



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Subject: EDI Clearinghouse Trading Partner instructions for BCBSM's new e-Prescribing (e-RX platform)

Thank you for expressing interest in accessing BCBSM's e-RX platform. Our e-RX platform is designed to provide eligibility which includes drug formularies and drug history for BCBSM and BCN members. NASCO information is available from RxHUB only.

Here are some steps that should be followed for connecting to BCBSM's e-RX platform:

- Sign TPA (Trading Partner Agreement).
- Test 270/271 (without XML wrapper).
- Contact EDI Business when testing is complete and passed.
- EDI Business will review passed test and approve.
- EDI Business will provide instructions for submitting e-RX and NCPDP transactions to BCBSM.
- EDI Business will monitor the first 270/271 and NCPDP transactions.

Please contact Robin Spielman with any questions pertaining to our e-RX platform, our e-Prescribing companion document or the steps outlined above; her number is 248-486-2422.

Sincerely,

A handwritten signature in black ink that reads 'Wanda Brideau'. The signature is written in a cursive, flowing style.

Wanda Brideau
Manager, Electronic Trading Partner Service and Support
(EDI Business Team)

American National Standards Institute (ANSI) ASC X12N 270/271 (004010X092A1) Health
Care Eligibility Benefit Inquiry and Response and NCPDP SCRIPT version 8.1
**Blue Cross Blue Shield of Michigan HIPAA
Companion Document for *e-Prescribing***

Published January 2008



Table of Contents

Table of Contents 1
Introduction 2
Telecommunication Options 2
System Availability 2
ANSI ASC X12N 270/271 (004010X092A1) – Reporting Instruction Clarifications 3
 General Overview 3
 Hierarchical Structure 3
 Supported Business Functions 3
 Information Linkage 4
 HIPAA Usage 4
 Search Options 4
 Maximums/Limitations 5
 Rejected Transactions 5
Eligibility Benefit Inquiry and Response 270/271 Interchange Envelope and Functional Group Structure 5
Eligibility Benefit Inquiry 270 Transaction Set Data Clarifications 6
Eligibility Benefit Response 271 Transaction Set Data Clarifications 8
NCPDP SCRIPT Version 8.1 Standard – Reporting Instruction Clarifications 9
 General Overview 9
 Identifiers 9
 Supported Business Functions 9
 Transaction (Message) Types 9
 Segment Layout for the RXHREQ Transaction (Message) 10
 Segment Layout for the RXHRES Transaction (Message) 10
 Segment Layout for the ERROR Transaction (Message) 10
 Rejected Transactions 11
NCPDP SCRIPT RXHREQ and RXHRES Interchange and Message Header Identifiers 11
NCPDP SCRIPT RXHREQ Transaction (Message) Clarifications 12
General EDI Terminology 12

Introduction

This document is the property of Blue Cross Blue Shield of Michigan and is for use solely in your capacity as a trading partner of health care transactions with BCBSM.

This document provides information related to specific elements within the addenda version of the ANSI ASC X12N 270/271 transactions, but:

- It does not change the definition, data condition, or use of a data element or segment in a standard.
- It does not add data elements or segments to the maximum defined data set.
- It does not use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s).
- It does not change the meaning or intent of the HIPAA standards implementation specifications.¹

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N 270/271 transaction set Addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company. Implementation guides can be downloaded from the Washington Publishing Company web site at wpc-edi.com.

It also provides information related to the version 8.1 NCPDP SCRIPT Standard which is used for requesting drug history and the subsequent response. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable NCPDP Prescriber/Pharmacist Interface SCRIPT Standard Implementation Guide published by the National Council for Prescription Drug Programs.

This document is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the BCBSM web site: bcbsm.com

Appropriate steps must be taken before submitting production addenda ANSI ASC X12N or NCPDP transactions, such as testing, completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please contact the EDI Help Desk at 800-542-0945 (choose **marketing** option).

Telecommunication Options

The 270/RXHREQ messages are sent in an XML wrapper to BCBSM and the 271/RXHRES messages are returned in an XML wrapper from BCBSM.

System Availability

The system is available 24 hours per day, 7 days per week with the exception of 8:00 p.m. through 10:00 p.m. each Sunday.

