Centers for Medicare & Medicaid Services (CMS)

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Standard Companion Guide Health Care Claim: Professional (837P)

Based on ASC X12N Technical Report Type 3 (TR3), Version 005010X222A1

Companion Guide Version Number: 6.0, May 2020

CMS 837P Version 005010X222A1

Disclosure Statement

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare claims is restricted under the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Companion Guide (CG) is to be used for conducting Medicare business only.

Preface

This CG to the Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) Version 005010 and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with Medicare. Transmissions based on this CG, used in tandem with the TR3 are compliant with both ASC X12N syntax and those guides. This CG is intended to convey information that is within the framework of the TR3 adopted for use under HIPAA. This CG is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

This CG contains instructions for electronic communications with the publishing entity, as well as supplemental information for creating transactions while ensuring compliance with the associated ASC X12N TR3s and the Council for Affordable Quality Healthcare – Committee on Operating Rules for Information Exchange (CAQH CORE) CG operating rules.

In addition, this CG contains the information needed by Trading Partners to send and receive electronic data with the publishing entity, who is acting on behalf of CMS, including detailed instructions for submission of specific electronic transactions. The instructional content is limited by ASC X12N's copyrights and Fair Use statement.

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1. Introduction

This document is intended to provide information from the author of this guide to Trading Partners to give them the information they need to exchange Electronic Data Interchange (EDI) data with the author. This includes information about registration, testing, support, and specific information about control record setup.

An EDI Trading Partner is defined as any Medicare customer (e.g., provider/supplier, billing service, clearinghouse, or software vendor) that transmits to, or receives electronic data from Medicare. Medicare's EDI transaction system supports transactions adopted under HIPAA as well as additional supporting transactions as described in this guide.

Medicare Fee-For-Service (FFS) is publishing this CG to clarify, supplement, and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12N Technical Report Type 3 (TR3) Version 005010 and associated errata for all transactions mandated by HIPAA and/or adopted by Medicare FFS for EDI.

This CG provides communication, connectivity, and transaction-specific information to Medicare FFS Trading Partners and serves as the authoritative source for Medicare FFS-specific EDI protocols.

Additional information on Medicare FFS EDI practices are referenced within Internet-only Manual (IOM) Pub. 100-04 Medicare Claims Processing Manual:

• Chapter 24 - General EDI and EDI Support, Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims. This document can be accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf.

1.1. Scope

EDI addresses how Trading Partners exchange professional and institutional claims, claim acknowledgments, claim remittance advice, claim status inquiry and responses, and eligibility inquiry and responses electronically with Medicare. This CG also applies to ASC X12N 837P transactions that are being exchanged with Medicare by third parties, such as clearinghouses, billing services or network service vendors.

This CG provides technical and connectivity specification for the 837 Health Care Claim: Professional transaction Version 005010X222A1.

1.2. Overview

This CG includes information needed to commence and maintain communication exchange with Medicare. In addition, this CG has been written to assist you in designing and implementing the ASC X12N 837P transaction standards to meet Medicare's processing standards. This information is organized in the sections listed below:

- **Getting Started:** This section includes information related to hours of operation, data services, and audit procedures. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.
- **Testing and Certification Requirements:** This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.
- **Connectivity/Communications:** This section includes information on Medicare's transmission procedures as well as communication and security protocols.
- **Contact Information:** This section includes EDI customer service, EDI technical assistance, Trading Partner services and applicable websites.
- **Control Segments/Envelopes:** This section contains information needed to create the Interchange Control Header/Trailer (ISA/IEA), Functional Group Header/Trailer (GS/GE), and Transaction Set Header/Trailer (ST/SE) control segments for transactions to be submitted to or received from Medicare.
- **Specific Business Rules and Limitations:** This section contains Medicare business rules and limitations specific to the ASC 837P.
- **Acknowledgments and Reports:** This section contains information on all transaction acknowledgments sent by Medicare and report inventory.
- **Trading Partner Agreement:** This section contains information related to implementation checklists, transmission examples, Trading Partner Agreements and other resources.
- **Transaction Specific Information:** This section describes the specific CMS requirements over and above the information in the ASC X12N 837P TR3.

1.3. References

The following websites provide information for where to obtain documentation for Medicare-adopted EDI transactions and code lists.

Table 1 - EDI Transactions and Code List References

Resource	Web Address
ASC X12N TR3s	The official ASC X12 website
Washington Publishing Company Health Care Code Lists	The official Washington Publishing Company website

1.4. Additional Information

The website linked in the following table provides additional resources for HIPAA Version 005010 implementation:

Table 2 - Additional EDI Resources

Resource	Web Address
Medicare FFS EDI Operations	https://www.cms.gov/ElectronicBillingEDITrans/

2. Getting Started

2.1. Working Together

First Coast Service Options Inc. (First Coast) is dedicated to providing communication channels to ensure communication remains constant and efficient. First Coast has several options to assist the community with their electronic data exchange needs. By using any of these methods, First Coast is focused on supplying the Trading Partner community with a variety of support tools.

An EDI help desk is established for the first point of contact for basic information and troubleshooting. The help desk is available to support most EDI questions/incidents while at the same time being structured to triage each incident if more advanced research is needed. Email is also accepted as a method of communicating with First Coast EDI. The email account is monitored by knowledgeable staff ready to assist you. When communicating via email, please exclude any Protected Health Information (PHI) to ensure security is maintained. In addition to the First Coast EDI help desk and email access, see Section 5 for additional contact information.

First Coast also has several external communication components in place to reach out to the Trading Partner community. First Coast posts all critical updates, system issues, and EDI-specific billing material to their website, https://medicare.fcso.com. All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. First Coast also distributes EDI-pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the website every three months. In addition to the website, a distribution list has been established in order to broadcast urgent messages. Please register for First Coast distribution list by signing up for eNews at https://medicare.fcso.com/Header/137525.asp.

2.2. Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, employer group, financial institution, etc.) that transmits electronic data to, or receives electronic data from, another entity.

Medicare FFS and First Coast support many different types of Trading Partners or customers for EDI. To ensure proper registration, it is important to understand the terminology associated with each customer type:

- **Submitter** – the entity that owns the submitter ID associated with the health care data being submitted. It is most likely the provider, hospital, clinic, supplier, etc., but could also be a third party submitting on behalf of one of these entities. However, a submitter must be directly linked to each billing National Provider Identifier (NPI). Often the terms submitter and Trading Partner are used interchangeably because a Trading Partner is defined as the entity engaged in the exchange or transmission of electronic transactions. Thus, the entity that is submitting electronic administrative transactions to First Coast is a Medicare FFS Trading Partner.
- **Vendor** – an entity that provides hardware, software, and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor, or clearinghouse.
- **Software Vendor** – an entity that creates software used by Trading Partners to conduct the exchange of electronic transactions with Medicare FFS.
- **Provider/Supplier** – the entity that renders services to beneficiaries and submits health care claims to Medicare.
- **Billing Service** – a third party that prepares and/or submits claims for a provider.
- **Clearinghouse** – a third party that submits and/or exchanges electronic transactions (claims, claim status or eligibility inquiries, remittance advice, etc.) on behalf of a provider.
- **Network Service Vendor** – a third party that provides connectivity between a Trading Partner and First Coast.

