Consolidated Clinical Document Architecture implementation guide

A new submitter's guide for sending Clinical Document Architecture documentation to UnitedHealthcare

Note: UnitedHealthcare closely follows Health Level 7 Consolidated Clinical Document Architecture Release 2.0 standards and allows use of older versions. However, there are exceptions and constraints in this guide. For a complete reference to HL7 standards on Clinical Document Architecture documentation, please refer to the **HL7 C-CDA Release 2.0 Implementation Guide.**

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United Healthcare

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Table of contents

Change log

Version	Release date	Changes
1.0	December 2021	Initial creation

Heads up!

Helpful tips and information

Submitters will be notified by their UnitedHealthcare representative when revisions of this document are released.

Definitions, abbreviations and acronyms

Abbreviation/acronym/term	Meaning
ANSI	American National Standards Institute
C-CDA	Consolidated Clinical Document Architecture
CDA	Clinical Document Architecture
CDC	Centers for Disease Control and Prevention
CPT	Current Procedures Terminology
CVX	CDC Vaccine Code
EDI	Electronic Data Interchange
EHR	Electronic Health Record
HCPCS	Health Care Common Procedure Coding System
HL7	Health Level Seven
ICD	International Classification of Diseases
LOINC	Logical Observation Identifiers Names and Codes
NCQA	National Committee of Quality Assurance
RxNorm	United States-specific terminology in medicine that contains all medications available on the U.S. market. RxNorm is part of the Unified Medical Language System (UMLS) terminology and is maintained by the U.S. National Library of Medicine (NLM).
SFTP	Secure File Transfer Protocol
SNOMED	Systematized Nomenclature of Medicine
SNOMED CT	SNOMED Clinical Terms
UCUM	Unified Code for Units of Measure
XML	Extensible Markup Language

Introduction

Scope

Implementation guide

This guide is to be used for the development of data interfaces to transmit Clinical Document Architecture (CDA®) documentation (such as patient summaries, discharge summaries, clinical care documents) to UnitedHealthcare. As the health care industry evolves toward standards-based communications for clinical data, UnitedHealthcare has recognized the need to move away from custom and proprietary methods and toward common standards that eliminate or substantially reduce the custom interface programming and program maintenance that may otherwise be required.

The UnitedHealthcare standard described in this companion guide is based on the Health Level Seven (HL7®) Release 2.1 documentation standard for electronic data exchange in health care environments, which was designed to conform to the requirements of the American National Standards Institute (ANSI). During the development of the UnitedHealthcare clinical care document Consolidated Clinical Documentation Architecture (C-CDA) exchange standard, a deliberate effort was made to support prior version implementations of HL7 for applications and systems that can generate HL7 release 2.1 documentation that our standard is based upon.

This document describes the elements of HL7 C-CDA documentation as they relate to the UnitedHealthcare standard for data transmission of clinical documentation and is not intended to be an introduction to HL7 messages and standards. Readers unfamiliar with HL7 should first review the HL7 C-CDA Release 2.0 Implementation Guide and/or the information describing the HL7 Release 2.1, available at hl7.org.

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Helpful tips and information

An account may need to be created with a unique username and password to utilize the full functionality of the HL7 International website. If not, the submitter is not an existing user.

Audience

This document has been written to aid in designing and implementing HL7 transactions to meet UnitedHealthcare processing standards. This guide is a constraint on the HL7 C-CDA Release 2.0 Implementation Guide. Submitters must utilize the HL7 C-CDA

Release 2.0 Implementation Guide as the set of standards for submitting clinical care documents (CCDs), and refer to this implementation guide for exceptions that fall out of those standards specific to UnitedHealthcare.

Within this document, key data elements are identified, which UnitedHealthcare requests all submitters provide. By following these recommendations, submitters are enabled to more effectively complete electronic data interchange (EDI) transactions with UnitedHealthcare.

Heads up!

Helpful tips and information

For a full description of messages, segments (i.e., definitions, usage, cardinality), fields, delimiters, values and formats, as well as other critical fundamental information not covered within this implementation guide, please refer to HL7 C-CDA Release 2.0 Implementation Guide as well as HL7.org.

For assistance accessing the HL7 C-CDA Release 2.0 Implementation Guide, refer to the Job Aid: Accessing the HL7 C-CDA Release 2.0 Implementation Guide or request assistance from the UnitedHealthcare representative.