¹Standards for Electronic Transactions, *Federal Register*, Vol. 65, No. 160, August 17, 2000 pg. 50368

ANSI ASC X12N 270/271 (004010X092A1) – Reporting Instruction Clarifications

General Overview

The addenda version of the ANSI ASC X12N 270/271 transaction sets was selected as the format to meet HIPAA requirements for electronic eligibility benefit inquiries and responses. They were designed so that inquiry submitters (information receiver) can determine:

- Whether an information source organization (e.g. payer) has a particular subscriber or dependent on file.
- The healthcare eligibility and/or benefit information about that subscriber and/or dependent(s).

The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use.

BCBSM has chosen to implement exchange of the addenda ANSI ASC X12N 270/271 transaction sets as a real-time application. When related to e-prescribing, Eligibility and benefit inquiries will be available for drug coverage inquiries for BCBSM Local, Medicare Advantage and BCN members.

Hierarchical Structure

The hierarchical structure identifies relationships between the information source, information receiver, subscriber and dependent.

- The information source is the entity that has the answer to the questions being asked in the inquiry. It is typically an insurer or payer.
- The information receiver is the entity who is asking the questions in an inquiry. It is typically the medical service provider.
- The subscriber is a person who can be uniquely identified to an information source. The subscriber may or may not be the patient.
- The dependent is a person who cannot be uniquely identified to an information source, but can be identified when associated with a subscriber.
- The patient can be either the subscriber or the dependent. The policy holder would be considered the subscriber. Related dependents are identified through the subscriber.

Supported Business Functions

The ANSI ASC X12N 270/271 transaction sets support general, categorical and specific requests and responses. The detail of the health care eligibility or benefit information being requested by the inquiry submitter from the information source organization is identified in an inquiry data segment. The response is based on a business agreement with the inquiry submitter and what information is available to provide.

Eligibility inquiries relating to e-prescribing will be limited to Service Type Codes 88 (Pharmacy) and 90 (Mail Order Prescription Drug) and allows for a service date (DTP01 = 472) to be reported for either the subscriber or dependent. Eligibility responses will provide active coverage (EB01 = 1) or inactive (EB01 = 6) along with the date range of eligibility (DTP01 = 307).

Multiple response transactions (ST through SE) will be returned if a patient match is made to more than one BCBSM/BCN contract.

Information Linkage

The Submitter Transaction Identifier is used to identify the transaction at a high level. It is particularly useful in reconciling 271 reject transactions that may not contain all of the hierarchical loops and must always be returned.

The information source may also create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels. It is optional, and will not be used in this process.

HIPAA Usage

The HIPAA defined implementation guide represents its full functionality but does not necessarily represent the business needs of an individual provider, payer or other trading partner. The guide identifies the framework an information source can utilize. HIPAA requires information sources to support an eligibility transaction, either directly or through a clearinghouse. The guide also identifies the minimum an information source or clearinghouse is required to support in order to offer a compliant ANSI ASC X12N 270/271 transaction set. The minimum requirements are detailed below:

270 – The information source must support a generic request for eligibility.

271 – The information source must respond with either an acknowledgement that the individual has active or inactive coverage or that the individual was not found in their system.

Search Options

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify the patient are:

- Patient's member ID
- Patient's first name
- Patient's last name
- Patient's date of birth

If all four of these elements are present, the information source must generate a response if the patient is in their database. All information sources are required to support this search option. For e-prescribing related eligibility inquiries,

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify the patient are:

- Subscriber's member ID
- Patient's first name
- Patient's last name
- Patient's date of birth

If all four of these elements are present, the information source must generate a response if the patient is in their database.

BCBSM is not requiring submission of the Patient's/Subscriber's member ID. However, to ensure a unique match to an individual member you are encouraged to report it. If it is not present, an alternate search option will be invoked and available data elements will be used to make a unique member match.

