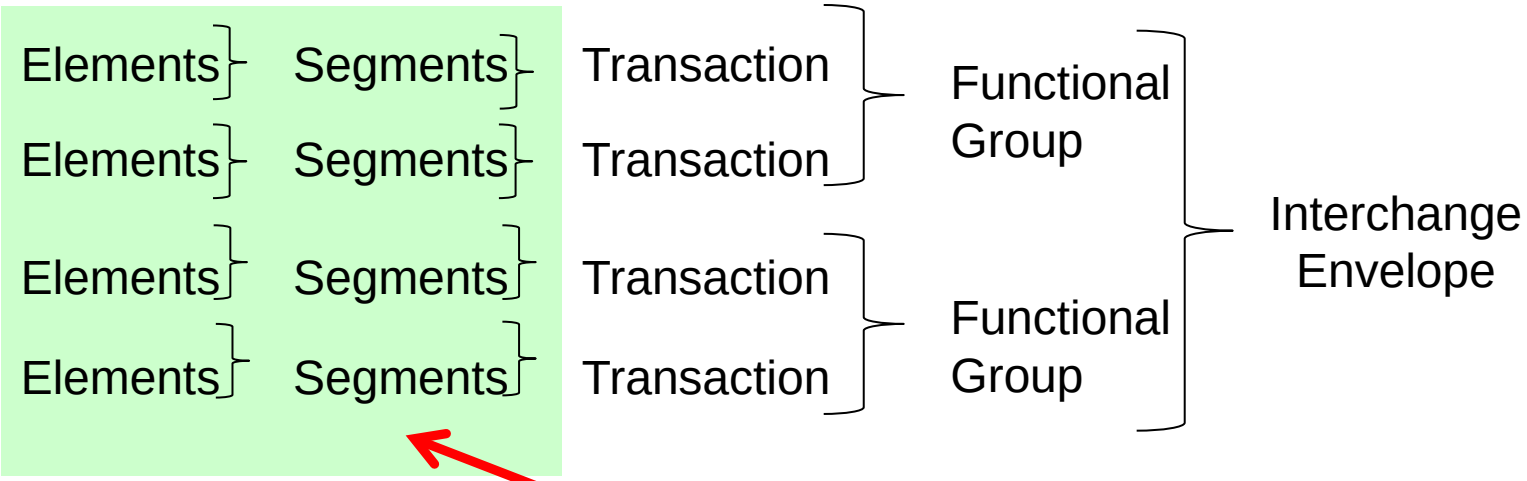
277CA

Source: Slides 28 through 30 based on or adapted from 005010X214 4

- Business Purpose
  - Acknowledges the validity and acceptability of claims at the pre-processing stage
  - Indicates Accepted or Rejected into the adjudication system (not pended)
  - This transaction is instrumental in tracking claim submissions through to payer adjudication.
  - The 277CA will be used to replace proprietary error reporting

Return to Table

277CA 1.1



277CA:

- Is the only notification of pre-adjudication claim status.
- Reports errors such as:
  - “missing the rendering provider number”; “source of payment (claim filing indicator) was not valid”; “date of service was either missing or invalid”; “claim was submitted to the wrong payer”;
- Does not report final adjudication of claims.
  - Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to claims processing guidelines. Final adjudication of claims is reported in the 835.

277CA 1.2

- Business Usage
  - The 277CA should be created by the receiver of the 837 transaction set to acknowledge units of work.
  - Acknowledgment responses can be at the transaction set, provider, or claims/encounter, dependent upon whether or not it is accepted or rejected.

Addressing Problems/Errors – General Guidelines

Type of Problem/ Error	Acknowledgement to use	Follow-up/Action to be Taken
Technical Problems	Generally, **use the TA1 or 999 to reflect technical problems** that must be addressed by changes in the software used in preparing the EDI transmission.	• These problems will likely be addressed by technical resources to identify corrections needed before resubmission.
Data Problems	The **277CA reflects a data problem** that must generally be addressed by resources in the Provider office.	• Provider staff will likely need reports to be produced using the 277CA transaction in order to identify corrections before resubmission. • Clearinghouses and Vendors may consider offering a 277CA reporting capability.

Addressing Problems/Errors – 999

Acknowledgment	Actions
When a 999R (Rejected) is received	• Recognize that syntax/guide errors occurred and begin a correct/resubmit action.
When a 999E (Accepted with Errors) is received	• While all transactions were accepted, recognize that there were errors and they should be corrected before your next submittal; • Watch for additional acknowledgment detail for claim submissions on the 277CA .
When a 999P (Partial) is received	• Correct the transaction in error and send back all data within the ST-SE that rejected.
Note: The receiver of a 999 does not respond with another 999 acknowledgement because the 999 does not require any additional acknowledgments.	

Addressing Problems/Errors - **277CA**

Acknowledgment	Action
When a 277CA is received [with errors]	• Recognize that business rule errors occurred and begin a correct/resubmit action on specific units of work; • Recognize that each claim level (CLM) unit was either accepted or rejected; • You may receive a claim number (ICN) in the REF (1K) segment that is to be used in future claims inquiries.
Note: It is recommended that a receiver of a 277CA send a 999 to acknowledge receipt.	

Quick recap – Recommended usage best practices

- Only send the TA1 when the interchange is noncompliant and is rejected
  - Senders of transactions set the ISA14 to zero
- When possible, when receiving a claims transaction, send both the 999 and the 277CA
- Also --
  - Acknowledge a 277CA with 999
  - Do not acknowledge a 999 with another 999 (to avoid endless looping of acknowledgments)
- See scenarios in the following section for examples

IV. Acknowledgement Scenarios

Introduction to Best Practice Scenarios

- The following scenarios do not depict all flows or acknowledgments that may occur in the exchange of transactions.
- The intent of the depicted flows is to provide a best practice model to be used when planning your acknowledgment process.

837 Claims Acknowledgement Scenarios

Acknowledgement Scenarios for Claims (837)

Scenario	Transaction	Claim Status
Scenario A (slide 38)	Provider to Payer (X12)	No Errors
Scenario B (slide 39)	Provider to CH (proprietary), CH to Payer (X12)	No Errors
Scenario C (slides 40-42)	Provider to CH (proprietary), CH to CH (X12), CH to Payer (X12)	No Errors
Scenario D (slide 43)	Provider to CH (proprietary), CH to Payer (X12)	Accepted with Errors

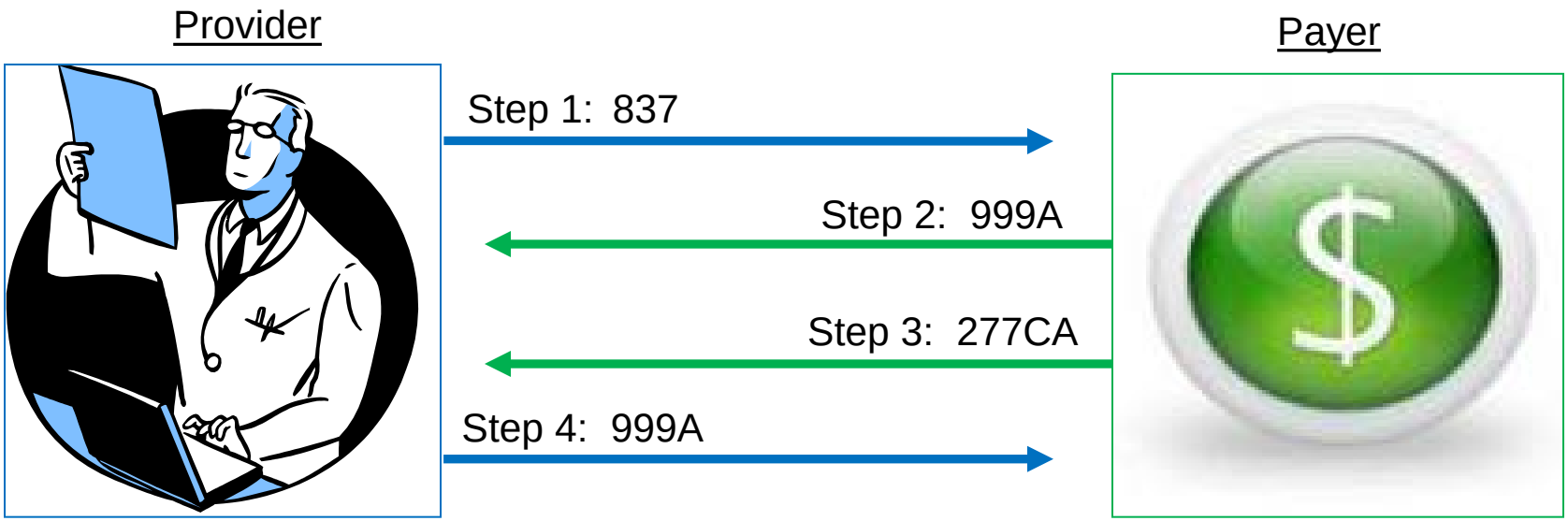
More to follow …

Table 1: Acknowledgement Scenarios for Claims (837)