Medicare requires all trading partners to complete an EDI enrollment form and sign an EDI agreement. The EDI enrollment form designates the Medicare contractor the entity agrees to engage in EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of the information being exchanged. The EDI enrollment form can be found at http://medicare.fcso.com/EDI_Forms/.

Once the form is completed, it can be faxed, emailed or mailed to First Coast Medicare EDI. (See Section 5 for contact information). When the EDI enrollment form has been processed, First Coast will notify the entity whether the enrollment has been completed or the form rejected.

Under HIPAA, EDI applies to all covered entities transmitting the following HIPAA-established administrative transactions: 837I and 837P, 835, 270/271, 276/277, and the National Council for Prescription Drug Programs (NCPDP) D.0. Additionally, Medicare Administrative Contractors (MACs) and Common Electronic Data Interchange (CEDI) will use the Interchange Acknowledgment (TA1), Implementation Acknowledgment (999), and 277 Claim Acknowledgement (277CA) error-handling transactions.

Medicare requires that First Coast furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires First Coast to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in Section 3), and enroll and assign submitter EDI identification numbers to those approved to use EDI.

A provider must obtain an NPI and furnish that NPI to First Coast prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. First Coast is required to verify that NPI is on the Provider Enrollment Chain and Ownership System (PECOS). If the NPI is not verified on the PECOS, the EDI Enrollment Agreement is denied, and the provider is encouraged to contact First Coast enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for Durable Medical Equipment [DME] suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A provider's EDI number and password serve as an electronic signature and the provider would be liable for any improper usage or illegal action performed with it. A provider's EDI access number and password are not part of the capital property of the provider's operation and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password.

If providers elect to submit/receive transactions electronically using a third party such as a billing agent, a clearinghouse, or network services vendor, then the provider is required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or using Medicare beneficiary data. These agreements are not to be submitted to Medicare but are to be retained by the provider. Providers will notify First Coast which third party agents they will be using on their EDI Enrollment form.

Third parties are required to register with First Coast by completing the third-party agreement form. This will ensure that their connectivity is completed properly, however they may need to enroll in mailing lists separately in order to receive all publications and email notifications.

Additional third-party billing information can be found at https://medicare.fcso.com/Getting_started/206578.asp.

The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse, or network service vendor. Providers must also not share their personal EDI access number with anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a Provider's

EDI number and password to access Medicare systems. Clearinghouse and other third-party representatives must obtain and use their own unique EDI access number and password from First Coast. For a complete reference to security requirements, see Section 4.4.

2.3. Trading Partner Certification and Testing Process

Medicare FFS requires all Trading Partners to send a test file containing at least 25 claims, which are representative of their practice or services.

To begin the testing and certification process, trading partners should contact Medicare EDI at 1-888-670-0940 for available test dates and times. Tests submitted without a scheduled appointment will not be evaluated. If you are unable to submit on the day of your appointment, you must reschedule.

Test claims can be new or previously submitted paid claims. Your test is submitted into a separate testing environment and is not processed for payment. It is recommended to submit multiple transmissions (the day of your appointment) until you receive a positive acknowledgment. If you are unable to correct your file and resubmit on the day of your appointment, you must reschedule.

The First Coast Medicare EDI team will evaluate the submission and contact the submitter with the test results and next steps.

3. Testing and Certification Requirements

3.1. Testing Requirements

All submitters must produce accurate electronic test files before being allowed to submit claim transactions in production. Test claims are subject to ASC X12N standard syntax and TR3 semantic data edits. Documentation will be provided when this process detects errors.

All submitters must send a test file containing at least 25 claims, which are representative of their practice or services. The number of claims could be increased or decreased, on a case by case basis, to ensure adequate testing of any given submitter. Test claims are subject to standard syntax and TR3 semantic data edits; documentation will be provided when this process detects errors.

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax tests before submission to production is approved.
- TR3 Semantic Data testing validates data required for claims processing, e.g., procedure/ diagnosis codes, modifiers. A submitter must demonstrate, at a minimum, 95 percent accuracy rate in data testing before submission in production is approved where, in the judgment of First Coast, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For MACs, the minimum 95 percent accuracy rate includes the front-end edits applied TR3 editing module at https://medicare.fcso.com/edi_resources/138174.pdf.
    - Test results will be provided to the submitter within three business days; during HIPAA version transitions this time period may be extended, not to exceed ten business days.

Many submitters use the same software, or the same clearinghouse to submit their electronic transactions to Medicare. Once a vendor or clearinghouse passes the testing process, clients of that entity using the approved software will not be required to test prior to being migrated to production. If a vendor or clearinghouse supports multiple software products, each product will require testing. Third party agents who have passed testing will be required to provide First Coast with their client migration schedule.

Trading Partners who submit transactions directly to more than one A/B MAC must contact each A/B MAC with whom they exchange EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional EDI transaction, different or significantly modified software for submission of a previously used EDI transaction, or before a billing agent or clearinghouse begins to submit transactions on behalf of an additional Trading Partner. The individual A/B MAC may need to retest at that time to re- establish compatibility and accuracy, particularly if there will also be a change in the telecommunication connection to be used.

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a Provider prior to submission of written authorization by the Trading Partner that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See Section 2.2 for further information on EDI enrollment.

3.2. Certification Requirements

Medicare FFS does not certify Trading Partners. However, First Coast does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list that can be accessed at: http://medicare.fcso.com/Getting_started/.

4. Connectivity / Communications

4.1. Process Flows

The Electronic Data Interchange (EDI) Gateway is the system for managing data and communications between its electronic trading partners and the various First Coast lines of business (Medicare A & Medicare B). The EDI Gateway is the only means of exchanging electronic transactions with First Coast. The EDI Gateway receives and delivers transaction data (claims, claim status, remittances, etc.) between First Coast and its trading partners. The system is available 24 hours a day, 7 days a week. The diagrams below provide a high-level transaction flow for both internet and non-internet EDI transactions.

