



Immediate Batch Response (IBR) Specifications and Examples

Availity has developed a proprietary Immediate Batch Response (IBR) report that immediately acknowledges accepted claims and identifies rejected claims due to HIPAA compliance edits and payer-specific edits (PSE) that Availity conducted on behalf of payer(s). Availity will return the IBR to the sender's **ReceiveFiles** mailbox within minutes after transmission or up to 24 hours depending upon the volume of claims processing at that time. Availity will generate the IBR after an accepted (A), accepted with errors (E) or a partial accepted (P) ACK has been posted to your mailbox. Each IBR represents one ISA – IEA. If a batch contains multiple ISA – IEA, Availity generates an IBR for each ISA – IEA. The IBR is available in both a delimited and text format and is modeled after the EBR. The delimited IBR file has an extension of **.ibr** at the end of the file name, and the text IBR file has an extension of **.ibt**. If you would like to discontinue either the delimited or the text format, or if you prefer to receive these files aggregated into a single file on a daily basis, you can change these preferences using the EDI Reporting Preferences page in the Availity portal.

The IBR provides transaction totals and individual claim detail for both accepted and rejected claims. Senders should correct and resubmit rejected claims immediately to avoid claim adjudication delays. The IBR is created immediately upon file submission. An IBR report cannot be recreated for a previously submitted file. If the IBR was created at the time of transmission, Availity client services can load another copy of the IBR to your mailbox if necessary. We recommend you save these files on your system for reference or retrieval at a later date, as necessary.

The IBR was set up for all previous THIN automatically registered users. Existing Availity users must request the IBR by selecting the report in the desired format on the EDI Reporting Preferences page. Refer to "EDI Reporting Preferences" in Chapter 4 of the EDI Companion Guide for more information on selecting report preferences.

An IBR will not be generated or returned in the following situations:

1. If the batch file was completely rejected on a negative 997 ACK file.
2. For non-claims transactions.

Important Notes:

- Rejected claims on the IBR will also appear as rejected claims on the EBR response file.
- IBR/IBT will be generated for real-time (**RT**) claims including Humana and BCBS Florida and if any payer information, such as payer name or ID is invalid.
- An IBR is created for each logical file (ISA-IEA). If multiple logical files are submitted in one transmission / physical file, you will receive multiple IBRs.
- The error message field on the IBT (text report) has been reformatted to wrap within printable margins.
- The total counted and total charges shown in the IBR at the batch level is **NOT** the total submitted, it is the total that passed file format and syntax validated. For example, if you received a partial negative 997 ACK file because some transaction sets in the batch were rejected during file format and structure validations, the count of total claims submitted excludes the claims in the rejected transaction sets.
- On IBT text report, the title "Submitter ID" is shown **NOT** "Submitter Batch ID".

Following are specifications for both IBR formats, along with examples of each report. Please review these carefully and decide which format fits your individual needs. Remember to log into the portal and make any necessary report changes. In an effort to avoid duplication and confusion, we encourage you to select only one format.

***Changes to the specifications are highlighted to assist with identifying them.**

Immediate Batch Response – Delimited Version

(.ibr file extension)

1 | Date Received | Time Received | Internal Usage | Availity Batch ID | File Control Number | Total Submitted Claims | Total Submitted Charges | Total Accepted Claims | Total Accepted Charges | Total Rejected Claims | Total Rejected Charges | Availity Message |

Line 1 will occur once per file.

2 | Payer Name | NA | NA | NA | NA | NA | NA | Payer ID |

Line 2 can occur multiple times per file.

3 | Patient Name | From Date | To Date | Patient Control Number | Charge | Provider Billing ID | Clearinghouse Trace Number | NA | Availity Trace Number | Submitter Batch ID | Status |

Note:

- **Submitter Batch ID = BHT03 of original ID from the submitter**
- **Status = Error severity: If the claim rejects for HIPAA and PSE edits then "Status" would = (R) Reject. If the claim passes HIPAA and PSE edits then 'Status' would = (A) Accepted.**

Line 3 will occur once per claim. On Accepted claims, only Line 3 displays. On Rejected claims, Line 3 and 3e display. Note: The Availity Trace Number will not appear on a HIPAA rejection.