Test Case	Transaction	Claim Status
Scenario E (slide 44)	Provider to Payer (X12)	Errors on First Transaction But Not Second Transaction
Scenario F (slide 45)	Provider to Payer (X12)	Errors on First and Second Transaction
Scenario G (slide 46)	Provider to CH, CH to Payer (X12)	With Errors

Scenario A:

Provider submits claim directly to Payer – No Errors



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer acknowledges transaction set has completed ST/SE edits and sends 999A to Provider. (As per slide 16 recommendation above, the TA1 should only be sent when the interchange is noncompliant and the transaction is rejected.)

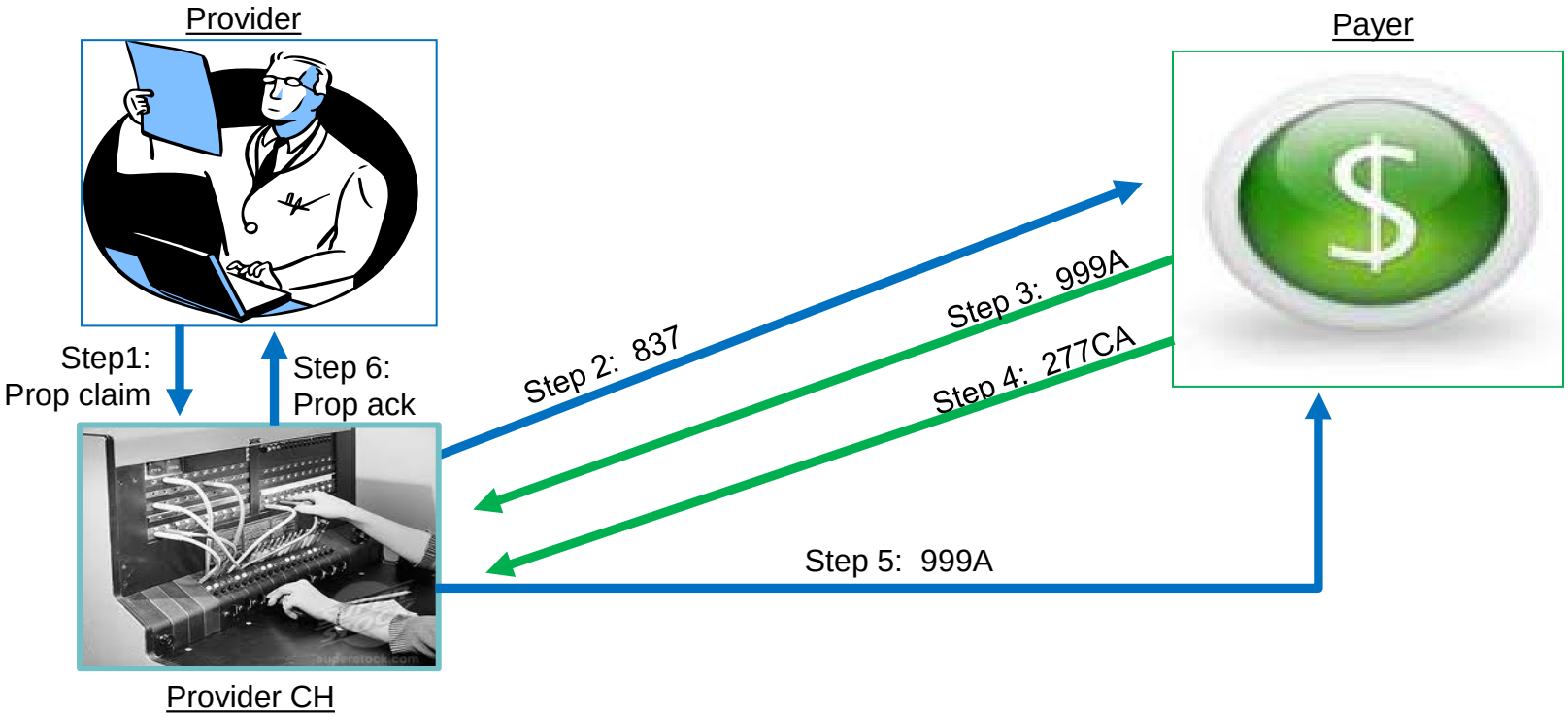
Step 3: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 4: Provider acknowledges 277CA and sends 999A. (Per slide 28 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario B:

Provider to CH (proprietary), CH to Payer (X12) – No Errors



Step 1: Provider submits proprietary claim format to its Clearinghouse.

Step 2: Provider's Clearinghouse creates compliant electronic 837 and sends to Payer.

Step 3: Payer acknowledges transaction set received and sends 999A to Provider's Clearinghouse.

Step 4: Payer also sends Provider's Clearinghouse 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

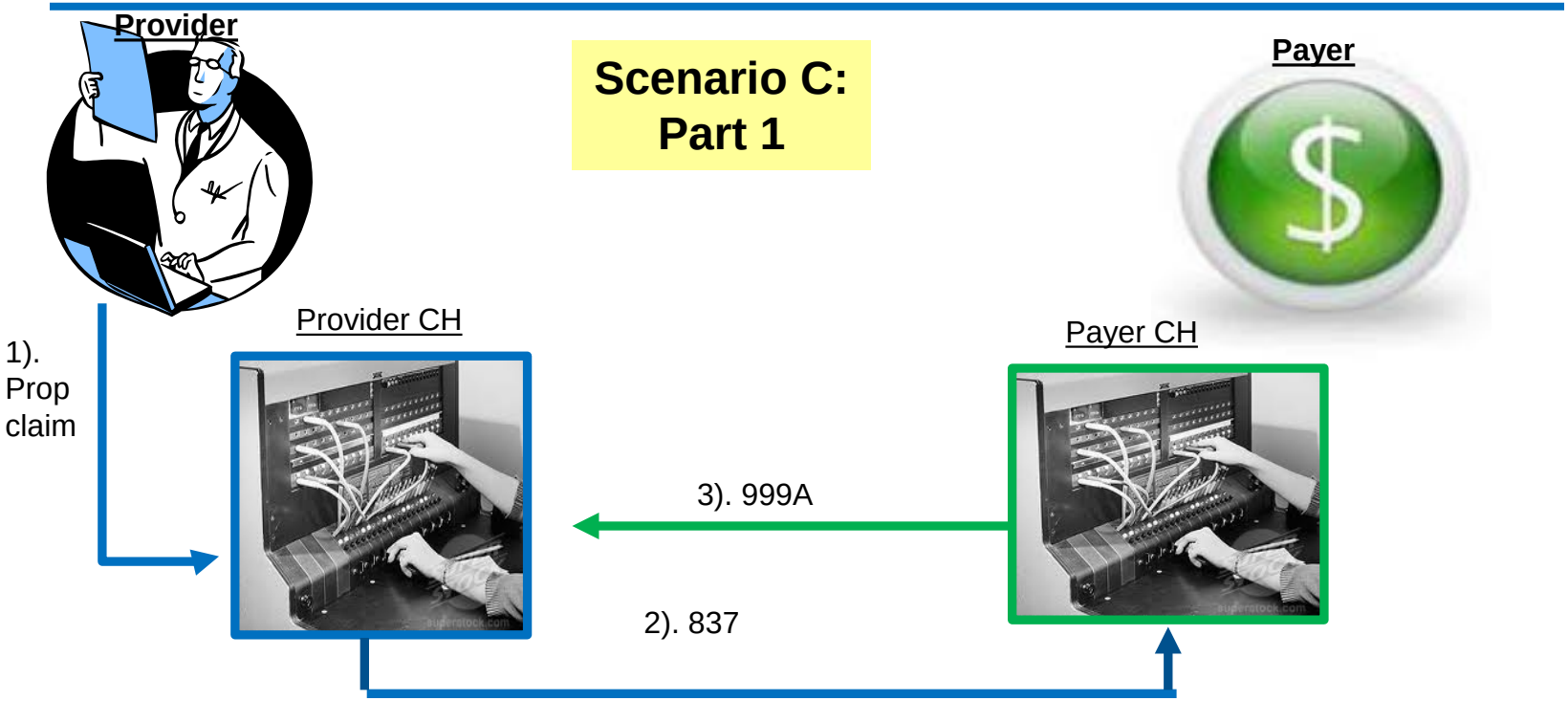
Step 5: Provider's Clearinghouse acknowledges 277CA and sends 999A to the Payer.