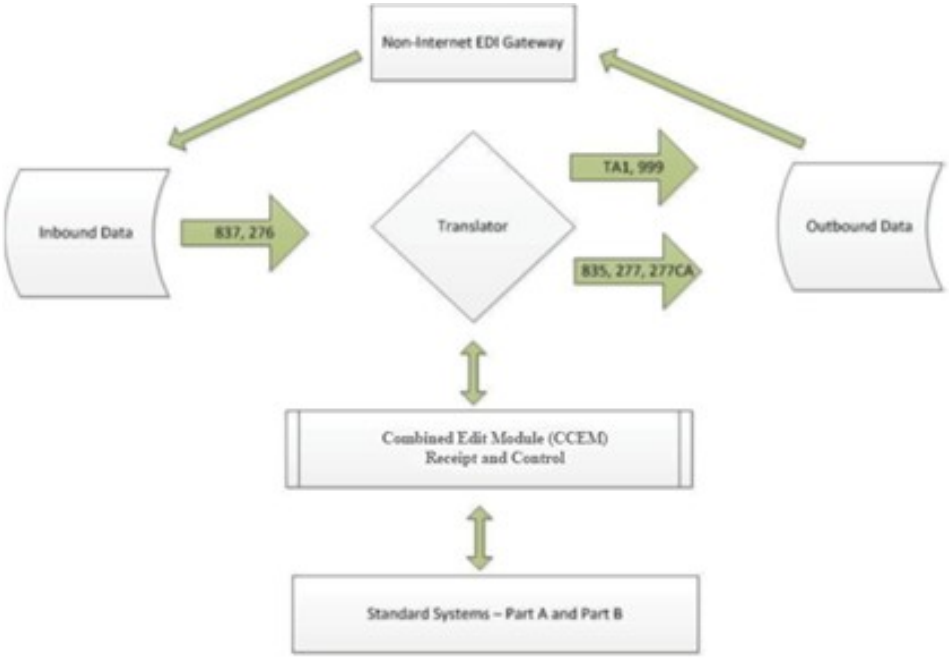

Figure 1 – Process Flow Diagram

Trading Partner submits Electronic Media Claim (EMC) to EDI Gateway Files are passed through the translator and validates that file is syntactically compliant. If file is not syntactically compliant, a TA1 or 999 Initial Acknowledgement report will be delivered in the outbound data. If the file meets syntax requirements; claims are then passed through Combined Common Edit Module (CCEM). The CCEM validates the data elements and returns the 277 Claim Acknowledgment. Once claims pass the 277CA, they are then forwarded to the Medicare processing system for adjudication and results are returned on the 835 Electronic Remittance Advice (ERA).

4.2. Transmission

For connectivity specifications access the First Coast's Guide to Gateway at: http://medicare.fcso.com/EDI_resources/138174.pdf

4.2.1. Re-transmission Procedures

Submitters can retransmit rejected files at their discretion. To avoid a file duplication reject we suggest - batching of your file to change the control number in the ISA segment.

- Re-batch your file to change the control number in the ISA segment
- Add or remove a claim
- Correct the cause of the rejection

4.3. Communication Protocol Specifications

First Coast Service Options, Inc. supports the following types of Communication Protocols

- Non-Internet
  - Secure File Transfer Protocol (SFTP)
- Internet
  - Hypertext Transfer Protocol (HTTPS)
  - Simple Object Access Protocol (SOAP)

All Medicare EDI Trading Partners submissions and retrievals are required to use a Network Service Vendor (NSV) for connectivity to the EDI Gateway including using the public internet for encrypted Transport Layer Security (HTTP/S) transport, or a Simple Object Access Protocol using X.509 Client Certificates over Secure Socket Layer for 276/277 batches and 835 transactions. For a list of NSV and their contact information visit: https://medicare.fcso.com/Getting_started/206578.asp.

The EDI Gateway is **file** oriented. All commands and health care transactions that the trading partner sends or receives are in a file and are broken down into the following simple phases of file transfer: **LOGON, SUBMIT, OBTAIN**, and **LOGOFF**.

A typical session consists of the following steps:

- Trading Partner **connects** with Gateway
- Gateway Sends Session Start Text ("**+++**")
- Trading Partner Sends **LOGON** command file
- Trading Partner Sends **SUBMIT** command file
- Trading Partner Sends **data** file
- Trading Partner Sends **OBTAIN** command file
- Trading Partner Receives **data** file
- Trading Partner Sends **LOGOFF** command file
- Trading Partner Receives **Session Messages** file
- Mutual **Disconnect**

4.4. Security Protocols and Passwords

All Trading Partners must adhere to CMS information security policies; including, but not limited to, the transmission of electronic claims, claim status, receipt of the remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information. Violation of this policy will result in revocation of all methods of system access. First Coast is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS. Additional information can be found at: https://www.cms.gov/Research-Statistics- Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library- Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html.

Trading Partners must first complete and submit an EDI enrollment form. Upon successful enrollment, First Coast will assign a unique submitted ID and mailbox ID with a temporary password. The Trading Partner will receive notification of the next steps.

The mailbox ID and password are used in your logon command within your billing software and must remain current to avoid transmission disruptions.

4.4.1. Mailbox ID criteria

Mailbox IDs are case sensitive. The mailbox ID is exactly 9 characters long and may contain upper or lower case letters [A-Z, a-z] or numbers [0-9]. The mailbox ID does not expire and must be entered exactly as given.

4.4.2. Password criteria

Passwords must be exactly eight characters long and may contain a combination of letters and numbers, but the letters must be upper case. The password expires every 60 days, may not be repeated within 10 updates and must differ from previous passwords by at least four characters. Passwords cannot be the same as your mailbox ID and it cannot be the word “PASSWORD.”

4.4.3. Password resources

Password expiration date: https://medicare.fcso.com/Gateway/check.asp

Password reset: https://medicare.fcso.com/Gateway/

5. Contact Information

5.1. EDI Customer Service

- Hours of Operation
  - Monday – Friday from 8:00 am to 5:00 pm eastern standard time. For a list of First Coast Holidays and training closures visit https://medicare.fcso.com/Contacts/index.asp.
- Fax
  - 904-361-0470
- Email Address
  - MedicareEDI@fcso.com

5.2. EDI Technical Assistance

- 1-888-670-0940

5.3. Trading Partner Service Number

- Not available

5.4. Applicable Websites / Email

- English website: https://medicare.fcso.com/
- Spanish website: https://medicareespanol.fcso.com/

6. Control Segments Envelopes

Enveloping information must be as follows:

Table 3 – Control Segments / Envelope Requirements

Page #	Element	Name	Codes/Content	Notes/Comments
	ISA	Interchange Control Header		
C.4	ISA01	Authorization Information Qualifier	00	Medicare expects the value to be 00.
C.4	ISA02	Authorization Information		ISA02 shall contain 10 blank spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare expects the value to be 00.
C.4	ISA04	Security Information		Medicare does not use Security Information and will ignore content sent in ISA04.
C.4	ISA05	Interchange ID Qualifier	27, ZZ	Must be “27” or “ZZ”.
C.4	ISA06	Interchange Sender ID		MAC or CEDI assigned Submitter ID. This is also required in the GS02.
C.5	ISA07	Interchange ID Qualifier	27, ZZ	Must be “27” or “ZZ”.
C.5	ISA08	Interchange Receiver ID		First Coast contract number 592015694.
C.5	ISA11	Repetition Separator		Defined by Submitter.
C.6	ISA14	Acknowledgement Requested	1	Medicare requires submitter to send code value 1 - Interchange Acknowledgment Requested (TA1). Medicare will only return a TA1 segment when there is an error in the ISA/IEA Interchange Envelope.
	GS	Functional Group Header		
C.7	GS02	Application Sender Code		Each MAC or CEDI will assign its own assigned Submitter ID
C.7	GS03	Application Receiver’s Code		First Coast payer IDs: Florida: 09102 Puerto Rico: 09202 US Virgin Islands: 09302

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS04	Functional Group Creation Date		Must not be a future date.
C.7	GS08	Version Identifier Code	005010X222A1	Medicare expects value "005010X222A1".