Getting started

Connectivity with UnitedHealthcare

Submitting CCD data to UnitedHealthcare is available through a comprehensive electronic communication channel that is rapid and secure.

Transmission options

During the implementation process, submitters must transmit electronic data using one of the following methods:

- Secure File Transfer Protocol (SFTP) – Requires a submitter to obtain credentials and folder set up with UnitedHealthcare
- ONC Direct Messaging – Two-step process requiring a submitter to be provisioned prior to sending CCDs to identify senders of the CCD to the correct tax ID number (TIN) or submitter ID, as well as requiring setup in the host system in order to send data

For existing accounts, submitters can request to add CCD transactions to their current profile and complete the testing and production implementation process.

Submitting a test file

The purpose of the testing phase is to provide submitters with a mechanism to produce the same reports they will receive once in production. Through this test phase, submitters can submit data content and receive reports that detail any errors or problems found as a result of their file submission. UnitedHealthcare requests that submitters provide a minimum of 50 to 100 CCDs with clinical information for testing — actual patient details are not required.

Transactions are processed by the file transport and validation facility but are not sent for processing within the production environment. Reports will be generated specifically related to the submitter's file submission for each message within the file.

Please note that during the test phase, field and segment format validation are checked for data within required segments. After production promotion, data content and quality are validated, which may require additional changes.

The steps to sending a test file are described below:

1. The submitter will submit a CCD file formatted according to the specifications in the HL7 C-CDA Release 2.0 Implementation Guide as well as any noted exceptions within

this guide

2. In response, the submitter will receive a set of reports that correspond to the data sent
    - These reports will show any errors or problems that were found in the submitted transactions
3. The submitter should continue to test until data has been submitted successfully without any reported errors
4. Once a successful submission is achieved, the submitter will request production status for the CCD transaction

Troubleshooting

Contact UnitedHealthcare EDI Support at **supportEDI@uhc.com** for troubleshooting assistance.

Contact information

Most questions can be answered by referencing the materials posted at **EDI Connectivity | UHCprovider.com.** For specific issues or questions, please reference the table below:

Topic	Contact
Clinical	UnitedHealthcare network representative
Hospital contracts	UnitedHealthcare network account manager
Connectivity	UnitedHealthcare EDI Support Email: **supportEDI@uhc.com**
Login or password issues, account setup, transaction questions during testing	Customer Support Phone: **800-445-8174** Email: **unitedhelpdesk@ediconnect.com** Hours: 8 a.m.–5 p.m. ET, Monday–Friday
Data quality review	UnitedHealthcare Clinical Data Operations and Quality
Reporting delay in file submission	
File management	

Section 5.0 documentation

Each year, the National Committee of Quality Assurance (NCQA) audits incoming clinical data submitted to UnitedHealthcare. This helps ensure that the data chain of custody meets NCQA audit guidelines, which includes approval of data sources. To remain in NCQA compliance, submitters must inform UnitedHealthcare of any changes in how clinical data is submitted year-over-year from provider groups. This information allows UnitedHealthcare to regularly evaluate the impact such changes may have on NCQA data integrity.

Roster and membership matching

During the submitter's implementation, UnitedHealthcare will provide a membership roster to assist the submitter in identifying UnitedHealthcare members and provide their clinical data accordingly during appropriate trigger events. UnitedHealthcare will send the initial roster once the submitter completes their intake form.

Clinical Document Architecture Release 2 (CDA R2)

Compliant clinical documentation communicates information between health care providers and conforms with local policies, laws and regulations. The HL7 Standard defines clinical documents with the following 6 characteristics:

- Persistence
- Stewardship
- Potential for authentication
- Context
- Wholeness
- Human readability

A CDA must contain 2 major sections — a header, which is used for classification and management, and the document body, which contains the information from the clinical record.

Preferred data exchange by UnitedHealthcare

The Continuity of Care Document (CCD) represents a core data set of the most-relevant administrative, demographic and clinical information facts about a patient's health care, covering 1 or more health care encounters. It provides a means for one health care practitioner, system or setting to aggregate all of the pertinent data about a patient and forward it to another to support the continuity of care.