Step 6: Provider's Clearinghouse sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario C: Part 1- Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

Note: This is a longer scenario, presented in 3 parts.



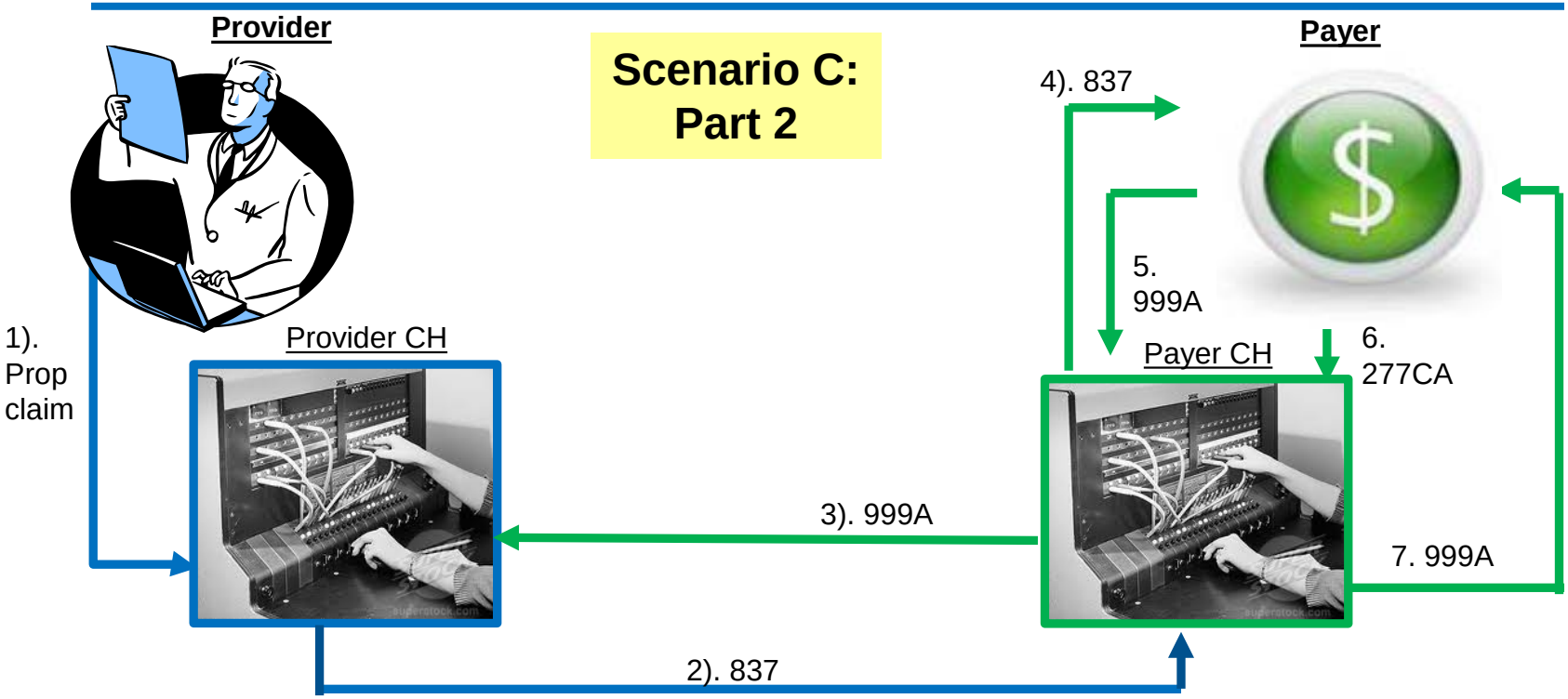
Step 1: Provider submits proprietary claim format to its CH.

Step 2: Provider CH creates compliant electronic 837 and sends to Payer's CH.

Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.

Scenario C: Part 2- Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

Note: This is a longer scenario, presented in 3 parts.



Step 1: Provider submits proprietary claim format to its CH.

Step 2: Provider CH creates compliant, electronic 837 and sends to Payer's CH.

Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.

Step 4: After receiving electronic 837 from Provider's CH, Payer's CH sends 837 to Payer.

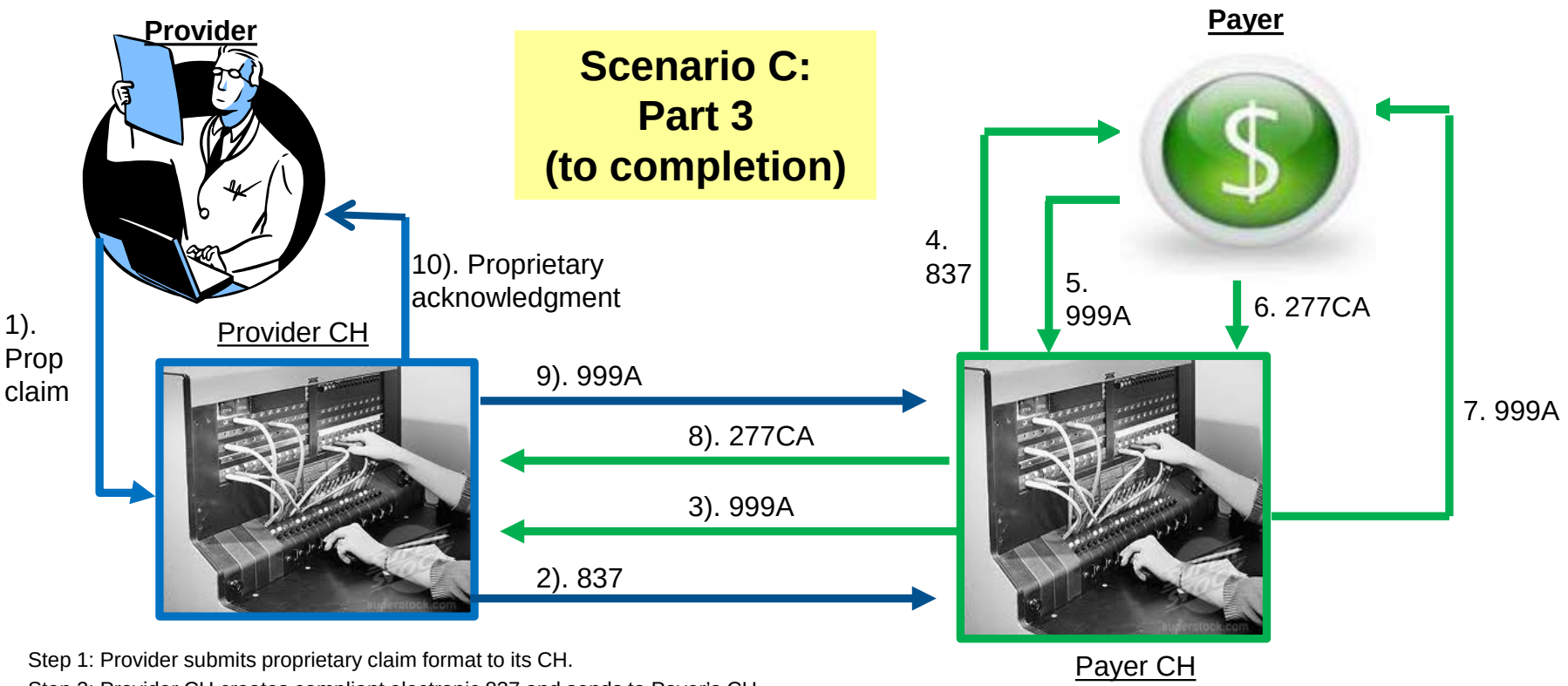
Step 5: Payer sends 999A to its CH acknowledging receipt of 837.