Interchange Control (ISA/IEA) and Function Group (GS/GE) and the Transaction (ST/SE) sets must be used as described in the TR3. Medicare's expectations for the Control Segments and Envelopes are detailed in Sections 6.1, 6.2, and 6.3.

6.1. ISA-IEA

Delimiters – Inbound Transactions

As detailed in the TR3, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions inbound to Medicare FFS, these characters are determined by the submitter and can be any characters as defined in the TR3 and must not be contained within any data elements within the ISA/IEA Interchange Envelope.

Delimiters – Outbound Transactions

Medicare recommends the use of the following delimiters in all outbound transactions; trading partners/submitters should contact their local A/B MAC or CEDI for any deviations. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

Table 4 – First Coast Delimiters

Delimiter	Character Used	Dec Value	Hex Value
Data Element Separator	*	42	2A
Repetition Separator	^	94	5E
Component Element Separator	:	58	3A
Segment Terminator	~	126	7E

Inbound Data Element Detail and Explanation

All data elements within the ISA/IEA interchange envelope must follow ASC X12N syntax rules as defined within the TR3.

6.2. GS-GE

Functional group (GS-GE) codes are transaction-specific. Therefore, information concerning the GS/GE Functional Group Envelope can be found in Table 3.

6.3. ST-SE

Medicare FFS follows the HIPAA-adopted TR3 requirements.

7. Specific Business Rules

This section describes the specific requirements over and above the standard information in the TR3.

7.1. General Notes

Errors identified for business level edits performed prior to the Subscriber loop (2000B) will result in immediate file failure at that point. When this occurs, no further editing will be performed beyond the point of failure.

The billing provider must be associated with an approved electronic submitter. Claims submitted for billing providers that are not associated to an approved electronic submitter will be rejected. The following table describes segments/elements not accepted by Medicare.

Table 5 - Segment / Elements Not Accepted by Medicare

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
85	2000A	CUR	Foreign Currency Information		Medicare does not support the submission of foreign currency.
96	2010AA	REF	Billing Provider UPIN/License Information		Must not be present.
106	2010AC	Loop Rule	Pay To Plan Loop		Must not be present.
129	2010BA	REF	Subscriber Secondary Identification (REF01 = “SY”)		Must not be present.
138	2010BB	REF	Payer Secondary Identification		Must not be present.
140	2010BB	REF	Billing Provider Secondary Identification		Must not be present.
142	2000C	HL	Patient Hierarchical Level		Must not be present. For Medicare, the subscriber is always the same as the patient.
144	2000C	PAT	Patient Information		Must not be present. For Medicare, the subscriber is always the same as the patient.
147	2010CA	Loop Rule	Patient Name Loop		Must not be present.

Page #	Loop ID	Reference	Name	Codes	Notes/Comments
186	2300	CN1	Contract Information		Must not be present.
191	2300	REF	Mandatory Medicare (Section 4081) Crossover Indicator		Must not be present.
196	2300	REF	Payer Claim Control Number		Must not be present.
332	2330C	Loop Rule	Other Payer Referring Provider		Must not be present.
336	2330D	Loop Rule	Other Payer Rendering Provider		Must not be present.
340	2330E	Loop Rule	Other Payer Service Facility Location		Must not be present.
343	2330F	Loop Rule	Other Payer Supervising Provider		Must not be present.
347	2330G	Loop Rule	Other Payer Billing Provider		Must not be present.
395	2400	CN1	Contract Information		Must not be present.
416	2400	HCP	Line Pricing/Repricing Information		Must not be present.

7.2. General Transaction Notes

The following are Medicare-specific general rules pertaining to the 837P transaction:

- The maximum number of characters to be submitted in any dollar amount field is seven characters. Claims containing a dollar amount in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts with values in excess of 99.99 will be rejected.

- For the exception of the CAS segment, all amounts must be submitted as positive amounts. Negative amounts submitted in any non-CAS amount element will cause the claim to be rejected.
- Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.
- Only loops, segments, and data elements valid for the TR3 will be translated. Submitting invalid data will cause files to be rejected.
- Medicare requires the NPI be submitted as the identifier for all claims. Claims submitted with legacy identifiers will be rejected. (Non-VA contractors)
- National Provider Identifiers will be validated against the NPI algorithm. Claims which fail validation will be rejected.
- The MAC will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
- Submissions with more than one GS-GE (Functional Group) per ISA-IEA (interchange) will be rejected.

8. Acknowledgments and Reports

Medicare has three acknowledgement transactions with the Version 005010 implementation: the 277CA, the 999, and the TA1 segment – which 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.

Medicare FFS has a process to only reject claim submissions that are out of compliance with the ASC X12N Version 005010 standard; the appropriate response for such errors will be returned on a 999. Batch submissions with errors will not be rejected in totality, unless warranted.

8.1. Report Inventory

First Coast does not provide any proprietary acknowledgments.

9. Trading Partner Agreement

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

Medicare FFS requires all Trading Partners to sign a Trading Partner Agreement with First Coast. This agreement can be found at https://medicare.fcso.com/EDI_Forms/.

There are no additional requirements for the Trading Partner Agreement. All procedures are outlined in the EDI enrollment and registration process section 2.2 of this guide.

10. Transaction-Specific Information

This section defines the specific CMS requirements over and above the standard information in the TR3.

10.1. Header

The following sub-sections contain specific details for the header.

10.1.1. Header and Information Source

The following table defines specific details associated with Header and Information Source:

Table 6 – Header and Information Source

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
70		ST02	Transaction Set Control Number		9	The MAC will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
		BHT	Beginning of Hierarchical Transaction			
71		BHT02	Transaction Set Purpose Code	00	2	Must equal "00" (ORIGINAL).
		ST	Transaction Set Header			
72		BHT06	Claim/Encounter Identifier	CH	2	Must equal "CH" (CHARGEABLE).

10.1.2. Loop 1000A Submitter Name

The following table defines specific details associated with Loop 1000A Submitter Name:

Table 7 - Loop 1000A Submitter Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	1000A	NM1	Submitter Name			
75	1000A	NM105	Submitter Middle Name or Initial			The first position must be alphabetic (A-Z).
75	1000A	NM109	Submitter ID		80	The MAC will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission. Submitter ID must match the value submitted in ISA06 and GS02.

10.1.3. Loop 1000B Receiver Name

The following table defines specific details associated with Loop 1000B Receiver Name.

Table 8 – Loop 1000B Receiver Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	1000B	NM1	Receiver Name			
80	1000B	NM109	Receiver Primary Identifier		80	The MAC will reject an interchange (transmission) that is not submitted with a valid Part B MAC code. Each individual MAC determines this identifier. Submitter ID must match the value submitted in ISA08 and GS03.

10.2. Billing Provider

The following sub-sections contain specific details associated with Billing Provider.

10.2.1 Loop 2000A Billing Provider Detail

The following table defines specific details associated with Loop 2000A Billing Provider.

Table 9 – Loop 2000A Billing Provider Detail

Loop ID	Notes/Comments
2000A	The Billing Provider Detail Section of this CG contains no unique CMS Medicare requirements that differ from the TR3. Refer to the TR3 specifications for the following Loops: 2000A, 2010AA, 2010AB.
2010AA	REF: must not be present (non-VA contractors). NM109: billing provider must be “associated” to the submitter (from a Trading Partner management perspective) in 1000A NM109.
	First Coast will provide appropriate direction to VA providers.

