Centers for Medicare & Medicaid Services (CMS)

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Standard Companion Guide
Health Care Status Request and Response (276/277)

Based on ASC X12N Implementation Guide, Version 005010X212

Companion Guide Version Number: 6.0, May 2020

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.

- Chapter 31 - X12 Formats Other than Claims or Remittance. This document can be accessed at https://www.cms.gov/manuals/downloads/clm104c31.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 276/277 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 276/277 Health Care Claim Status Request/Response transaction Version 005010X212.

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 276/277 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 X12N 276/277.
- **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 276/277.

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

First Coast does not require testing for 276/277 Claims Statusinquiries.

3. Testing and Certification Requirements

3.1. Testing Requirements

All submitters must produce accurate electronic test files before being allowed to submit claimtransactions 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. Testing of the 276/277 paired transactions is dependenton successful and accurate exchange of electronic claims data between Trading Partners. This CG recommends testing the 276/277 prior to production status whenever possible.

- 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 relationaledits.
- TR3 Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes and modifiers. A submitter must demonstrate, at a minimum, 95 percent accuracy rate indata 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.

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.

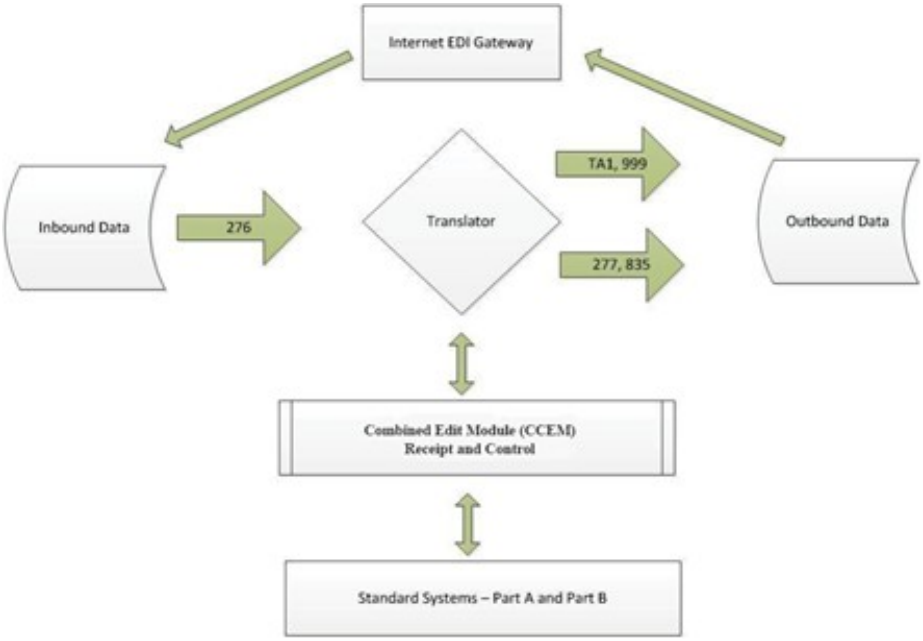

Figure 1 – High Level transaction flow for EDI transaction

Trading Partner submits 276 Claims Status Request to the EDI Gateway. Files are passed through a translator that validates the file is syntactically compliant. If file is not syntactically compliant, a TA1 or 999 Initial Acknowledgment report will be delivered in the outbound data. If the file meets syntax requirements; 276 Claims Status Requests are then passed through the Combined Common Edit Module (CCEM). The data is then sent to the Medicare processing systems. Results are returned on the 277 Claim Status Response.

4.2. Transmission

First Coast provides trading partners information and instruction on transmission requirements. For additional information please access First Coast's Guide to the EDI 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 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** between Trading Partner and Gateway

NOTE: As of April 2017, internet connectivity is now a valid communication protocol for 276/277 Status Inquiry and Response transactions and with CMS prior approval.

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.

Providers who wish to use the EDI Gateway must first complete and submit an EDI enrollment form. Upon successful enrollment, First Coast will assign a unique mailbox ID and an initial password to the provider. Trading Partners will receive notification of the next steps.

The mailbox ID and password are used in your logon command in 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."