Step 6: Payer also sends 277CA to its CH.

Step 7: Payer's CH sends 999A to Payer. (General recommendation: send 999A in response to 277CA)

Scenario C: Part 3- Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

Note: This is a longer scenario, presented in 3 parts.



Step 1: Provider submits proprietary claim format to its CH.

Step 2: Provider CH creates compliant electronic 837 and sends to Payer's CH.

Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.

Step 4: Payer's CH repackages claims that were accepted and forwards transaction to the Payer.

Step 5: Payer sends 999A to its CH acknowledging receipt of 837.

Step 6: Payer also sends 277CA to its CH.

Step 7: Payer's CH sends 999A to Payer.

Step 8:The CH repackages 277CA from the Payer to match original 277CA transactions for claims sent to Payer in step 1 and sends repackaged 277CA to the Provider.

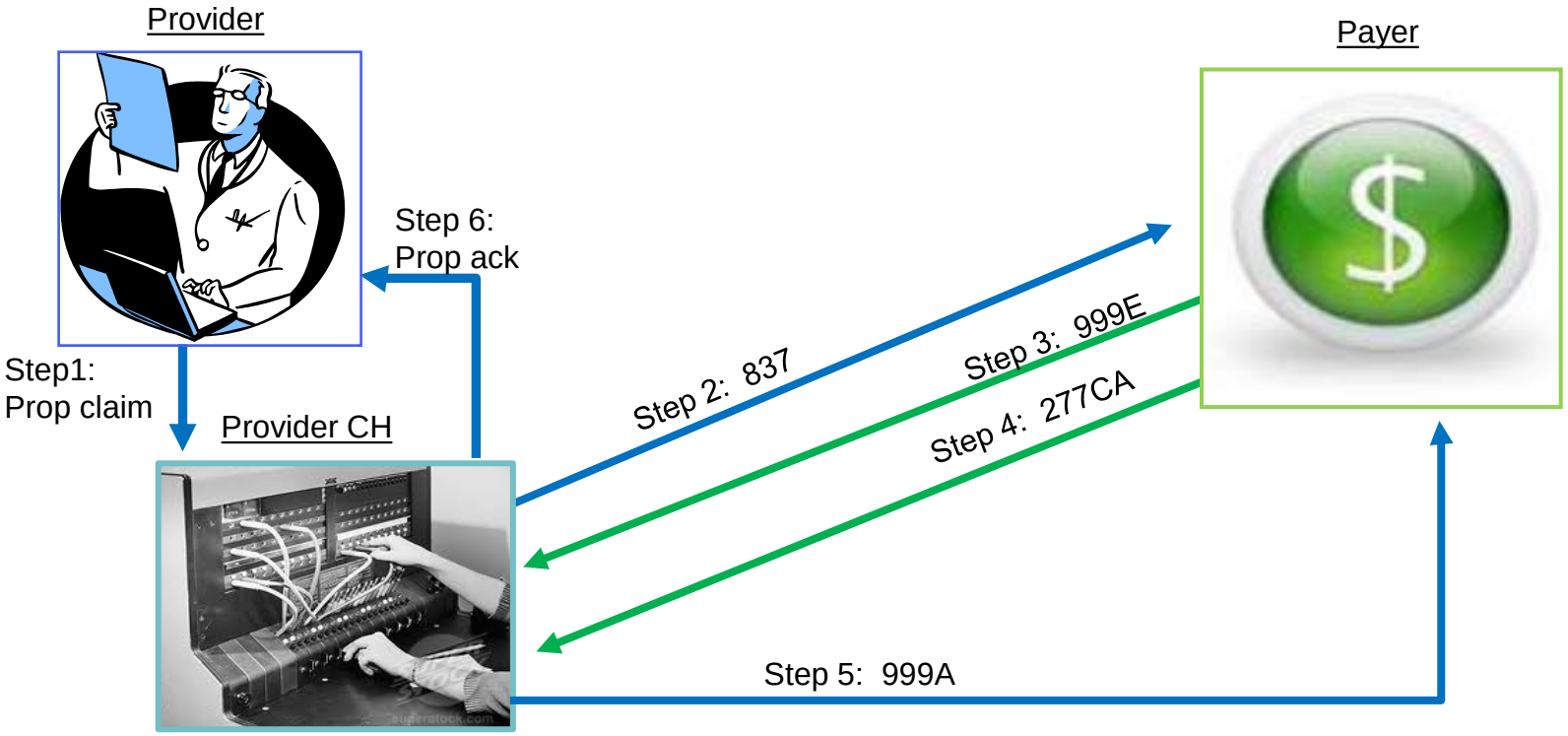
Step 9: Provider's CH responds with 999A to Payer's CH.

Step 10: Provider's CH sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario D:

Provider to CH (proprietary), CH to Payer (X12) – Accepted with Errors

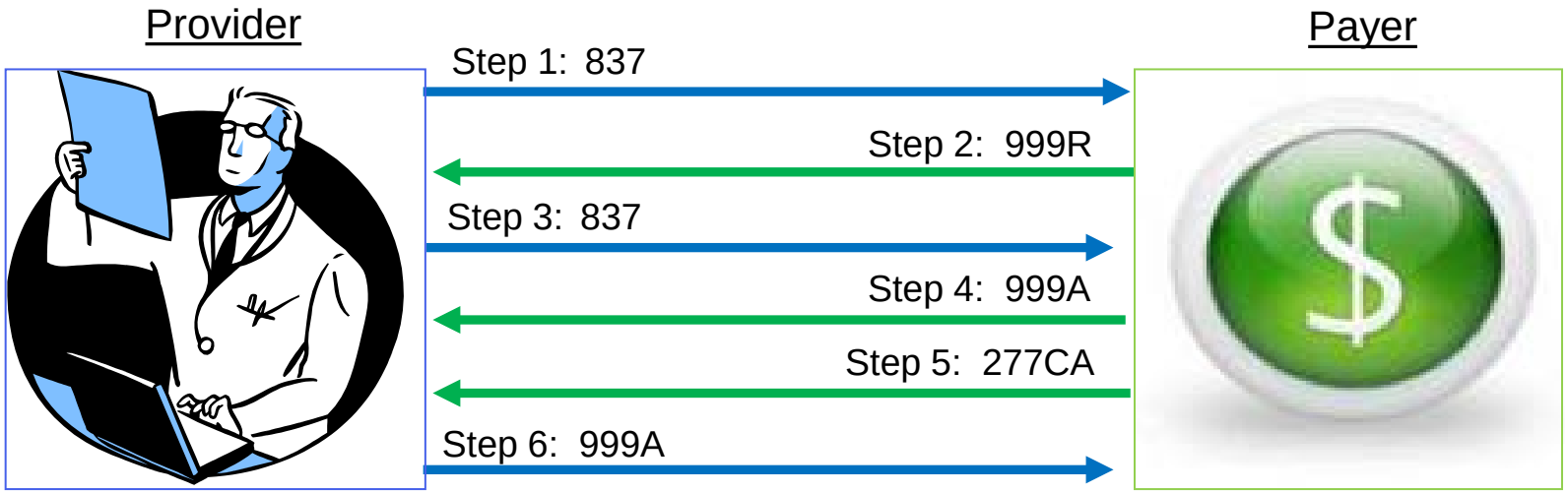


Step 1: Provider submits proprietary claim format to its Clearinghouse.
Step 2: Provider's Clearinghouse creates compliant electronic 837 and sends to Payer.
Step 3: Payer accepts transaction set with errors and sends 999E acknowledgement to Provider's Clearinghouse.
Step 4: Payer also sends Provider's Clearinghouse 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.
Step 5: Provider's Clearinghouse acknowledges 277CA and sends 999A to the Payer.
Step 6: Provider's Clearinghouse sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario E:

Provider submits claim directly to Payer – Errors on First Transaction but Not Second Transaction



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer rejects transaction set and sends 999R to Provider.