10.2.2 Loop 2010AA Billing Provider Name

The following table defines the specific details associated with Loop 2010AA Billing Provider Name.

Table 10 – Loop 2010AA Billing Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2010AA	NM1	Billing Provider Name			
89	2010AA	NM105	Billing Provider Middle Name			The first position must be alphabetic (A-Z).

10.3. Subscriber Detail

The following sub-sections contain specific details associated with Subscriber.

10.3.1. Loop 2000B Subscriber Hierarchical Level

The following table defines the specific details associated with Loop 2000B Subscriber Hierarchical Level.

Table 11 – Loop 2000B Subscriber Hierarchical Level

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000B	HL	Subscriber Hierarchical Level			
115	2000B	HL04	Hierarchical Child Code	0	1	The value accepted is “0”.
	2000B	SBR	Subscriber Information			
116	2000B	SBR01	Payer Responsibility Sequence Number Code	P, S	1	The values accepted are “P” or “S”.
117	2000B	SBR02	Individual Relationship Code	18	2	For Medicare, the subscriber is always the same as the patient.
118	2000B	SBR09	Claim Filing Indicator Code	MB	2	For Medicare, the subscriber is always the same as the patient.
	2000B	PAT	Patient Information			
120	2000B	PAT08	Patient Weight		10	For DME claims only, a maximum of 4 whole numbers and up to 2 decimal positions are allowable.

10.3.2. Loop 2010BA Subscriber Name

The following table defines the specific details associated with Loop 2010BA Subscriber Name.

Table 12 – Loop 2010BA Subscriber Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2010BA	NM1	Subscriber Name			
122	2010BA	NM102	Subscriber Entity Type Qualifier	1	1	The value accepted is 1.
122	2010BA	NM105	Subscriber Middle Name		25	The first position must be alphabetic (A-Z).
122	2010BA	NM108	Subscriber Identification Code Qualifier	MI	2	The value accepted is “MI”.
123	2010BA	NM109	Subscriber Primary Identifier		80	If a Medicare Health Insurance Claim Number (HICN): Must be 10 – 11 positions in the format of NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where “A” represents an alpha character and “N” represents a numeric digit. If Railroad IDs: 2010BA NM109 must be 7 – 12 positions in the format of ANNNNNN, AANNNNNN, ANNNNNNNNN, AANNNNNNNNN, AAANNNNNN, or AAANNNNNNNNN where “A” represents an alpha character and “N” represents a numeric digit. If MBI: must be 11 positions in the format of C A AN N A AN N A A N N where “C” represents a constrained numeric 1 thru 9, “A” represents alphabetic character A – Z but excluding S, L, O, I, B, Z, “N” represents numeric 0 thru 9, and “AN” represents either “A” or “N”.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2010BA	DMG	Subscriber Demographic Information			
127	2010BA	DMG02	Subscriber Birth Date		35	Must not be a future date.

10.3.3.Loop 2010BB Payer Name

The following table defines the specific details associated with Loop 2010BB Payer Name.

Table 13 – Loop 2010BB Payer Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2010BB	NM1	Payer Name			
134	2010BB	NM108	Payer Identification Code Qualifier	PI	2	The value accepted is “PI”

10.4. Patient Detail

The following sub-sections contain specific requirements for the Patient Detail.

10.4.1. Loop 2300 Claim Information

The following table defines the specific details associated with Loop 2300 Claim Information.

Table 14 - Loop 2310B Operating Physician Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2300	CLM	Claim Information			
158	2300	CLM01	Patient Control Number		38	Only 20 characters will be stored and returned by Medicare.
159	2300	CLM02	Total Claim Charge Amount		18	Must be >= 0 and <= 99,999.99. When Medicare is primary payer, CLM02 must equal the sum of all SV102 service line charge amounts. When Medicare is Secondary. Total Submitted Charges (CLM02) must equal the sum of all 2320 & 2430 CAS amounts and the 2320 AMT02 (AMT01=D).
159	2300	CLM05-3	Claim Frequency Code	1	1	Must be equal to “1” (ORIGINAL).
163	2300	CLM20	Delay Reason Code		2	Data submitted in CLM20 will not be used for processing.
	2300	DTP	Date Elements			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
164	2300	DTP03	Onset of Current Illness or Injury Date		35	Must not be a future date.
165	2300	DTP03	Initial Treatment Date		35	Must not be a future date.
167	2300	DTP03	Acute Manifestation Date		35	Must not be a future date.
168	2300	DTP03	Accident Date		35	Must not be a future date.
169	2300	DTP03	Last Menstrual Period Date		35	Must not be a future date.
170	2300	DTP03	Last X-Ray Date		35	Must not be a future date.
171	2300	DTP03	Prescription Date		35	Must not be a future date.
173	2300	DTP03	Disability From Date		35	Future dates are allowed in this situation.
174	2300	DTP03	Last Worked Date		35	Must not be a future date.
176	2300	DTP	Admission Date			If 2400.SV105 = "21", "51" or "61" then 2300.DTP with DTP01 = "435" must be present.
176	2300	DTP03	Related Hospitalization Admission Date		35	Must not be a future date.
177	2300	DTP03	Related Hospitalization Discharge Date		35	Must not be a future date.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2300	PWK	Claim Supplement Information			Only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.
184	2300	PWK02	Attachment Transmission Code	BM, FX, EL, FT	2	Must be “BM”, “FX”, “EL”, or “FT”.
	2300	CR1	Ambulance Transport Information			
212	2300	CR102	Patient Weight		10	A maximum of 4 whole numbers and up to 2 decimal positions are allowable. Patient weight in excess of 9,999.99 pounds will be rejected.
213	2300	CR106	Transport Distance		15	Must not exceed 4 digits. Transport distance in excess of 9,999 miles will be rejected.
	2300	HI	Health Care Diagnosis Code			All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes (pointed to or not) will be rejected.

10.4.2. Loop 2310A Referring Provider Name

The following table defines specific details associated with Loop 2310A Referring Provider Name.

Table 15 - Loop 2310A Referring Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2310A	NM1	Referring Provider Name			
258	2310A	NM105	Referring Provider Middle Name			The first position must be alphabetic (A-Z).

10.4.3. Loop 2310B Rendering Provider Name

The following table defines specific details associated with Loop 2310B Rendering Provider Name.

Table 16 - Loop 2310D Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2310B	NM1	Rendering Provider Name			
263	2310B	NM105	Rendering Provider Middle Name			The first position must be alphabetic (A-Z).

10.4.4. Loop 2310D Supervising Provider Name

The following table defines the specific details associated with Loop 2310D Supervising Provider Name.

Table 17– Loop 2310D Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2310D	NM1	Supervising Provider Name			
281	2310D	NM105	Supervising Provider Middle Name			The first position must be alphabetic (A-Z).

10.4.5. Loop 2320 Other Subscriber Information

The following table defines specific details associated with Loop 2320 Other Subscriber Information.