CCDs are an HL7 version 3 CDA document type represented in a structured Extensible Markup Language (XML) format. The CCD represents a core data set of the most relevant administrative, demographic and clinical information about a patient's health care, covering 1 or more health care encounters. CCDs provide a method for health care practitioners, systems or settings to aggregate all pertinent data about a patient and forward it to another source to support continuity of care.

Why are CCDs the preferred data exchange format for UnitedHealthcare?

- CCDs are the industry standard and can sustain NCQA digital changes for clinical data and quality measures
- The CCD format (.xml) is standard across all electronic health records (EHRs)
- One CCD has the potential to close multiple gap closures
- The potential of file rejection and manual human errors are reduced
- SMOMED codes can be included

Transaction-specific information

Specifications

Submitters should follow the standards as outlined in the HL7 C-CDA Release 2.0 Implementation Guide in designing and programming the information UnitedHealthcare needs in order to submit CCDs.

Inpatient documentation in the form of HL7 C-CDA 2.1 Discharge Summary documents and inpatient progress notes, operative notes and any other relevant documents for significant clinical events in the inpatient setting will be delivered for all acute inpatient encounters at participating submitter facilities.

All document types shall conform to the HL7 C-CDA Release 2.0 Implementation Guide.

In addition, information is included to describe UnitedHealthcare usage for composite and simple data elements, as well as other information. All segments, data elements and codes supported in the HL7 guidelines are acceptable. However, all data may not be used in the processing of this transaction by UnitedHealthcare.

Heads up!

Helpful tips and information

UnitedHealthcare processes C-CDA and C32/CCD files, each file having its own extensible stylesheet language (XSL). To invoke the XSL, UnitedHealthcare utilizes the **templateID** tag found within the input XML file and requires submitters to ensure this tag is present all submitted C-CDA and C32/CCD data.

File naming convention

Submitters must utilize the following file naming convention when sending CCD data:

<<SubmitterShortName>>_<<ProviderGroupID>>_<<EMRSYSTEM_UNIQUEID>>_<<CCDEXTRACTDATETIME>>_<<TRANSPORTPROTOCOL>>.xml

Please see a list of definitions for each element of the file name:

File name element	Definition
SubmitterShortName	Name of organization sending CCDs

File name element	Definition
ProviderGroupID	Unique identifier of the provider group or health system (i.e., TIN, Dec, Network ID, Health System ID, Provider Group roll-up)
EMRSYSTEM_UNIQUEID	Name of EMR system from which the CCD is extracted
CCDEXTRACTDATETIME	Generation date and time of the CCD (not the transmitted date and time) Four standard format options are accepted — submitters must use one of the following: • MM/DD/YYYY • CCYY – mm – dd • MM – DD – CCYY • CCYYMMDD
TRANSPORTPROTOCOL	Default to **02** since CCDs are sent via SFTP

Coding systems

UnitedHealthcare supports the following standard code systems/vocabularies:

- Current Procedural Terminology (CPT2 and CPT4)
- Healthcare Common Procedure Coding System (HCPCS)
- SNOMED CT
- Logical Observation Identifiers Names & Codes (LOINC)
- International Classification of Diseases (ICD-10-CM, ICD-9-CM, ICD-10-PCS, ICD-9-PCS) (diagnosis and procedure codes)
- RxNorm
- CDC Vaccine Code (CVX)
- Unified Code for Units of Measure (UCUM)
- Revenue codes

Heads up!

Helpful tips and information

When multiple, different code systems could potentially be used for a single data element (i.e., [Facility][MedicalGroup], submitters should follow the code system as specified in **HL7 C-CDA Release 2.0 Implementation Guide.** Submitters must not use proprietary codes unless no suitable standard code is available. A translation table must be provided in case of proprietary codes.

Acceptable code systems by CCD section

Code system									
Name	**OID**	**Procedures**	**Functional status**	**Mental status**	**Immunizations**	**Results**	**Vital signs**	**Problem**	**Encounters**
CDT-2	2.16.840.1.113883.6.13	✗	-	-	-	-	-	-	-
CPT-4	2.16.840.1.113883.6.12	✓	-	-	-	-	-	-	✓
CVX	2.16.840.1.113883.6.59	-	-	-	✓	-	-	-	-
HCPCS		-	-	-	-	-	-	-	-
ICD-10-CM	2.16.840.1.113883.6.90	-	-	-	-	-	-	✓	-
ICD-10-PCS	2.16.840.1.113883.6.4	✗	-	-	-	-	-	-	-
LOINC	2.16.840.1.113883.6.1	✗	✗	✗	-	✓	✓	-	✗
RxNorm	2.16.840.1.113883.6.88	-	-	-	-	-	-	-	-
SNOMED CT	2.16.840.1.113883.6.96	✗	✗	✗	-	✗	-	✗	✗