Maximums/Limitations

There may be some situations when not all of the above listed pieces of information are available. In that case, the 270 inquiry may be sent with as many of those pieces of information that are available as well as any other items identified in the transaction. The information source should attempt to look up the patient if there is a reasonable amount of information present. An information source may outline additional search options available in their Trading Partner Agreement; however under no circumstances may they require the use of a search option that differs from those outlined above. The dependent loop (Loop 2100D) will currently be accepted on 270 transactions. However, at this time the 271 transaction will return only the subscriber loop (Loop 2100C) with the patient's information whether the patient is the subscriber or a dependent.

Rejected Transactions

- A 271 response will include at least one Eligibility or Benefit Information (EB) segment or one Request Validation (AAA) segment. The only rejection that will be returned in an AAA segment is when the patient is not found (reject code 67).
- Other errors (e.g. system down or time out) will be returned as an error message. In this case a 271 transaction will not be returned.
- Reported submitter identification numbers will be validated. Transactions submitted for unauthorized submitters will be rejected.

Eligibility Benefit Inquiry and Response 270/271 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure guidelines for HIPAA that are located in the HIPAA Implementation Guide in appendices A and B. Trading partners should also follow the basic character set guidelines as noted in the Implementation Guide. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for populating specific data elements within the ISA and GS segments are:

Transaction Set	Element	Instruction	Imp Gde Pg #
Eligibility Benefit Inquiry 270	ISA05 – Interchange ID Qualifier	Report ZZ	B.4
Eligibility Benefit Inquiry 270	ISA06 – Interchange Sender ID	Report the 6 position e-prescribing EDI-assigned submitter ID.	B.4
Eligibility Benefit Inquiry 270	ISA07 – Interchange ID Qualifier	Report ZZ	B.4
Eligibility Benefit Inquiry 270	ISA08 – Interchange Receiver ID	Report 382069753	B.5
Eligibility Benefit Inquiry 270	ISA14 – Acknowledgement Requested	Report a value of 0. Acknowledgements will not be provided.	B.6
Eligibility Benefit Inquiry 270	GS02 – Application Sender's Code	Report the 6 position e-prescribing EDI-assigned submitter ID. Must be registered with BCBSM EDI.	B.8

Transaction Set	Element	Instruction	Imp Gde Pg #
Eligibility Benefit Inquiry 270	GS03 – Application Receiver’s Code	Report 382069753	B.8
Eligibility Benefit Inquiry 270	GS08 – Version/Release/Industry Identifier Code	Report 004010X092A1	B.9
Eligibility Benefit Response 271	ISA05 – Interchange ID Qualifier	ZZ will be returned from EDI	B.4
Eligibility Benefit Response 271	ISA06 – Interchange Sender ID	382069753 will be returned from EDI	B.4
Eligibility Benefit Response 271	ISA07 – Interchange ID Qualifier	ZZ will be returned from EDI	B.4
Eligibility Benefit Response 271	ISA08 – Interchange Receiver ID	The Interchange Sender ID from the inquiry transaction will be returned.	B.5
Eligibility Benefit Response 271	GS02 – Application Sender’s Code	382069753 will be returned	B.8
Eligibility Benefit Response 271	GS03 – Application Receiver’s Code	The Application Sender’s Code from the inquiry transaction will be returned.	B.8
Eligibility Benefit Response 271	GS08 – Version/Release/Industry Identifier Code	004010X092A1 will be returned	B.9

Eligibility Benefit Inquiry 270 Transaction Set Data Clarifications

Loop	Segment/Element	Instruction	Industry/Element Name
Header	BHT02	Code value 13 (Request) is the only transaction set purpose code that will be recognized.	Transaction Set Purpose Code
2100A	NM101	Report PR (Payer)	Entity Identifier Code
2100A	NM102	Report 2 (Non-Person Entity)	Entity Type Qualifier
2100A	NM108	Report PI (Payer Identification)	Identification Code Qualifier
2100A	NM109	Report a value of 382069753.	Information Source Primary Identifier
2100B	NM101	Report 1P (Provider)	Identification Code Qualifier
2100B	NM108	Report SV (Service Provider) or XX (NPI – National Provider Identifier)	Identification Code Qualifier