Table 18 – Loop 2320 Other Subscriber Information

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2320	SBR	Other Subscriber Information			
296	2320	SBR01	Payer Responsibility Sequence Number Code		1	2320 SBR01 = ”P” must be present when 2000B SBR01 = ”S”.
298	2320	SBR09	Claim Filing Indicator Code		2	The value cannot be “MA” or “MB”.
	2320	CAS	Claim Level Adjustments			CAS segment must not be present when 2000B SBR01 = “P”.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount			
305	2320	AMT01	COB Payer Paid Amount	D		Medicare requires one occurrence of 2320 loop with an AMT segment AMT01 = ”D” must be present when 2000B SBR01 = ”S”.

10.4.6. Loop 2330A Other Subscriber Name

The following table defines specific details associated with Loop 2330A Other Subscriber Name.

Table 19 – Loop 2330A Other Subscriber Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2330A	NM1	Other Subscriber Name			
313	2330A	NM105	Other Insured Middle Name			The first position must be alphabetic (A-Z).
	2330A	REF	Other Subscriber Secondary Identification			
319	2330A	REF02	Other Insured Additional Identifier		9	Must be 9 digits with no punctuation. First 3 digits cannot be higher than “272”. Digits 1-3, 4-5, and 6-9 cannot be zeros (0).

10.4.7.Loop 2330B Other Payer Name

The following table defines specific details associated with Loop 2330B Other Payer Name.

Table 20 – Loop 2330B Other Payer Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2330B	DTP	Claim Check or Remittance Date			
325	2330B	DTP03	Date Time Period		35	Must not be a future date.

10.4.8.Loop 2400 Service Line Number

The following table defines specific details associated with Loop 2400 Service Line Number.

Table 21 – Loop 2400 Service Line Number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2400	SV1	Professional Service			
352	2400	SV101-1	Product or Service ID Qualifier	HC	2	Must be “HC”.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
353	2400	SV101-3, SV101-4, SV101-5, SV101-6	Procedure Modifier		2	For DME only: These segments cannot have a value of “EX.” For DME only: When billing for capped rentals and pen pumps with 2 units of service, one of SV101-3, SV101-4, SV101-5, SV101-6 must have a value of “RT” and one of one of SV101-3, SV101-4, SV101-5, SV101-6 must have a value of “LT”.
354	2400	SV102	Line Item Charge Amount		18	SV102 must be greater than 0. SV102’s decimal positions are limited to 0, 1, or 2.
355	2400	SV103	Unit or Basis for Measurement Code	MJ, UN	2	SV103 must be “UN” for DME claims. SV103 must be "MJ" when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be "UN".
355	2400	SV104	Service Unit Count	MJ	15	Anesthesia claims must be submitted with minutes (qualifier MJ). Does not apply for DME claims.
355	2400	SV104	Service Unit Count	MJ		The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Cannot exceed 9,999. Does not apply for DME claims.
355	2400	SV104	Service Unit Count	UN		Must be > 0 with maximum of 4 whole numbers and 1 decimal position (cannot exceed 9999.9). For DME only: SV104 must be “1” or “2” for capped rentals and pen pumps.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
360	2400	SV503	Quantity			DME Only: Must be > 0 with a maximum of 3 whole numbers (must not exceed 999).
360	2400	SV504	Monetary Amount			DME Only: Must be > 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.
360	2400	SV505	Monetary Amount			DME Only: Must be > 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.
	2400	CR1	Ambulance Transport Information			
369	2400	CR102	Patient Weight			Must not exceed 4 whole numbers and 2 decimals. Patient weight in excess of 9,999.99 pounds will be rejected.
370	2400	CR106	Transport Distance		15	Must not exceed 4 digits. Transport distance in excess of 9,999 miles will be rejected.
	2400	CR3	Durable Medical Equipment Certification			Must not be present on Part B claims. CR3 segment must be present when DME CMN information is included with the claim.
371	2400	CR303	Unit or Basis for Measurement Code		2	DME Only: Must not exceed 2 digits. DME Only: Must be > 0 unless 2400 L02 = “08.02”.
	2400	CRC	Condition Indicator/ Durable Medical Equipment			Must not be present on a Part B Claim. DME only: CR3 segment must be present when DME CMN information is included with the claim.
378	2400	CRC01	Code Category	09		DME Only: When CRC Condition Indicator (CRC01 = “09”) is submitted, either CRC03 or CRC04 must be “38”.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2400	DTP	Service Date			
381	2400	DTP03	Date – Service Date		35	Must not be a future date. DME only: Must not be a single date of service when modifier RR is reported with more than 1 unit of service. DME only: When a Service Date range extends into the future, the procedure code must equate to an Inexpensive Supply, PEN Amino Acid, PEN Enteral, PEN Immunosuppressant Drug, PEN Kit/Supply, PEN Lipid, PEN Pump, PEN Special Parenteral, or PEN Dextrose/Home Mix. DME only: Must be a single DOS when procedure code is NOT “E0935” or “E0936” and the procedure code is not considered a Glucose Monitoring or Inexpensive Supply, and the procedure code is categorized as Frequently Serviced DME, Inexpensive or Routinely Purchased DME, Capped Rental DME, Stationary Liquid and Portable Oxygen Equipment, Oxygen Concentrators, Gaseous Oxygen Equipment, Liquid Oxygen Equipment, or Portable Oxygen Equipment.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
382	2400	DTP03	Date – Prescription Date		35	Must not be a future date.
	2400	DTP	Date – Certification Revision / Recertification Date			DME only: Must not be present on a Part B claim. DME only: Must not be a future date.
	2400	DTP	Date – Begin Therapy Date			DME only: Must not be present on a Part B claim. DME only: Must not be a future date.
	2400	DTP	Date – Last Certification Date			DME only: Must not be present on a Part B claim. DME only: Must not be a future date.
	2400	DTP	Date - Last Seen Date			Part B only: Must not be a future date Part B only: Segment must not be present for DME claims.
387	2400	DTP03	Test Performed Date		35	Must not be a future date.
389	2400	DTP03	Last X-Ray Date		35	Part B only: Must not be a future date. Part B only: Segment must not be present for DME claims.
390	2400	DTP03	Initial Treatment Date		35	Must not be a future date.
	2400	QTY	Ambulance Patient Count			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
391	2400	QTY02	Ambulance Patient Count		15	Must be between 1 and 99.
	2400	QTY	Obstetric Anesthesia Additional Units			
392	2400	QTY02	Obstetric Additional Units		15	Must be between 1 and 99.
	2400	MEA	Test Results			
394	2400	MEA03	MEA – Test Results		20	Must not exceed 2 whole numbers and 1 decimal position. Must be a value greater than or equal to 0 and less than or equal to 99.9.

10.4.9. Loop 2410 Drug Identification

The following table defines specific details associated with Loop 2410 Drug Identification.