Heads up!
Helpful tips and information

Key for acceptable code systems table above:
✗ = CCD section **not accepted** by UnitedHealthcare
✓ = CCD section **accepted** by UnitedHealthcare

Recommended data for UnitedHealthcare

UnitedHealthcare utilizes XML schema and schematron validation methods when receiving CCDs, but also emphases the importance of submitting quality data in order to close gaps of care for members. The importance of data quality cannot be emphasized enough as it affects patient safety and quality of care.

In the simplest of terms, submitters should provide the following information to UnitedHealthcare for processing CCDs. Please see the table below for a high-level overview:

Data	Element extracted from	Optionality	Comments
Member information			
Header section			
Member ID	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/participant[@typeCode="COV"]/participantRole/id/@extension	**Recommended**	Should be alphanumeric + spaces + punctuation up to 50 characters
Patient first name	/ClinicalDocument/recordTarget/patientRole/patient/name/given[1]	**Required**	UnitedHealthcare will not process the CCD without this data
Patient last name	/ClinicalDocument/recordTarget/patientRole/patient/name/family	**Required**	UnitedHealthcare will not process the CCD without this data
Date of birth	/ClinicalDocument/recordTarget/patientRole/patient/birthTime/@value	**Required**	• UnitedHealthcare will not process the CCD without this data • Date validation is conducted on this data: If date of birth is more than 150 years in the past, data will not be processed

Data	Element extracted from	Optionality	Comments
Gender	/ClinicalDocument/recordTarget/patientRole/patient/ administrativeGenderCode/@code	**Optional**	With code system: 2.16.840.1.113883.5.1
Race	/ClinicalDocument/recordTarget/patientRole/patient/ raceCode/@code	**Recommended**	
Ethnicity	/ClinicalDocument/recordTarget/patientRole/patient/ethnic GroupCode/@code	**Recommended**	
Address 1	/ClinicalDocument/recordTarget/patientRole/addr/ streetAddressLine[1]	**Recommended**	
Address 2	/ClinicalDocument/recordTarget/patientRole/addr/ streetAddressLine	**Optional**	
City	/ClinicalDocument/recordTarget/patientRole/addr/city	**Recommended**	
State	/ClinicalDocument/recordTarget/patientRole/addr/state	**Recommended**	
ZIP code	/ClinicalDocument/recordTarget/patientRole/addr/ postalCode	**Recommended**	
Provider information			
NPI	/ClinicalDocument/author/assignedAuthor/id/@extension where @root is 2.16.840.1.113883.4.6 (author)	**Recommended**	
Provider first name	ClinicalDocument/component/structuredBody/component/ section/entry/performer/assignedEntity/assignedPerson/ name/given	**Required**	
Provider last name	ClinicalDocument/component/structuredBody/component/ section/entry/performer/assignedEntity/assignedPerson/ name/family	**Required**	

Data	Element extracted from	Optionality	Comments
City	ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/city	**Required**	
State	ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/state	**Required**	Please note UnitedHealthcare requires the provider's state data be provided. This is an exception to the HL7 standard.
Procedure section			
Provider first name	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/assignedPerson/name/given	**Required**	
Provider last name	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/assignedPerson/name/family	**Required**	
Address 1	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/streetAddressLine	**Recommended**	
Address 2	<addr>	**Optional**	
City	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/city	**Required**	
State	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/state	**Required**	Please note UnitedHealthcare requires the provider's state data be provided. This is an exception to the HL7 standard.
ZIP code	/ClinicalDocument/component/structuredBody/component/section/entry/performer/assignedEntity/addr/postalCode	**Recommended**	

Data	Element extracted from	Optionality	Comments
Problem section			
Provider first name	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/assignedPerson/name/given /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/assignedPerson/name/given	**Required**	
Provider last name	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/assignedPerson/name/family /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/assignedPerson/name/family	**Required**	
Address 1	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/addr/streetAddressLine /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/addr/streetAddressLine	**Recommended**	
Address 2	<addr>	**Optional**	