Loop	Segment/Element	Instruction	Industry/Element Name
2100B	NM109	<p>Professional BCBSM and BCN: Report the NPI or the 10-digit number assigned to the billing provider by BCBSM. If reporting the BCBSM/BCN legacy provider number, the first two positions must contain the specialty code, position 3 through 9 must equal the core provider ID and position 10 should equal the certification code. Medicare Advantage: Report the NPI or the assigned 7 digit Medicare B provider number.</p> <p>Institutional BCBSM and BCN: Report the NPI or the 5-digit facility code assigned to the provider by BCBSM. Medicare Advantage: Report the NPI or the assigned 6 digit Medicare A provider number.</p> <p>Dental Report the NPI or the dental provider code assigned to the provider by BCBSM.</p>	Information Receiver Identification Number
2100C	NM109	<p>Report the contract number of the subscriber in loop 2100C, if available.</p> <p>BCBSM Local, Medicare Advantage and BCN: Identification cards include three leading alphabetic characters. If so, report them followed by the nine-digit contract number. The member ID can continue to be entered without the alpha prefix.</p>	Identification Code
2100C	REF01	<p>BCBSM Local and BCN: To help protect our members security and to meet legislation requirement, BCBSM Local, Medicare Advantage and BCN replaced all Social Security Numbers with new randomly assigned contract numbers on members' ID cards and all correspondences. Therefore, we recommend that Social Security Numbers (Qualifier SY) are not reported. Medicare Advantage: Social Security Numbers (Qualifier SY) cannot be reported for any Federally administered program.</p>	Subscriber Additional Identification
2100C	N407	Reporting of the zip code may assist in making a unique member match, but is not required.	Subscriber Zip Code
2100C	DMG02	Report the birth date of the subscriber when the inquiry is for the subscriber.	Date Time Period
2100C	DTP01	Report 472 (Service) when the inquiry is for the subscriber.	Date/Time Qualifier
2100C	EQ01	Report applicable Service Type Codes of 88 and/or 90 if the inquiry is for the subscriber.	Service Type Code
2100D	Multiple	The dependent loop (Loop 2100D) will currently be accepted on 270 transactions. However, at this time the 271 transaction will return only the subscriber loop (Loop 2100C) with the patient's information whether the patient is the subscriber or a dependent.	Dependent Loop
2100D	REF01	<p>BCBSM Local and BCN: To help protect our members security and to meet legislation requirement, BCBSM Local, Medicare Advantage and BCN replaced all Social Security Numbers with new randomly assigned contract numbers on members' ID cards and all correspondences. Therefore, we recommend that Social Security Numbers (Qualifier SY) are not reported.</p>	Dependent Additional Identification
2100D	N407	Reporting of the zip code may assist in making a unique member match, but is not required.	Dependent Zip Code
2100D	DMG02	Report the birth date of the patient if the inquiry is for a dependent.	Date Time Period
2100D	DTP01	Report 472 (Service) when the inquiry is for a dependent.	Date/Time Qualifier
2100D	EQ01	Report applicable Service Type Codes of 88 and/or 90 if the inquiry is for a dependent.	Service Type Code

Eligibility Benefit Response 271 Transaction Set Data Clarifications

Loop	Segment/Element	Instruction	Industry/Element Name
2100C	NM109	Will be returned if a unique member match is made or if the member ID was reported in the 270 transaction.	Member ID Number
2100C	REF01	The following values will be returned: 18 (Plan Number) 1W (Members Identification Number) 6P (Group Number) IF (Issue Number) IG (Insurance Policy Number)	Reference Identification Qualifier
2100C	REF02	When REF01 = 18, the Plan Number will be returned. When REF01 = 1W, the members Identification Number will be returned. When REF01 = 6P, the Group Number will be returned. When REF01 = IF, the Formulary List ID will be returned. When REF01 = IG, the Co-pay ID will be returned.	Reference Identification
2100C	REF03	When REF01 = 18, the Plan Sponsor Name will be returned. When REF01 = 6P, the Group Name will be returned. When REF01 = IF, the Alternate List ID will be returned. When REF01 = IG, the Co-pay ID will be returned.	Description
2100C	N3 Segment	Will be returned if a unique member match is made even if not reported in the 270 transaction.	Street Address
2100C	N4 Segment	Will be returned if a unique member match is made even if not reported in the 270 transaction.	City, State and Zip Code
2100C	AAA03	A reject reason code value of 67 will be returned when the patient is not found.	Reject Reason Code
2100C	DTP01	The following code will be returned: 307 (Eligibility)	Date/Time Qualifier
2110C	EB01	One of the following codes will be returned: 1 – Active Coverage 6 – Inactive	Eligibility or Benefit Information
2110C	EB03	The following codes will be returned: 88 – Pharmacy 90 – Mail Order Prescription Drug	Service Type Code
2100D	Multiple	The dependent loop (Loop 2100D) will currently be accepted on 270 transactions. However, at this time the 271 transaction will return only the subscriber loop (Loop 2100C) with the patient’s information whether the patient is the subscriber or a dependent.	Dependent Loop