Table 22 – Loop 2410 Drug Identification

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2410	LIN	Drug Identification			For DME claims, must be present when 2400 SV101-1 contains a default Healthcare Common Procedure Coding System (HCPCS) code.
425	2410	LIN02	Product or Service ID Qualifier	N4	2	Must be N4.
425	2410	LIN03	National Drug Code		11	Must be exactly 11 alphanumeric positions.
	2410	CTP	Drug Quantity			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
426	2410	CTP04	National Drug Unit Count		15	Must be greater than 0 and less than or equal to 9,999,999.999.
427	2410	CTP05-1	Unit or Basis for Measurement Code			For DME claims only: Must be "UN" when 2410 LIN03 NDC is found on Medicare file as associated to an Oral Cancer Drug HCPCS code.
	2410	REF	Prescription or Compound Drug Association Number			Must be submitted with REF01 = "XZ" if service line includes modifier J1.
428	2410	REF01	Reference Identification Qualifier	XZ		If service line (SV1) includes Modifier J1, REF01 = "XZ" must be present.

10.4.10. Loop 2420A Rendering Provider Name

The following table defines specific details associated with Loop 2420A Rendering Provider Name.

Table 23 – Loop 2420A Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2420A	NM1	Rendering Provider Name			
431	2420A	NM105	Rendering Provider Middle Name			The first position must be alphabetic (A-Z).

10.4.11. Loop 2420D Supervising Provider Name

The following table defines specific details associated with Loop 2420D Supervising Provider Name.

Table 24 – Loop 2420D Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2420D	NM1	Supervising Provider Name			
450	2420D	NM105	Supervising Provider Middle Name			First position of Supervising Provider Middle Name must be alphabetic (A-Z).

10.4.12. Loop 2420E Ordering Provider Name

The following table defines specific details associated with Loop 2420E Ordering Provider Name

Table 25 – Loop 2420E Ordering Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2420E	NM1	Ordering Provider Name			
455	2420E	NM105	Ordering Provider Middle Name			First position of Ordering Provider Middle Name must be alphabetic (A-Z).

10.4.13. Loop 2420F Referring Provider Name

The following table defines specific details associated with Loop 2420F Referring Provider Name.

Table 26 – Loop 2420F Referring Provider Name

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2420F	NM1	Referring Provider Name			
466	2420F	NM105	Referring Provider Middle Name			First position of Referring Provider Middle Name must be alphabetic (A-Z).

10.4.14. Loop 2430 Line Adjudication Information

The following table defines specific details associated with Loop 2430 Line Adjudication Information.

Table 27 – Loop 2430 Line Adjudication Information

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2430	SVD	Line Adjudication Information			
481	2430	SVD03-1	Product or Service ID Qualifier	HC	2	Must be "HC". Claims with "ER", "IV" or "WK" will be rejected.
483	2430	SVD05	Paid Service Unit Count		15	Must not exceed 4 whole numbers and one decimal position. Must be a value greater than or equal to 0 and less than or equal to 9999.9
483	2430	SVD06	Bundled Line Number			Must be an integer (no decimals).
	2430	DTP	Line Check or Remittance Date			
490	2430	DTP03	Adjudication or Payment Date			Must not be a future date.

10.4.15. Loop 2440 Form Identification Code

The following table defines the specific requirements for the Loop 2440 Form Identification Code data.

Note: This loop is only for Durable Medical Equipment (DME) Claims. This loop must not be present for Part B Claims.

Table 28 – Loop 2440 Form Identification Code

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2440	LQ	Form Identification Code			DME claims only. Not valid for Part B Claims.
493	2440	LQ01	Code List Qualifier Code	UT	3	DME Must be “UT”. DME claims only. Not valid for Part B Claims.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2440	FRM	Supporting Documentation			FRM segment is used for DME claims only. Not valid for Part B Claims.
495	2440	FRM01	Question Number/Letter		20	DME claims only. Not valid for Part B Claims. When LQ02='484.03' and FRM01='6A' or '6B', an occurrence of FRM01 with the value of '6C' is required.
495	2440	FRM01	Question Number/Letter		20	DME claims only. Not valid for Part B Claims. When LQ02='484.03' and FRM01='6C', an occurrence of FRM01 with the value of '6A' or '6B' is required.
495	2440	FRM01	Question Number/Letter		20	FRM01 Question number must be valid for the LQ02 CMN/DIF number.
495	2440	FRM01	Question Number/Letter		20	When LQ02 = ‘484.03”, occurrences of FRM01 = "1A" or "1B", and FRM01 = "1C", and FRM01 = "05" must be present.
495	2440	FRM01	Question Number/Letter		20	When LQ02 = ‘484.03” and FRM01 = “1A”, and FRM03 is greater than or equal to “55.5” and less than or equal to “59.4”, occurrences of FRM01 = “07”, “08” and “09” must be present.
495	2440	FRM01	Question Number/Letter		20	When LQ02 = ‘484.03” and FRM01 = “1B”, and FRM05 is greater than or equal to “88.5” and less than or equal to “89.4”, occurrences of FRM01 = “07”, “08” and “09” must be present.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
495	2440	FRM02	Question Number/Letter		1	DME claims only. Not valid for Part B Claims. When LQ02 = '484.03" and FRM with FRM01 = "04", "07", "08" or "09" is present, then FRM02 must be present.
495	2440	FRM03	Question Response		50	DME claims only. Not valid for Part B Claims. When LQ02 = "04.04" and FRM01 = "07B", "09B", "10B" or "10C", FRM03 must be present.
495	2440	FRM03	Question Response		50	DME claims Only. Not valid for Part B Claims. When LQ02 = "06.03" and FRM01 = "02" or "03", FRM03 must be present.
495	2440	FRM03	Question Response		50	DME claims Only. Not valid for Part B Claims. When LQ02 = "09.03" and FRM01 = "01", "01A", "01B", "01C", "02", "02A", "02B", "02C", "03" or "04", FRM03 must be present.
495	2440	FRM03	Question Response		50	DME claims Only. Not valid for Part B Claims. When LQ02 = "10.03" and FRM01 = "03", "03A", "03B", "04", "04A", "04B", "05", "06", "08A", "08C", "08D", "08F", "08G" or "09", FRM03 must be present.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
495	2440	FRM03	Question Response		50	DME claims Only. Not valid for Part B Claims. When LQ02 = '484.03" and FRM with FRM01 = "1A", "1B", "02", "03" or "05" is present, then FRM03 must be present.
495	2440	FRM04	Question Response		8	DME claims Only. Not valid for Part B Claims. Must not be a future date.
495	2440	FRM04	Question Response		8	DME claims Only. Not valid for Part B Claims. When LQ02 = "484.03" and FRM with FRM01 = "1C" or “6C” is present, then FRM04 must be present.
495	2440	FRM05	Question Response		6	DME claims Only. Not valid for Part B Claims. When LQ02 = "10.03" and FRM01 = "08B", "08E" or "08H", FRM05 must be present.
495	2440	FRM05	Question Response		6	When LQ02 = ”484.03” and FRM01 = “1B” or “6B”, FRM05 must be present.
495	2440	FRM05	Question Response		6	DME claims Only. Not valid for Part B Claims. Must be between 0 and 100 and can contain up to one decimal place.

10.4.16. Transaction Set Trailer

The following table defines the specific details associated with the Transaction Set Trailer.

Table 29 – Transaction Set Trailer

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		SE	Transaction Set Trailer			
496		SE02	Transaction Set Control Number		9	Must have the same value as ST02. Must be greater than zero.