Data	Element extracted from	Optionality	Comments
City	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/addr/city /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/addr/city	**Required**	
State	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/addr/state /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/addr/state	**Required**	Please note UnitedHealthcare requires the provider's state data be provided. This is an exception to the HL7 standard.
ZIP code	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/performer/assignedEntity/addr/postalCode /ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/author/assignedAuthor/addr/postalCode	**Recommended**	
Encounter section			
Provider first name	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/assignedPerson/name/given	**Required**	
Provider last name	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/assignedPerson/name/family	**Required**	

Data	Element extracted from	Optionality	Comments
Address 1	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/addr/streetAddressLine	**Recommended**	
Address 2	<addr>	**Optional**	
City	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/addr/city	**Required**	
State	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/addr/state	**Required**	Please note UnitedHealthcare requires the provider's state data be provided. This is an exception to the HL7 standard.
ZIP code	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/performer/assignedEntity/addr/postalCode	**Recommended**	
Medical claims information			
Encounter section			
Code system	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/entryRelationship/act/entryRelationship/observation/value@codeSystem	**Required**	
Code type value	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/entryRelationship/act/entryRelationship/observation/value@code	**Required**	Should be alphanumeric + spaces + punctuation up to 10 characters
Date of service	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/entryRelationship/act/entryRelationship/observation/effectiveTime/	**Required**	Date validation is conducted on this data: If date of service is more than 2 days in the future, data will not be processed

Data	Element extracted from	Optionality	Comments
From date	/ClinicalDocument/component/structuredBody/component/section/entry/encounter/entryRelationship/act/entryRelationship/observation/effectiveTime/low/@value	**Required**	Must not be null
Procedures section			
Code system	/ClinicalDocument/component/structuredBody/component/section/entry/procedure/code	**Required**	
Code type value	/ClinicalDocument/component/structuredBody/component/section/entry/procedure/code@code	**Required**	• If code type is ICD Procedure or Diagnosis, then the version must be present • If code type is LOINC, then value must be present
Date of service	/ClinicalDocument/component/structuredBody/component/section/entry/procedure/effectiveTime	**Required**	Date validation is conducted on this data: If date of service is more than 2 days in the future, data will not be processed
From date	/ClinicalDocument/component/structuredBody/component/section/entry/procedure/effectiveTime	**Required**	Must not be null
Member ID	/ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/participant[@typeCode="COV"]/participantRole/id/@extension	**Recommended**	
Vitals section			
Code system	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code@codeSystem	**Required**	

Data	Element extracted from	Optionality	Comments
Code type value	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code@code	**Required**	• If code type is ICD Procedure or Diagnosis, then the version must be present • If code type is LOINC, then value must be present
Date of service	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime@value	**Required**	Date validation is conducted on this data: If date of service is more than 2 days in the future, data will not be processed
From date	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime	**Required**	Must not be null
Results section			
Code system	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code@codeSystem	**Required**	
Code type value	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code@code	**Required**	• If code type is ICD Procedure or Diagnosis, then the version must be present • If code type is LOINC, then value must be present
Date of service	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime	**Required**	Date validation is conducted on this data: If date of service is more than 2 days in the future, data will not be processed

Data	Element extracted from	Optionality	Comments
From date	/ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime	**Required**	Must not be null
Mental Status section (if applicable)			
LOINC codes only	/ClinicalDocument/component/structuredBody/component/section (Section Loinc= 10190-7)/entry/observation(oid= 2.16.840.1.113883.10.20.22.4.69)/code@code	**Required**	
Past Medical History section			
Clinical codes	/ClinicalDocument/component/structuredBody/component/section (Section Loinc= 11348-0)/entry/observation (urn oid: 2.16.840.1.113883.10.20.22.4.4)/value@code	**Required**	

UnitedHealthcare standards

Constraints on HL7 Standards

- **Problems section**
  - UnitedHealthcare will only process information provided within the Problem section if a date is present
  - If an encounter is associated with a problem, a valid date is required
  - If there is no encounter associated with a problem, a valid service date must be present at Observation < effective time
- **Observations**
  - UnitedHealthcare requires a valid code system, code and date within Observations and/or Diagnosis fields to process submitted data
  - If a valid code system and corresponding code is not available, UnitedHealthcare requires either a valid transaction within the Observation/Value or Observation/Value/Translation
  - If Translation is not provided, UnitedHealthcare requires that a valid code system under Observation/Interpretation Code be included
- **Diagnoses**
  - UnitedHealthcare requires a valid code system, date and code to process the diagnosis

By providing this information, the data can be utilized more holistically, enabling greater quality of patient care, as well as decreasing the number of clinical care gaps.