NCPDP SCRIPT Version 8.1 Standard – Reporting Instruction Clarifications

General Overview

SCRIPT is an NCPDP standard format created to facilitate the transfer of prescription data between pharmacies, prescribers, value added networks/switches/intermediaries and payers (or a third party administrator of their prescription drug program). For BCBSM's e-prescribing process only one of the three supported business functions will be supported which is the Medication History Function.

Medication History Request Transaction – A patient specific request, supplying enough information to uniquely identify the patient, from an entity to an entity requesting a list of medications that have been prescribed, dispensed, claimed or indicated (OTCs) by patient.

Medication History Response Transaction – Response from an entity to an entity to describe the patient's medication history. The medication history result includes the medications that were dispensed or obtained within a certain timeframe, optionally including the physician that prescribed it. The entity returns the prescriptions that fill the request criteria in the order of the most current if a timeframe was not provided. If a timeframe was provided, they will be returned starting with the end date.

The data included in the segments is subject to agreements between business partners as well as State and Federal laws.

Participating entities must ensure that appropriate security measures are in place to protect against fraud, abuse and patient confidentiality.

Identifiers

It is the prescriber's system, not the prescriber that is identified at the interchange level. For pharmacy claims processing, the BIN is commonly used to identify a payer.

Supported Business Functions

While the SCRIPT format has multiple uses, in this case it will be used to accept a drug history inquiry and provide the applicable response.

Transaction (Message) Types

RXHREQ – This indicates a message from an entity requesting medication history from an entity.

RXHRES – This message is a response from an entity to an entity to describe the patient's medication history. A RXHRES is the response to a request for medication history (RXHREQ). The entity must return the prescriptions that fill the request criteria in the order of the most recent date filled first. The entity must evaluate the Patient consent for accurate reporting.

ERROR – This transaction indicates an error has occurred indicating that the request was terminated. An ERROR can be generated when there is a communication problem or when the transaction actually has an error. The error is reported in the STS segment.

Segment Layout for the RXHREQ Transaction (Message)

The RXHREQ message consists of multiple segments which are outlined below:

UNA – Service String Advice
UIB – Interactive Interchange Control Header
UIH – Interactive Message Header
PVD – Provider Segment
PTT – Patient Segment
COO – Coordination of Benefits Segment
UIT – Interactive Message Trailer Segment
UIZ – Interactive Interchange Trailer Segment

Segment Layout for the RXHRES Transaction (Message)

The RXHRES message consists of multiple segments which are outlined below:

UNA – Service String Advice
UIB – Interactive Interchange Control Header
UIH – Interactive Message Header
RES – Response Segment
PVD – Provider Segment
PTT – Patient Segment
COO – Coordination of Benefits Segment

Drug Loop – Loops through up to 300 times.

DRU – Drug Segment
PVD – Provider Segment (Prescriber)
PVD – Provider Segment (Pharmacy)

UIT – Interactive Message Trailer Segment
UIZ – Interactive Interchange Trailer Segment

Segment Layout for the ERROR Transaction (Message)

The ERROR message consists of multiple segments which are outlined below:

UNA – Service String Advice
UIB – Interactive Interchange Control Header

UIH – Interactive Message Header
STS – Status Segment
UIT – Interactive Message Trailer Segment
UIZ – Interactive Interchange Trailer Segment

Rejected Transactions

- A STATUS response message will be used to relay rejection of the RXHREQ transaction back to the sender.