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 for the 276:

Table 3 – 276 Control Segments / Envelope Requirements

Page #	Element	Name	Codes/Content	Notes/Comments
	ISA	Interchange Control Header		
C.4	ISA01	Authorization Information Qualifier	00, 03	ISA01 must be “00” or “03”.
C.4	ISA02	Authorization Information		Medicare expects 10 spaces.
C.4	ISA03	Security Information Qualifier	00, 01	Medicare expects the value to be “00” or “01”.
C.4	ISA04	Security Information		Medicare expects 10 spaces.
C.4	ISA05	Interchange ID Qualifier		ISA05 = “27”, “28”, or “ZZ”.
C.4	ISA06	Interchange Sender ID	First Coast-assigned Submitter ID.	This value is required to be in the 2100A Loop, NM1 Segment, NM109 data element.
C.5	ISA07	Interchange ID Qualifier	27, 28, ZZ	ISA07 = “27”, “28”, or “ZZ”.
C.5	ISA08	Interchange Receiver ID	592015694	First Coast's Tax ID 592015694
C.5	ISA11	Repetition Separator		ISA 11 must be "|".
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		Submitter number assigned by First Coast.
C.7	GS03	Application Receiver Code		First Coast receiver ID.
C.7	GS08	Version Identifier Code	005010X212	GS08 must also match the ST03.

Enveloping information will be sent as follows for the 277:

Table 4 – 277 Control Segments / Envelope Requirements

Page #	Element	Name	Codes/Content	Notes/Comments
	ISA	Interchange Control Header		
C.4	ISA01	Authorization Information Qualifier	00, 01	Medicare will send “00”.
C.4	ISA02	Authorization Information		Medicare will send 10 spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare will send “00”.
C.4	ISA04	Security Information		Medicare will send 10 spaces.
C.4	ISA05	Interchange ID Qualifier		Medicare will send “ZZ”.
C.4	ISA06	Interchange Sender ID	First Coast Payer ID	First Coast payer IDs: Florida: Part A: 09101 Florida Part B: 09102 Puerto Rico Part B: 09202 US Virgin Islands & Puerto Rico Part A: 09201 US Virgin Islands Part B: 09302
C.5	ISA07	Interchange ID Qualifier		Medicare will send “ZZ”.
C.5	ISA08	Interchange Receiver ID		MAC/CEDI-assigned Trading Partner ID.
C.5	ISA11	Repetition Separator		First Coast EDI repetition separator character "|".
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		

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code		First Coast payer IDs: Florida: Part A: 09101 Florida Part B: 09102 Puerto Rico Part B: 09202 US Virgin Islands & Puerto Rico Part A: 09201 US Virgin Islands Part B: 09302
C.7	GS03	Application Receiver Code		Submitter number assigned by the First Coast.
C.8	GS08	Version Identifier Code	005010X212	GS08 must match ST03.

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.

Note: Medicare FFS only accepts one functional group per ISA/IEA, based upon the TR3 for the transaction. If a transaction is submitted based upon a different TR3, it must be contained within its own Interchange.

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 5 – Transaction 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 and 4.

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

The following general notes pertain to the 276/277 transaction:

- The response to a 276 Version 005010X212 request will always be the paired 277 Version 005010X212 response. The 277CA Version 005010X214 will never be used to respond to a 276 Version 005010X212 request.

7.2. General Transaction Notes

The following general transaction notes pertain to the 276/277 transaction:

- Part A will be returning claim level status information, but not line level status information.
- Information Receiver Status Information (Loop ID 2200B, STC – Segment Rule) has a limitation of up to five iterations allowed for all occurrences in these transactions.
- Dependent level is never used for Medicare.
- Reference TR3 Appendix B.1.1.3.1.2 for notes regarding amount fields in this transaction set.

7.3. Medicare Specific Business Rules

Medicare generates a series of reports based on the incoming transaction. Below are the reports related to the 276 Claim Status Request.

- Upon receipt of the 276 Claim Status Request we will generate a TA1 or 999 if errors are in the file
- The 277 Claim Status Response will be available the next business day for accepted 276 Claim Status files.
- The 277 will remain available for 60 days.

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. TA1 Interchange Acknowledgment

The TA1 is used by Medicare FFS to communicate the rejection of a 276 based on errors encountered with ASC X12N compliance, formatting, or CMS-specific requirements of the ISA/IEA Interchange segments.

The following are examples of conditions when a TA1 may be returned:

- A 276 request is received, and the version of the transmission cannot be determined.
- A 276 request is received, and the version of the transmission is unsupported by Medicare FFS.
- The Trading Partner has not been authorized for the submitted ASC X12N version.
- The sender is not authorized as an active Medicare FFS Trading Partner.