Step 3: Provider corrects errors and resubmits the 837 claim transaction.

Step 4: Payer sends Provider 999A acknowledgment.

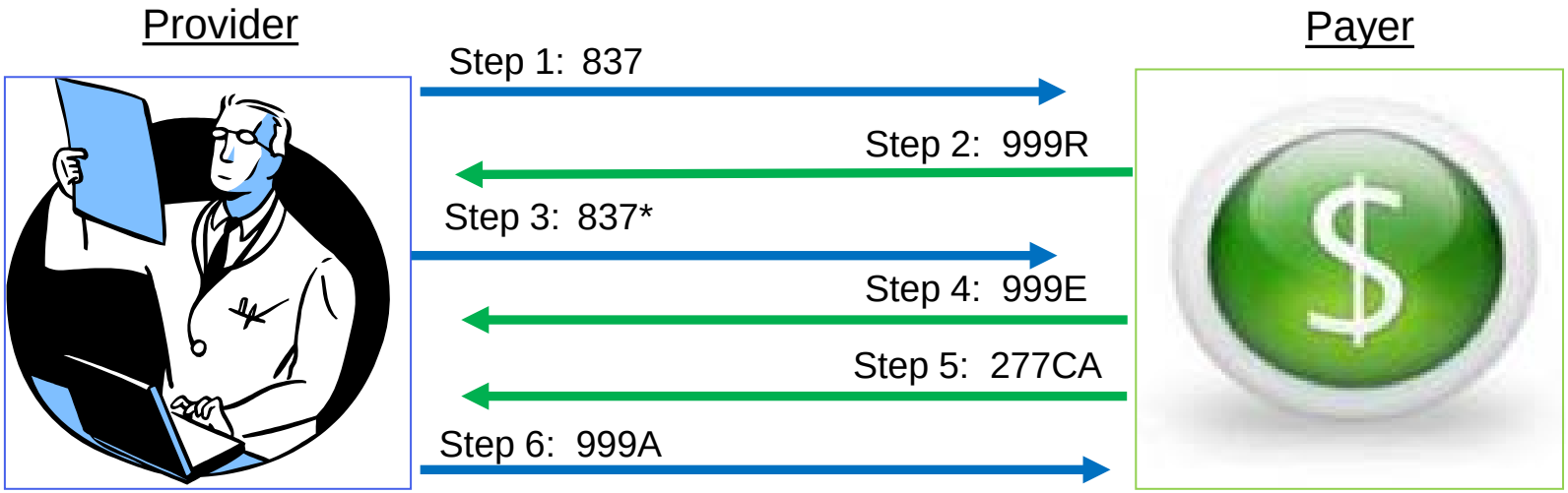
Step 5: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 6: Provider acknowledges 277CA and sends 999A. (Per slide 28 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario F:

Provider submits claim directly to Payer – Errors on First and Second Transactions



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer rejects transaction set and sends 999R to Provider.

Step 3: Provider corrects errors and resubmits 837 claims.

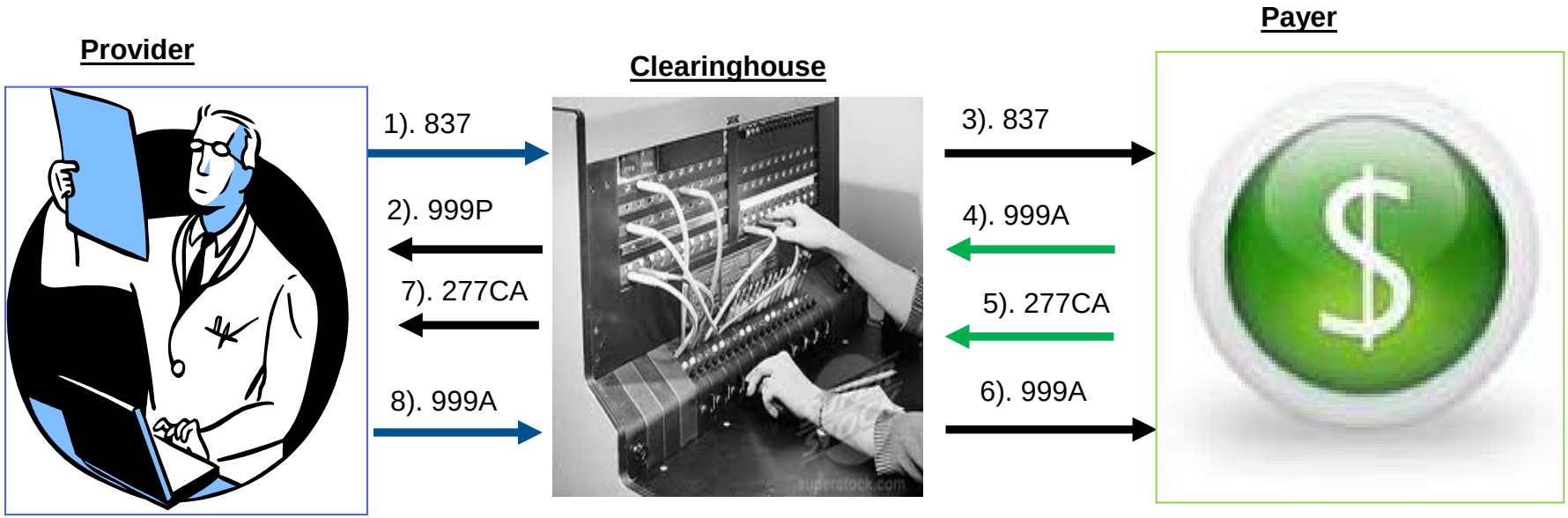
Step 4: Payer sends Provider 999E, acknowledging there are still errors on the second transaction set.

Step 5: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 6: Provider acknowledges 277CA and sends 999A. (Per slide 28 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario G:
Provider to CH, CH to Payer – With Errors



Step 1: Provider sends seven transactions, one claim per transaction to CH.
Step 2: CH responds with 999P to indicate partial acceptance; in this scenario, it has accepted two of the Provider's seven claims and rejected five.
Step 3: CH repackages the two claims that were accepted and forwards them as one transaction to the Payer.
Step 4: Payer acknowledges transaction set has completed ST/SE edits and sends 999A to CH.
Step 5: Payer also sends CH a 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.
Step 6: The CH responds to the Payer's 277CA with a 999A to the Payer.
Step 7: The CH repackages 277CA from the Payer to match original 837 transactions for claims sent to Payer in step 1 and sends repackaged 277CA to the Provider.
Step 8: The Provider responds to the 277CA with a 999A to the CH.