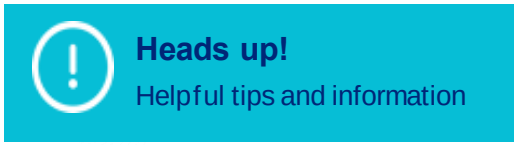
Note: These fields are required/recommended/optional for UnitedHealthcare processing. This is not an all-inclusive list of required fields. Submitters should refer to previous sections of this document as well as the HL7 C-CDA Release 2.0 Implementation Guide for all required elements.

Additional tips

Please see additional recommended tips below for cleaner data and faster processing:

- Ensure values that are numeric are noted within those fields (i.e., do not enter a number into a text field)
- Do not enter special characters (i.e., <, >) into a numeric field. Only enter numerals.

- Do not include special characters (i.e., commas, periods, etc.) within a tag. Only empty or expected values are accepted.
- Include the **templateID** tag within the input XML
- Provide data for UnitedHealthcare members only
- Review data to ensure it is clinically appropriate and makes sense (i.e., 80/120 for a blood pressure reading, instead of 120/80)
- Ensure a maximum of 99 characters is provided within the manufactured product/manufactured material/name
- Only send a single code for each component within the Procedure section
- Ensure the From date is not null
- Ensure a code system, code value and date of service is provided
- Review data to ensure completeness and appropriate syntax
- Ensure codes appropriately match narratives
- Confirm the following:
  - Medications are encoded in RxNorm
  - Vital signs and results are using LOINC coding, as well as unified code of units of measure (UCUM) for physical values
  - Inclusion of conflicting status information for medications
  - Accurate drug terminology and medical dosages are used
  - The encounter or visit time period are within the HEDIS® timelines



For acceptable codes regarding HEDIS®, Centers for Medicare & Medicaid Services (CMS) Part D, CAHPS® and HOS measures/gap closures, please refer to **UnitedHealthcare Quality Reference Guide.**

Frequently asked questions

1. **How does a submitter obtain feedback about the success or failure of an individual file submission?**

   Each file submission will result in a set of reports with detailed error information shared with the submitter.

2. **Does the submitter's connection to UnitedHealthcare have to be set up prior validating their format per the published CCD standard**?

   Yes.

3. **Does the Submitter ID have to be assigned by UnitedHealthcare?**

   Yes. This ID will be identified by UnitedHealthcare during the connectivity setup process.

4. **Can submitters expect to receive 1 response for a single file or batch, and 1 MSA response for each message of that batch?**

   Yes. A typical response will be a corresponding single file containing 1 MSA response transaction for each MSH submitted in the batch.

5. **What is PGP encryption?**

   PGP stands for Pretty Good Privacy. It is a computer program that provides cryptographic privacy and authentication. PGP is often used for signing, encrypting and decrypting emails to increase the security of email communications.

   UnitedHealthcare accepts PGP-encrypted CCD files via FTP.

6. **If the submitter is transmitting via FTP, how is an acknowledgment received?**

   All transaction responses are sent to the Electronic Communication Gateway (ECG) mailbox associated with the FTP account.

7. **Does a submitter have to purchase any additional software from UnitedHealthcare or Optum if they are connecting directly to UnitedHealthcare to submit a CCD?**

   No.

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8. What is the process for correcting rejected transactions?

Rejected CCD messages that could not be processed due to errors can be resubmitted once a submitter has incorporated corrections or updates. A new file containing the corrected message can be submitted with the same file segment and batch segment requirements as any other batch file submission.

9. Can test files be sent after a submitter has received approval for CCD transaction production submissions?

Even after being granted production status for CCD file submissions, the submitter has the ability to designate a file as a test file by sending a "T" in the MSH-11 Processing ID field. When doing so, the file will be treated as a test transaction file and will not be forwarded for processing. The submitter can still send CCD test transaction messages when granted production status for CCD transactions.
Note: If a submitter has not yet been approved for production status, all messages will be processed as test messages regardless of the value in the MSH-11 Processing ID element.