3e | Error Initiator (Source) | NA | Error Code | Error Text | Loop | Segment | Element | | | |

Line 3e will occur if the claim is rejected by an Availity, HIPAA, or a payer-specific edit (PSE). Line 3e can occur multiple times per claim.

If Error Initiator is a Payer Specific Edit (PSE), position 3 (Error Code) will contain the error code:

3e | Payer ID-PSE | NA | e12 | Availity is unable to accept electronic claims with dates of service earlier than 1/1/02. | 2400 | DTP | DTP03 | | | |

If Error Initiator is a HIPAA edit, position 3 (Error Code) will equal NA:

3e | HIPAA | NA | NA | Claim balancing is failed: total charge amount (CLM02) '130' does not equal sum of line charge amounts (SV102) '120'. Segment CLM is defined in the guideline at position 130. Invalid data: 130 | 2300 | CLM | 02 | | | |

Refer to the Immediate Batch Response Field Definitions on page 4 of this document for field values and data format.

IBR – Delimited PSE Example

```
1|2008-01-25|12.00.45.171||2008012512003100|282945590|3|390.00|2|260.00|1|100.00||
2|BCBS/TX (HCSC)|NA|NA|NA|NA|NA|NA|84980|
3|DOE,JANE|20010116|20010116|DOE184565|130.00|1234567890|122521877|NA|8864594|5002|R|
3e|PAYER ID-PSE|NA|e12|Availity is unable to accept electronic claims with dates of service
earlier than 1/1/02|2400|DTP|DTP03|||
```

IBR – Delimited HIPAA Example

```
1|2008-01-26|11.00.40.141||200801612003100|282945591|3|320.00|2|220.00|1|100.00||
2|BCBS/TX (HCSC)|NA|NA|NA|NA|NA|NA|84980|
3|DOE, JOHN|20080110|20080110|184328|100.00|1234567890|122521877|NA|NA|5003|R|
3e|HIPAA|NA|NA|Value of element NM109 is incorrect. Expected value is Employer's Identification
Number (format is '9 digits or '00-0000000') when NM108= '24'. Segment NM1 is defined in the
guideline at position 250.Invalid data:450018|2310D|NM1|09|||
```

IBT - Text Example

(.ibt file extension)

Immediate Batch Text Response			
Availability Messages: NA (date wrapped when present)			

BATCH SUMMARY			
Date Received:	2008-06-01	Time Received:	11.28.07.473
Availability Batch ID:	2008050100280500	File Control Number:	020000517
Total Submitted Claims:	4	Total Submitted Charges:	26,832.58
Total Accepted Claims:	3	Total Accepted Charges:	13,466.42
Total Rejected Claims:	1	Total Rejected Charges:	13,366.16

Payer:	UNITED HEALTHCARE (UHC)	Payer ID:	87726

Submitter Batch ID:	550075	Status:	A
Patient Name:	HOMTE, NICOLE	Patient Control Number:	039256668880
From Date:	20070517	To Date:	20070517
Charge:	4,003.24	Provider Billing ID:	1626001588
Clearinghouse Trace #:	NA	Availability Trace #:	313809_0

Submitter Batch ID:	550075	Status:	A
Patient Name:	HART, BRIAN	Patient Control Number:	039146668869
From Date:	20070517	To Date:	20070517
Charge:	7,155.06	Provider Billing ID:	1626001588
Clearinghouse Trace #:	NA	Availability Trace #:	313809_1

Payer:	BETNA INSURANCE COMPANY	Payer ID:	60054

Submitter Batch ID:	550075	Status:	A
Patient Name:	ALLEN, SANDRA	Patient Control Number:	034857667734
From Date:	20070517	To Date:	20070517
Charge:	2,308.12	Provider Billing ID:	1626001588
Clearinghouse Trace #:	NA	Availability Trace #:	313810_0