Return to Table 1

835 Remittance Advice Acknowledgement Scenarios

Table 2: Acknowledgement Scenarios for Remittance Advices (835)

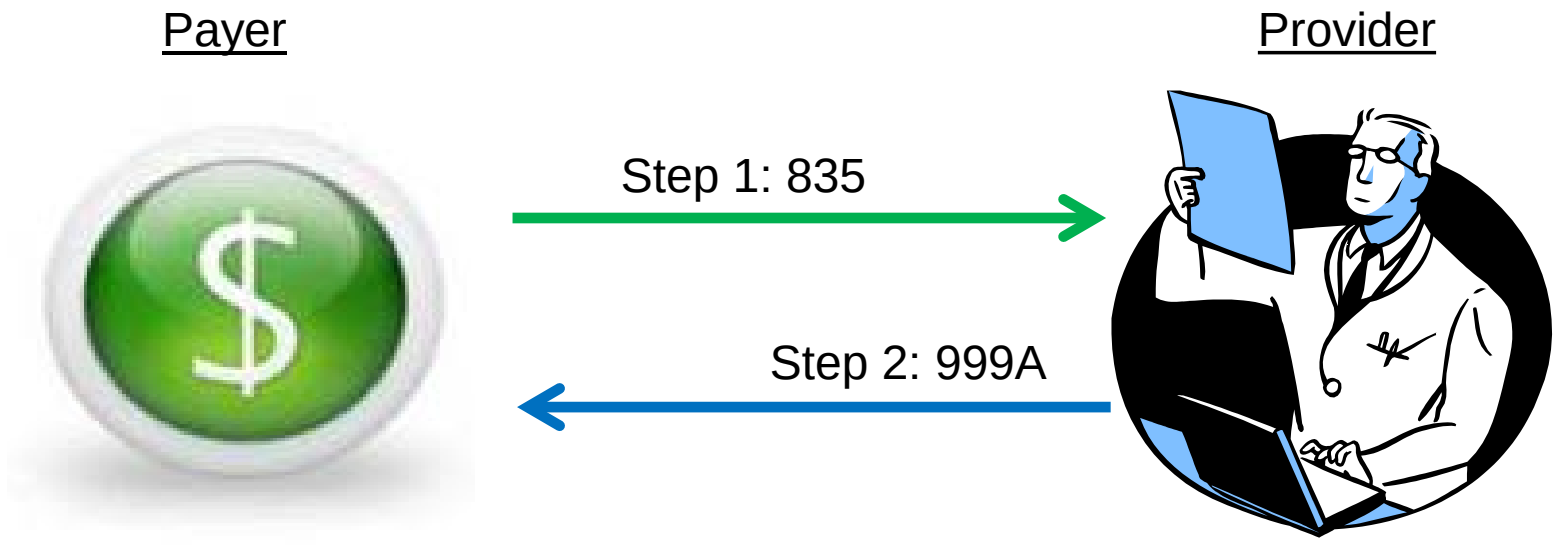
Scenario	Transaction	Claim Status
Scenario A (slide 50)	Payer to Provider	No Errors
Scenario B (slide 51)	Payer to Provider	Accepted with Errors
Scenario C (slide 52)	Payer to Provider	Reject Interchange
Scenario D (slide 53)	Payer to Provider	Reject Transaction

More to follow…

Acknowledgement Scenarios for Remittance Advices (835) – Cont.

Test Case	Transaction	Claim Status
Scenario E (slide 54)	Payer to Payer CH to Provider	No Errors
Scenario F (slide 55)	Payer to Payer CH to Provider CH to Provider	No Errors
Scenario G (slide 56)	Payer to Provider CH to Provider	No Errors

Scenario A:
Remittance: Payer to Provider – No Errors

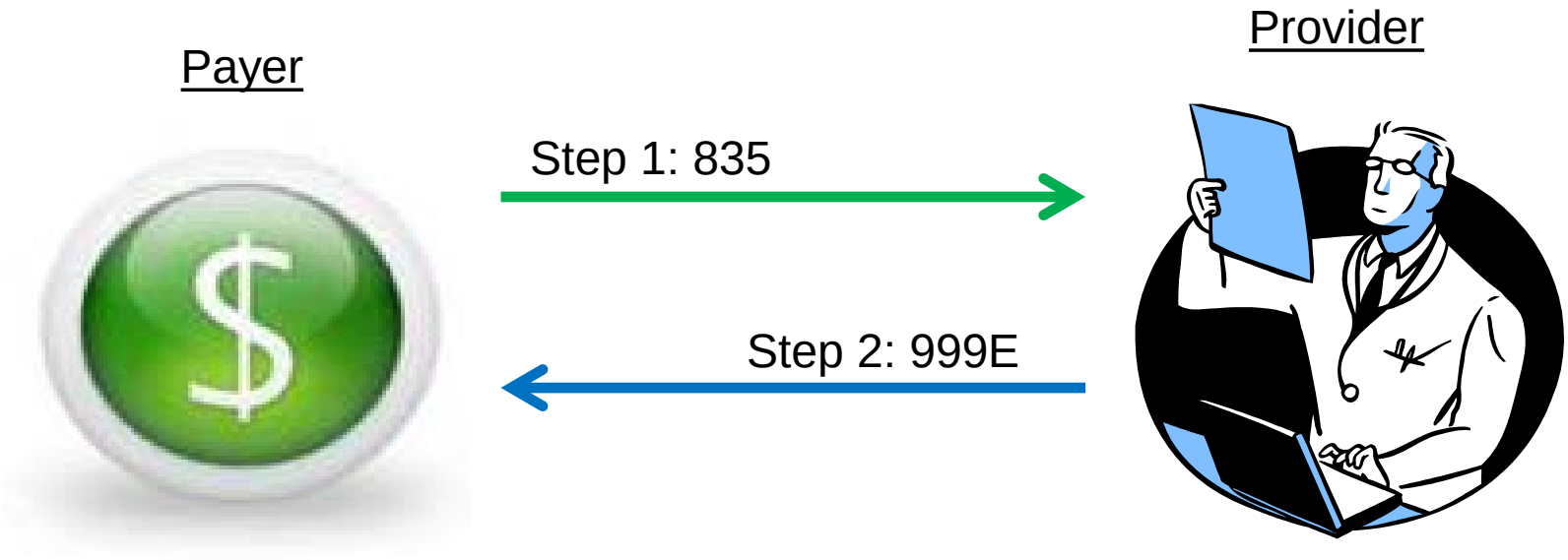


Step 1: Payer sends 835 remittance (transaction set) to Provider.

Step : Provider sends 999A to Payer to acknowledge file or transaction set has completed ST/SE edits.

Return to Table 2

Scenario B:
Remittance: Payer to Provider – Accepted with Errors

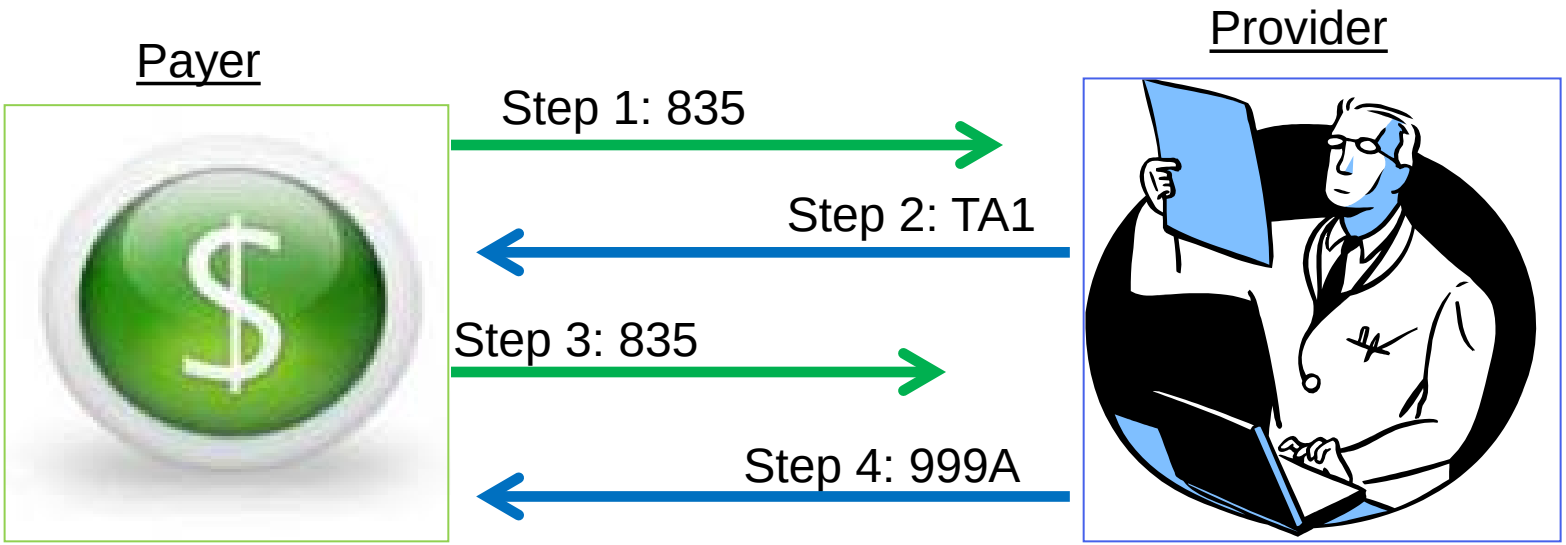


Step 1: Payer sends remittance to Provider in compliant format.