8.2. 999 Implementation Acknowledgment

Medicare FFS has elected to use the ASC X12 999. For submissions that are out of compliance with the ASC X12 Version 005010 standard, the appropriate response for such errors will be returned with a 999. Refer to Section 7.3 for Medicare-specific 999-related business rules.

Technical specifications for the ASC X12N 999 are published for the ASC X12N 276/277 Health Care Claim Status Request and Response transactions at the official ASC X12 website.

8.3. Report Inventory

This section does not apply to First Coast.

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 specific details associated with CMS over and above the standard information in the ASC X12N 276/277 TR3.

10.1. Health Care Claim Status Request Transaction (276)

The section describes the values required by CMS in 276 requests.

10.1.1. Loop 2000A Information Source Level Structure (276)

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

Table 6 – Loop 2000A Header and Information Source Data (276)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
		BHT	Beginning of Hierarchical Transaction			
	2000A	HL	Information Source Level			
	2100A	NM1	Payer Name			

42	2100A	NM108	Identification Code Qualifier	PI	2	Medicare expects "PI".
42	2100A	NM109	Payer Identifier		80	Sender ID must match the value submitted in ISA06 and GS02.

10.1.2. Loop 2000B Information Receiver Level Structures (276)

The following table defines the specific details associated with Information Receiver Structures.

Table 7 – Loop 2000B Information Receiver Detail (276)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000B	HL	Information Receiver Level			
	2100B	NM1	Information Receiver Name			
46	2100B	NM109	Information Receiver Identification Number		80	Receiver ID. Must match the value submitted in ISA08 and GS03.

10.1.3. Loop 2000C Service Provider Detail Structures (276)

Trading Partners that submit transaction on behalf of a provider must ensure that the correct, valid, and active Medicare Provider identification is submitted. The following table defines specific details associated with Service Provider Structures.

Table 8 – Loop 2000C Service Provider Detail (276)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000C	HL	Service Provider Level			
	2100C	NM1	Provider Name	1P		Medicare Limitation: Only one iteration allowed.
51	2100C	NM108	Identification Code Qualifier	XX, SV	2	For VA, 2100C NM108 must be “XX” or “SV.” For everyone except VA, 2100C NM108 must be “XX.”
51	2100C	NM109	Provider Identifier		80	

10.1.4. Loop 2000D Subscriber Level Structures (276)

Trading Partners must ensure that only one Medicare beneficiary request is submitted in the Subscriber level for each 276 request. For Medicare, the patient is always the Subscriber. The following table defines specific details associated with Subscriber level Structures.

Table 9 – Loop 2000D Subscriber Detail (276)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000D	HL	Subscriber Level			
	2000D	DMG	Subscriber Demographic Information			
55	2000D	DMG02	Subscriber Birth Date		35	Must not be a future date.
	2100D	NM1	Subscriber Name			
56	2100D	NM102	Entity Type Qualifier	1	1	Medicare requires value = “1”.
57	2100D	NM104	Subscriber First Name		35	Medicare requires Subscriber First Name.
57	2100D	NM108	Identification Code Qualifier	MI	2	Must be "MI".
57	2100D	NM109	Subscriber Identifier		80	Refer to Section 7.1 for Medicare-specific information.
	2200D	TRN	Subscriber Claim Status Tracking Number			
	2200D	REF	Payer Claim Control Number			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
59	2200D	REF02	Payer Claim Control Number		50	For VMS, must be 14 digits. For MCS, must be 13 digits. For Fiscal Intermediary Standard System (FISS), must be 14 - 23 characters.
	2200D	REF	Institutional Bill Type Identification			
60	2200D	REF01	Bill Type Qualifier	BLT	3	Part A only. Not allowed for Part B and CEDI.
60	2200D	REF02	Bill Type Identifier		50	
	2200D	REF	Application or Location System Identifier			
61	2200D	REF01	Location Number	LU		For VA, 2200D REF with REF01 = “LU” must be present.
61	2200D	REF02	Application or Location System Identifier			For VA, 2200D REF02 must be a value directly obtained from the contractor when beginning to exchange information.
	2200D	AMT	Claim Submitted Charges			
66	2200D	AMT02	Total Claim Charge Amount		10	2200D AMT02 must be <= 99,999,999.99. Refer to TR3 Section B.1.1.3.1.2.
	2200D	DTP	Claim Service Date			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
67	2200D	DTP01	Date Time Qualifier.		3	For Part A, 2200D.DTP with DTP01 = "472" must be present. For Part B professional claims, 2200D DTP with DTP01 = “472” must be present when 2210D DTP with DTP01 = “472” is not present.
68	2200D	DTP03	Claim Service Period		35	If 2200D DTP02 = "RD8" then the 2nd date listed in 2200D DTP03 must be >= the 1st date listed in 2200D DTP03.
	2210D	SVC	Service Line Information			
69	2210D	SVC01-1	Product or Service ID Qualifier	HC, HP, NU, N4	2	For Part A, must be “HC”, “HP”, or “NU”. For Part B, must be “HC”. For CEDI, must be “HC” or “N4”.
71	2210D	SVC01-2	Procedure Code		48	
72	2210D	SVC02	Line Item Charge Amount		10	2210D SVC02 must be >= 0. Refer to TR3 Section B.1.1.3.1.2.