11. Appendices

11.1. Implementation Checklist

For a step-by-step guide to getting started submitting electronic claims visit https://medicare.fcso.com/Getting_started/138080.asp.

11.2. Transmission Examples

11.2.1. TA1 - Interchange Acknowledgment - File Rejected

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *980903*1215*^*00501*100469823*1*P*>~

TA1*000000003*991229*1650*R*024

Note: ISA-14 must contain a “1” in order to receive a TA1 rejection. If the ISA-14 is populated with a “0” a TA1 will not be returned.

11.2.2. 999 - Implementation Acknowledgment - File Accepted

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *110126*1316*^*00501*000000001*0*P*:~

GS*FA*09102*P9999*20110126*131612*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*17001*005010X223A1~
AK2*837*000000001*005010X223A1~
IK5*A~
AK9*A*1*1*1~
SE*6*0001~
GE*1*1~
IEA*1*000000001~

11.2.3. 999 - Implementation Acknowledgment - File Accepted with Errors

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *110126*1316*^*00501*000000001*0*P*:~

GS*FA*09102*P9999*20110111*131550*1*X*005010X231A1~
ST*999*0001*005010X231A1~

CMS 837P Version 005010X222A1

AK1*HC*17001*005010X223A1~
AK2*837*000000001*005010X223A1~
IK3*SE*60*2430*4~
IK5*E*5~
AK9*E*1*1*1~
SE*7*0001~
GE*1*1~
IEA*1*000000001~

11.2.4.999 – Implementation Acknowledgment – File Rejected

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *110126*1316*^*00501*000000001*0*P*:~

GS*FA*09102*P9999*20101203*090751*1*X*005010X231A1~ ST*999*0001*005010X231A1~
AK1*HC*17001*005010X223A1~
AK2*837*69791639*005010X223A1~
IK3*DTP*46*2430*8~
IK4*3*1251*7*20100101~
IK3*AMT*47*2430*8~
IK4*1*522*7*EAL~
IK5*R*5~
AK9*R*1*1*0~
SE*10*0001~
GE*1*1~
IEA*1*000000001~

11.2.5. 277CA – Claim Acknowledgment

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *110126*1316*^*00501*000000001*0*P*:~

GS*HN*09102*P9999*20110113*102222*1*X*005010X214~
ST*277*000000001*005010X214~
BHT*0085*08*11013*20110113*102222*TH~
HL*1**20*1~
NM1*PR*2*First Coast SERVICE OPTIONS*****46*09101~
TRN*1*0910220110113000001~
DTP*050*D8*20110113~
DTP*009*D8*20110113~
HL*2*1*21*1~
NM1*41*2*First Coast BASE FILE*****46*A9999~
TRN*2*244579~ STC*A1:19:PR*20110113*WQ*100.00~
QTY*90*1~
AMT*YU*100.00~
HL*3*2*19*1~
NM1*85*2*DR SMITH*****XX*999999999~
TRN*1*First Coast12345~ STC*A1:19:PR**WQ*100.00~
QTY*QA*1~
AMT*YU*100.00~
HL*4*3*PT~
NM1*QC*1*TEST*BEATRICE****MI*100000000A~
TRN*2*BEA12345~
STC*A2:20:PR*20110113*WQ*100.00~
REF*1K*0211013001010~
REF*D9*17312345600006351~
DTP*472*RD8*20061003-20061010~
SE*27*000000001~
GE*1*1~
IEA*1*000000001~

11.2.6. 837 Professional Claim

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ISA*00*  *00        *ZZ*P9999          *ZZ*592015694    *081017*0852*^*00501*006745112*1*P*:~
GS*HC*P9999*09102*20081017*0929*6745112*X*005010X222A1~
ST*837*6847.060M*005010X222A1~
BHT*0019*00*244579*20061015*1023*CH~
NM1*41*1*JOHNSON*BARBARA*T***46*A0014~
PER*IC*MIKE*TE*9047916000*EX*231~
NM1*40*2*MEDICARE FLB*****46*09102~
HL*1**20*1~
PRV*BI*PXC*2085R0202X~
NM1*85*2*DR SMITH*****XX*9999999999~
N3*123 OCEAN AVE~
N4*JACKSONVILLE*FL*322051234~
REF*EI*568123456~
NM1*87*2~
N3*2345 RIVER RD~
N4*JACKSONVILLE*FL*322051234~
HL*2*1*22*0~
SBR*P*18**MEDICARE*****MB~
NM1*IL*1*SMITH*JANE****MI*200000000A~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
DMG*D8*19550501*F~
NM1*PR*2*MEDICARE*****PI*09102~
N3*PO BOX 44117~
N4*JACKSONVILLE*FL*322314117~
CLM*12345678*100***11:B:1*Y*A*Y*I~
REF*D9*17312345600006351~
HI*BK:0340*BF:V7389~
LX*1~
SV1*HC:99213*40*UN*1***1~
DTP*472*D8*20061003~
LX*2~
SV1*HC:87070*15*UN*1***1~
DTP*472*D8*20061003~
LX*3~
SV1*HC: 99214*35*UN*1***2~
DTP*472*D8*20061010~
LX*4~
SV1*HC:86663*10*UN*1***2~
DTP*472*D8*20061010~
SE*39*6847.060M~
GE*1*6745112~
IEA*1*006745112~
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11.3. Frequently Asked Questions

Frequently asked questions can be accessed at

http://medicare.fcso.com/FAQs/index.asp. CAQH CORE Operating Rules for Phase II and Phase III can be accessed at https://www.caqh.org/core/frequently-asked-questions.

11.4. Acronym Listing

Table 30 – Acronyms Listing and Definitions

Acronym	Definition
276/277	276/277 Claim Status Request and Response transaction
277CA	277 Claim Acknowledgement
999	Implementation Acknowledgment
ASC	Accredited Standards Committee
CAQH CORE	Council for Affordable Quality Healthcare - Committee on Operating Rules for Information Exchange
CEDI	Common Electric Data Interchange
CCEM	Combined Common Edits Module
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EMC	Electronic Media Claim
ERA	Electronic Remittance Advice
FFS	Medicare Fee-For-Service
GS/GE	GS – Functional Group Header / GE – Functional Group Trailer
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
IOM	Internet-only Manual
ISA/IEA	ISA – Interchange Control Header / IEA – Interchange Control Trailer
MAC	Medicare Administrative Contractor
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
ST/SE	ST – Transaction Set Header / SE – Transaction Set Trailer
TA1	Interchange Acknowledgment

Acronym	Definition
TR3	Technical Report Type 3
X12	A standards development organization that develops EDI standards and related documents for national and global markets (See: The official ASC X12 website)
X12N	Insurance subcommittee of X12

11.5. Change Summary

The following table details the version history of this CG.

Table 31 – Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
1.0	November 5, 2010	All	Initial Draft
2.0	January 3, 2010	All	1st Publication Version
3.0	April 2011	6.0	2nd Publication Version
4.0	September 2015	All	3rd Publication Version
5.0	March 2019	All	4th Publication Version
6.0	May 2020	1.3 and 11.4	5th Publication Version