Step 2: Provider 999E to acknowledge that the transaction set is accepted but there are errors which are reported in the AK2 loop of the 999.

Return to Table 2

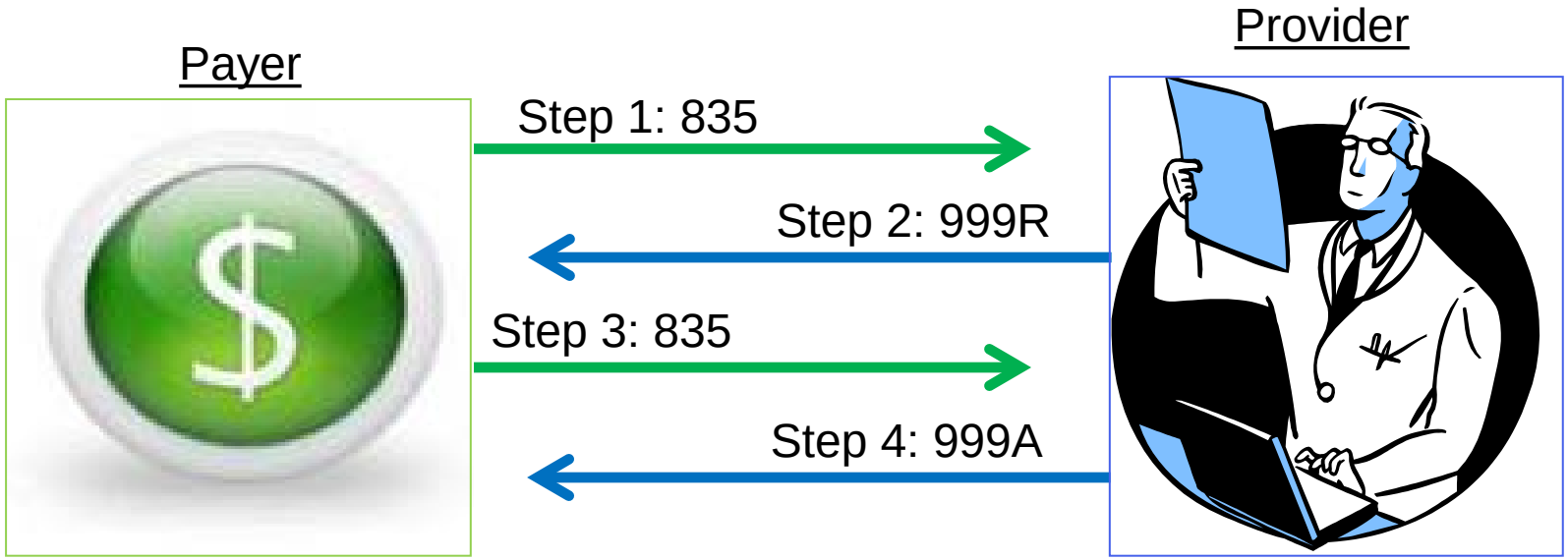
Scenario C:
Remittance: Payer to Provider – Reject Interchange



Step 1: Payer sends 835 remittance to Provider in compliant format.
Step 2: Provider reports a problem at the interchange and submits a TA1 report to Payer.
Step 3 Payer corrects the problem and resubmits the file to Provider.
Step 4: Provider accepts the file and sends 999A to Payer.

Return to Table 2

Scenario D:
Remittance: Payer to Provider – Reject Transaction



Step 1: Payer sends 835 remittance to Provider in compliant format.

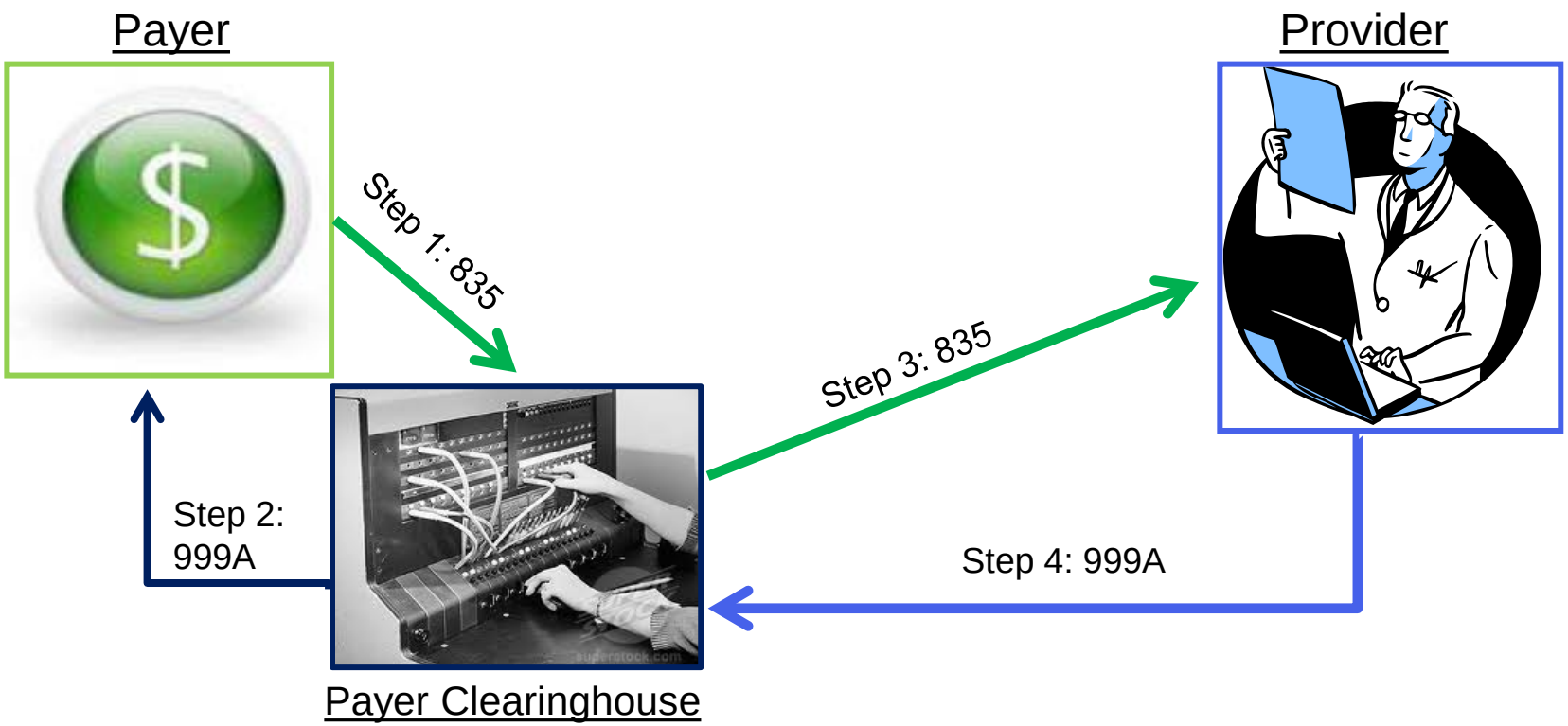
Step 2: Provider rejects the transaction and sends 999R acknowledgment to Payer.

Step 3: Payer corrects the problem and resubmits file to Provider.

Step 4: Provider accepts the file and sends 999A acknowledgment to Payer.

Return to Table 2

Scenario E:
Remittance: Payer to Payer CH to Provider – No Errors



Step 1: Payer sends 835 remittance to Payer CH in non-compliant format.

Step 2: Payer CH sends 999A acknowledgment to Payer.