10.1.5. Loop 2200E Dependent Level Structures (276)

The following table defines specific details associated with 276 Dependent Level Structures.

Table 10 – Loop 2200E Dependent Level Detail (276)

Loop ID	Notes/Comments
2200E	Dependent-level structures are not used by Medicare FFS. The patient is always the Subscriber.

10.2. Health Care Claim Response Transaction (277)

This section defines CMS-specific requirements in conjunction with the standard information in the ASC X12N 276/277 Version 005010X212. CMS will be the Information Source for all outbound Medicare transactions.

10.2.1. Loop 2000A Information Source Level Structures (277)

The following table defines the specific details associated with 277 Header and Information Source Structures.

Table 11 – Loop 2000A Header and Information Source Detail (277)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		ST	Transaction Set Header			
		BHT	Beginning of Hierarchical Transaction			
107		BHT03	Originator Application Transaction Identifier		50	BHT03 will be the cycle date in CCYYDDD Julian date format concatenated with value from ST02.
	2000A	HL	Information Source Level			
	2100A	NM1	Payer Name			
112	2100A	NM108	Identification Code Qualifier	PI	2	Medicare generates the value of "PI".
112	2100A	NM109	Payer Identifier		80	Transmitted value from the associated 276.
	2100A	PER	Payer Contact Information			The telephone number will always be transmitted in the first communication number set, an email address will be sent in the second communication number set, if the information is applicable and available. The third communication number set will not be transmitted.
114	2100A	PER02	Payer Contact Name.		60	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
114	2100A	PER03	Payer Contact Information.	TE	2	For DME the value "FX" will not be used.
114	2100A	PER05	Payer Contact Information.	EM	2	For DME the value "FX" will not be used.
115	2100A	PER07	Communication Number Qualifier	FX	2	For DME the value "FX" will not be used.

10.2.2. Loop 2000B Information Receiver Level Structures (277)

This following table defines specific details associated with 277 Information Receiver Structures.

Table 12 – Loop 2000B Information Receiver Detail (277)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000B	HL	Information Receiver Level			
	2100B	NM1	Information Receiver Name			
118	2100B	NM101	Entity Identifier Code		3	Transmitted value from the associated 276.
118	2100B	NM102	Entity Type Qualifier		1	Transmitted value from the associated 276.
119	2100B	NM103	Information Receiver Last or Organization Name		60	Transmitted value from the associated 276
119	2100B	NM104	Information Receiver First Name		35	Transmitted value from the associated 276
119	2100B	NM105	Information Receiver Middle Name		25	Transmitted value from the associated 276
119	2100B	NM108	Identification Code Qualifier		2	Transmitted value from the associated 276

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
119	2100B	NM109	Information Receiver Identification Number		80	Transmitted value from the associated 276. Same as GS02.
	2200B	TRN	Information Receiver Trace Identifier			
	2200B	STC	Information Receiver Status Information			Up to five iterations of the STC will be allowed for all occurrences in these transactions. When 2000B HL04 = "0", one iteration of 2200B STC is required. When not triggered, 2200B STC is not allowed.
121	2200B	STC01-1	Health Care Claim Status Category Code		41	
122	2200B	STC02	Status Information Effective Date		8	The current (system) date in CCYYMMDD format.
	2200B	STC10	Health Care Claim Status		16	
122	2200B	STC10-1	Health Care Claim Status Category Code		30	
	2200B	STC11	Health Care Claim Status		30	
123	2200B	STC11-1	Health Care Claim Status Category Code		30	

10.2.3. Loop 2000C Service Provider Level Structures (277)

The following table defines specific details associated with 277 Service Provider Structures.