Payer:	CIGNA	Payer ID:	62308

Submitter Batch ID:	550075	Status:	R
Patient Name:	SAWYER, DAHLEN	Patient Control Number:	010005668575
From Date:	20070517	To Date:	20070517
Charge:	13,366.16	Provider Billing ID:	1626001588
Clearinghouse Trace #:	NA	Availability Trace #:	NA
Error Initiator:	HIPAA	Loop:	2300
Segment ID:	HI	Element #:	01
Error Message:	Value of sub-element HI01-01 is incorrect. Value 'BR' (ICD-9-CM code) may be used only on inpatient hospital claims. Segment HI is defined in the guide line at position 231. Invalid data: BR		
Error Initiator:	HIPAA	Loop:	2300
Segment ID:	HI	Element #:	01
Error Message:	Value of sub-element HI01-01 is incorrect. Value 'BQ' (ICD-9-CM code) may be used only on inpatient hospital claims. Segment HI is defined in the guide line at position 231. Invalid data: BQ		
Error Initiator:	HIPAA	Loop:	2400
Segment ID:	SV2	Element #:	02
Error Message:	HCPCS Procedure Code is invalid in Institutional Service Line.		
Invalid data:	Q9966		

Note: IBT charge fields will display commas denoting thousands of dollars.

Immediate Batch Response Field Definitions

Availity Messages: (text file data wrapped when present)

BATCH SUMMARY

Date Received:	CCYY-MM-DD- Date Availity received the file	Time Received:	HH.MM.SS.SS – Time Availity received the file
Availity Batch ID:	CCYYMMDDHHMMS SSS	File Control Number:	Echo ISA13 from Inbound file.
Total Submitted Claims:	Total 2300/CLMs (Batch Total - total of all claims within one batch (Batch = 1 ISA/IEA)	Total Submitted Charges:	Total of 2300 CLM02
Total Accepted Claims:	Total of 2300/CLMs accepted	Total Accepted Charges:	Total of accepted 2300 CLM02
Total Rejected Claims :	Total of 2300/CLMs rejected	Total Rejected Charges:	Total of rejected 2300 CLM02

Payer:	Display payer name from Availity Payer file based on submitted payer ID. If payer ID invalid the value will = "UNKNOWN"	Payer ID:	Prof – 2010BB- NM109 Inst – 2010BC – NM109
Submitter Batch ID:	Echo BHT03 from inbound file.	Status: (claim level)	"A" - accepted, "R" - rejected, "W".
Patient Name:	Echo Subscriber – 2010BA – NM103, 104, 105, 107. Echo Patient 2010CA if present.	Patient Control Number:	Echo 2300/CLM01 from inbound file
From Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)	To Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)
Charge:	Total of 2300/CLM02s on inbound claim	Provider Billing ID:	Echo 2010AA/NM109
Clearinghouse Trace #:	Echo2300/REF02 (when REF02=D9)	Availity Trace #:	Availity assigned trace number
Error Initiator:	Availity, PSE or HIPAA (source)	Loop:	Identifies the loop where the error occurred.
Segment ID:	Identifies the segment in error.	Element #:	Identifies the element in error.

Error Message: Availity, PSE, HIPAA (text file data wrapped when present)

Payer:	Display payer name from Availity Payer file based on submitted payer ID. If payer ID invalid the value will = "UNKNOWN"	Payer ID:	Prof – 2010BB- NM109 Inst – 2010BC – NM109
Submitter Batch ID:	Echo BHT03 from inbound file.	Status:	"A" - accepted, "R" - rejected, "W".
Patient Name:	Echo Subscriber – 2010BA – NM103, 104, 105, 107. Echo Patient 2010CA if	Patient Control Number:	Echo 2300/CLM01 from inbound claim.

	present.		
From Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)	To Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)
Charge:	Total of 2300/CLM02s on inbound claim.	Provider Billing ID:	Echo 2010AA/NM109
Payer:	Display payer name from Availity Payer file based on submitted payer ID. If payer ID invalid the value will = “UNKNOWN”	Payer ID:	Prof – 2010BB – NM109 Inst – 2010BC – NM109
Patient Name:	Echo Subscriber – 2010BA – NM103, 104, 105, 107. Echo Patient 2010CA if present.	Patient Control Number:	Echo 2300/CLM01 from inbound claim.
From Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)	To Date:	Inst – 2300/DTP03 (434) Prof - 2400/DTP03 (472)
Charge:	Total of 2300/CLM02s on inbound claim.	Provider Billing ID:	Echo 2010AA/NM109
Clearinghouse Trace #:	Echo 2300/REF02 (when REF02=D9)	Availity Trace #:	Availity assigned trace number