NCPDP SCRIPT RXHREQ and RXHRES Interchange and Message Header Identifiers

Trading partners should follow the guidelines in the NCPDP Prescriber/Pharmacist Interface SCRIPT Standard Implementation Guide. Unique instructions for populating specific interchange related data elements are:

Transaction (Message)	Segment/Element	Instruction	Imp Gde Pg #
RXHREQ	UIB 060-01 Sender ID – Level One	Report the 6 position e-prescribing EDI-assigned value	64
RXHREQ	UIB 060-02 Level One ID Code Qualifier	Report ZZZ	64
RXHREQ	UIB 060-03 Sender ID – Level Two		64
RXHREQ	UIB 070-01 Receiver ID – Level One	Report 382069753	64
RXHREQ	UIB 070-02 Level One ID Code Qualifier	Report ZZZ	64
RXHREQ	UIB 070-03 Receiver ID – Level Two		64
RXHREQ	UIH 010-01 Message Type	Report value of SCRIPT	66
RXHREQ	UIH 010-02 Message Version Number	Report value of 008	66
RXHREQ	UIH 010-03 Message Release Number	Report value of 001	66
RXHREQ	UIH 010-04 Message Function	Report value of RXHREQ	66
RXHRES or ERROR	UIB 060-01 Sender ID – Level One	Report 382069753	64
RXHRES or ERROR	UIB 060-02 Level One ID Code Qualifier	Report ZZZ	64
RXHRES or ERROR	UIB 060-03 Sender ID – Level Two		64
RXHRES or ERROR	UIB 070-01 Receiver ID – Level One	Report the 6 position e-prescribing EDI-assigned value	64
RXHRES or ERROR	UIB 070-02 Level One ID Code Qualifier	Report ZZZ	64
RXHRES or ERROR	UIB 070-03 Receiver ID – Level Two	Not used	64
RXHRES or ERROR	UIH 010-01 Message Type	Report value of SCRIPT	66
RXHRES or ERROR	UIH 010-02 Message Version Number	Report value of 008	66
RXHRES or ERROR	UIH 010-03 Message Release Number	Report value of 001	66
RXHRES or ERROR	UIH 010-04 Message Function	Report value of RXHRES or ERROR	66

NCPDP SCRIPT RXHREQ Transaction (Message) Clarifications

Segment	Element	Instruction	Industry/Element Name
PTT	050-01 and 050-02	<p>BCBSM Local and BCN: To help protect our members security and to meet legislation requirement, BCBSM Local, Medicare Advantage and BCN replaced all Social Security Numbers with new randomly assigned contract numbers on members' ID cards and all correspondences. Therefore, we recommend that Social Security Numbers (Qualifier SY) are not reported.</p> <p>Medicare Advantage: Do not report Social Security Numbers (Qualifier SY) for members of any Federally administered program.</p>	Reference Number, Reference Qualifier

General EDI Terminology

Addenda – Refers to a version of the HIPAA mandated transaction sets that corrects identified implementation issues noted in the original implementation guides.

ANSI X12N 270/271 v4010 – HIPAA standardized (ANSI) ASC X12N 270/271 transaction format for Eligibility Benefit Inquiry and Response data.

BIN – Bank Identification Number used for network routing.

Data Segment – Corresponds to a *record* in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12N). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

Data Element – Corresponds to a *field* in data processing terminology. Assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are:

Nn	Numeric (with an assumed number of decimal positions)
R	Decimal Real Number (including decimal or negative sign)
ID	Identifier
AN	Alphanumeric string
DT	Date
TM	Time

Delimiter – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI – An acronym for Electronic Data Interchange.

Electronic Data Interchange – The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.

Implementation guides – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. The Washington Publishing Company publishes HIPAA implementation guides on their web site: wpc-edi.com.

Interface – The point at which two systems connect to pass data.

Loops – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

NCPDP – National Council for Prescription Drug Programs.

Routing – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

SCRIPT – NCPDP standard for the purpose of transmitting electronic prescription messages.

Trading partners – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Transaction Set – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.

X12N – An Accredited Standards Committee commissioned by the American National Standards Institute to develop standards for Electronic Data Interchange. While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.