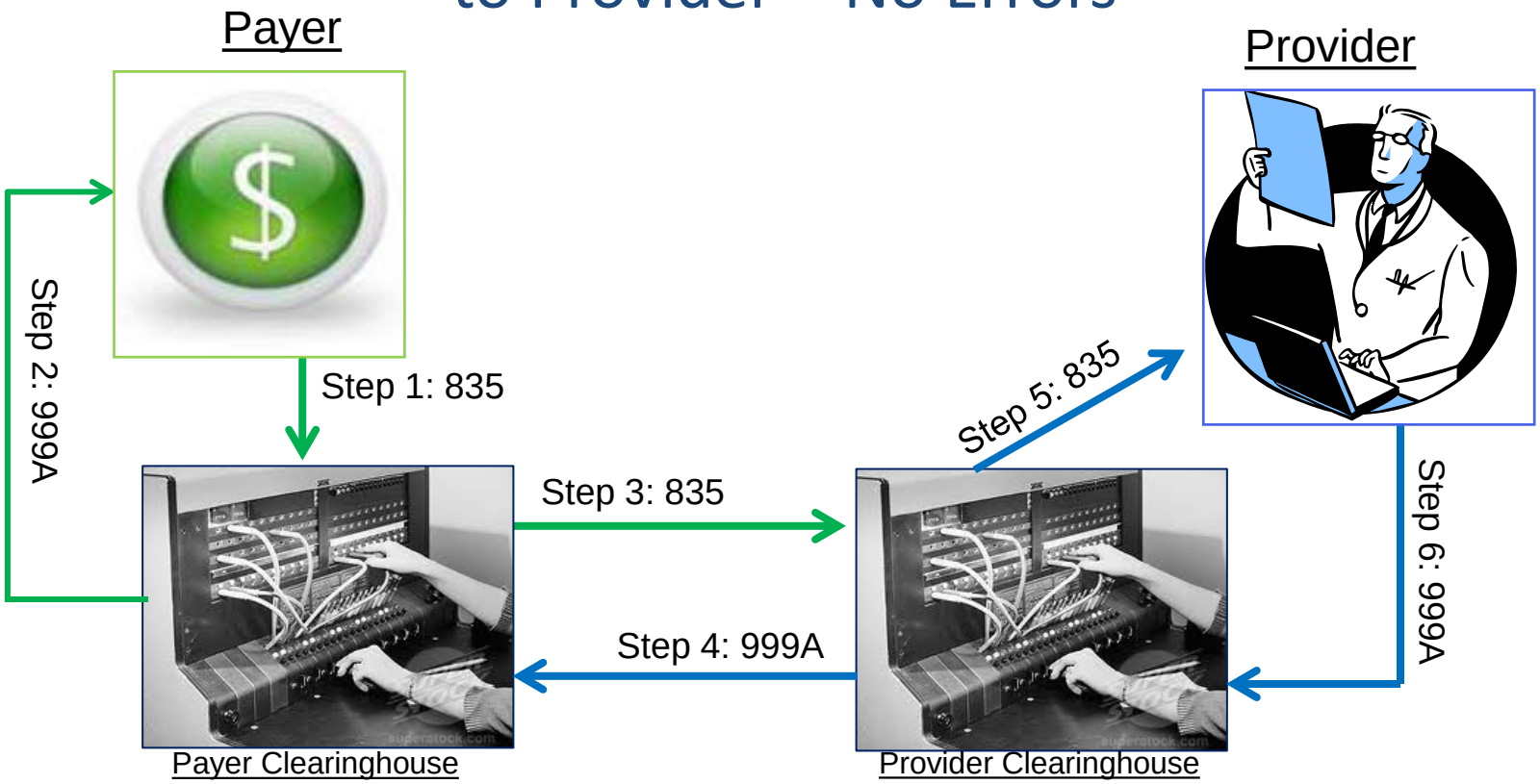
Step 3: Payer CH re-envelopes the data it received from the Payer and sends to Provider.

Step 4: Provider sends 999A acknowledgment to Payer CH.

Return to Table 2

Scenario F:

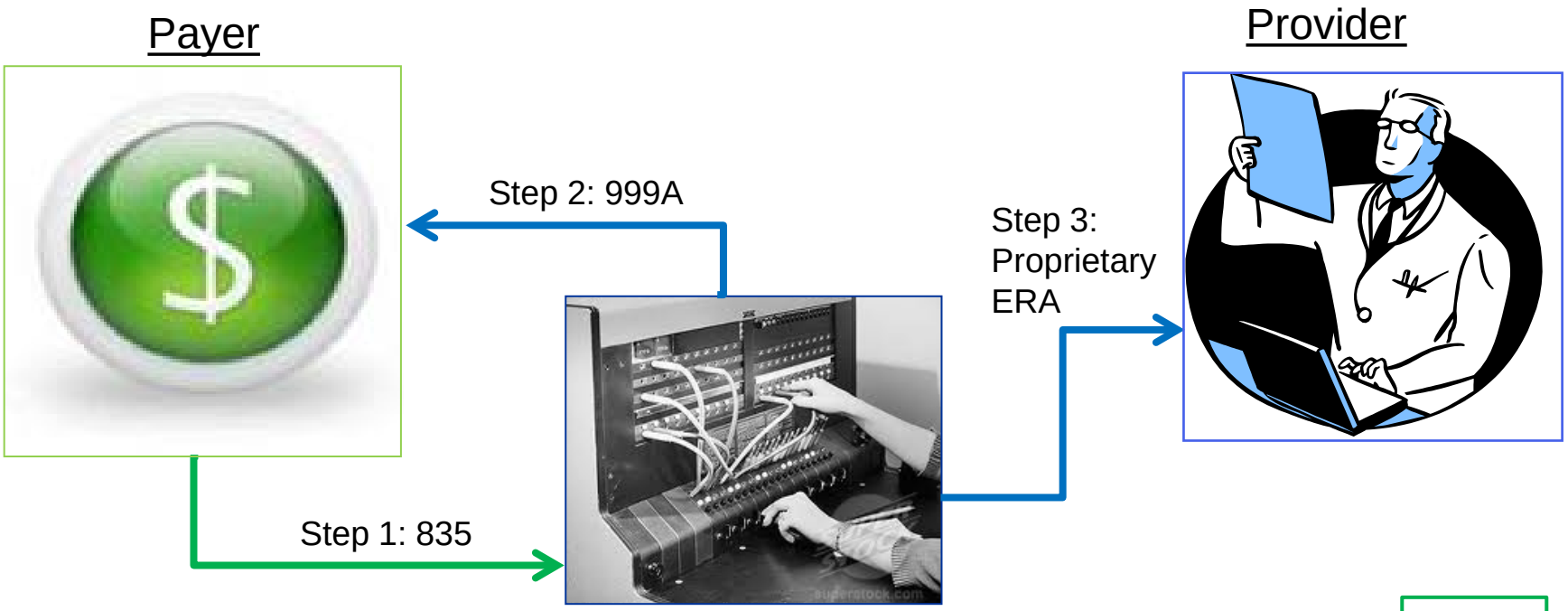
Remittance: Payer to Payer CH to Provider CH to Provider – No Errors



Step 1: Payer sends 835 remittance to Payer CH in non-compliant format.
Step 2: Payer CH sends 999A acknowledgment to Payer.
Step 3: Payer CH re-envelopes the data it received from the Payer and sends 835 remittance to Provider CH.
Step 4: Provider CH sends 999A acknowledgment to Payer CH.
Step 5: Provider CH re-envelopes the data received from Payer CH and sends 835 remittance to Provider.
Step 6: Provider sends 999A acknowledgment to Provider CH.

Return to Table 2

Scenario G:
Remittance: Payer to Provider CH to Provider – No Errors



Return to Table 2

Step 1: Payer sends 835 remittance to Provider CH in compliant format.

Step 2: Provider CH sends 999A acknowledgment to Payer.

Step 3: Provider CH re-envelopes the data it received from the Payer and sends Proprietary ERA to Provider .

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   Washington Publishing Company, January 2007
   <http://www.wpc-edi.com>. 8-9.