Table 13 – Loop 2000C Service Provider Detail (277)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000C	HL	Service Provider Level			Must be present.
	2100C	NM1	Provider Name			Only 1 iteration of the 2100C loop allowed by Medicare.
127	2100C	NM101	Entity Identifier Code		3	Transmitted value from the associated 276.
127	2100C	NM102	Entity Type Qualifier		1	Transmitted value from the associated 276.
127	2100C	NM103	Provider Last or Organization Name		60	Transmitted value from the associated 276.
127	2100C	NM104	Provider First Name		35	Transmitted value from the associated 276.
127	2100C	NM105	Provider Middle Name		25	Transmitted value from the associated 276.
127	2100C	NM107	Provider Name Suffix		10	Transmitted value from the associated 276.
128	2100C	NM108	Identification Code Qualifier		2	Transmitted value from the associated 276.
128	2100C	NM109	Provider Identifier		80	Transmitted value from the associated 276.
	2200C	TRN	Provider of Service Trace Identifier			
	2200C	STC	Provider Status Information			Up to five iterations of the STC will be allowed for all occurrences in these transactions.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
131	2200C	STC02	Status Information Effective Date		8	Current (system) date in CCYYMMDD format.
	2200C	STC10	Health Care Claim Status			
131	2200C	STC10-1	Health Care Claim Status Category Code		30	
	2200C	STC11	Health Care Claim Status			
132	2200C	STC11-1	Health Care Claim Status Category Code		30	2200C ST11-1 may be present if 2200C STC10-1 is present.

10.2.4. Subscriber Level Structures (277)

For Medicare FFS, the patient is always the subscriber. The following table defines specific details associated with 277 Subscriber Structures.

Table 14 – Loop 2000D Subscriber Detail (277)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2000D	HL	Subscriber Level			
	2100D	NM1	Subscriber Name			
135	2100D	NM102	Entity Type Qualifier	1	1	
136	2100D	NM103	Subscriber Last Name		60	Transmitted value from the associated 276.
136	2100D	NM104	Subscriber First Name		35	Transmitted value from the associated 276.
136	2100D	NM105	Subscriber Middle Name or Initial		25	Transmitted value from the associated 276.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
136	2100D	NM107	Subscriber Name Suffix		10	Transmitted value from the associated 276.
136	2100D	NM108	Subscriber Name		2	Transmitted from the associated 276.
136	2100D	NM109	Subscriber Identifier		80	For Medicare HICNs: 2100D NM109 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. For Railroad IDs: 2100D NM109 must be 7 - 12 positions in the format of ANNNNNN or AANNNNNN or AAANNNNNN or ANNNNNNNNN or AANNNNNNNNN 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; "AN" represents either "A" or "N".

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2200D	TRN	Claim Status Tracking Number			
137	2200D	TRN02	Referenced Transaction Trace Number		50	Transmitted value from the associated 276.
	2200D	STC	Claim Level Status Information			Part A returns claim level status information, but not line level status information. Up to five iterations of the STC will be allowed for all occurrences in these transactions.
138	2200D	STC01-1	Health Care Claim Status Category Code		30	Claim found: Any valid Health Care Claim Status Code Category, except "R". Claim not found: Category Code of "A4" will be generated.
138	2200D	STC01-2	Status Code		30	Valid Claim Status Code. Claim not found: Status code "35" will be generated.
144	2200D	STC01-4	Code List Qualifier Code		3	Not present.
145	2200D	STC02	Status Information Effective Date		8	Claim found: Date the claim moved to the current location status from the internal system, in CCYYMMDD format. Claim not found: Current (system) date, in CCYYMMDD format.
145	2200D	STC04	Total Claim Charge Amount		10	Refer to TR3 Section B.1.1.3.1.2

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
145	2200D	STC05	Claim Payment Amount		10	Refer to TR3 Section B.1.1.3.1.2
145	2200D	STC06	Adjudication Finalized Date		8	
146	2200D	STC08	Remittance Date		8	
146	2200D	STC09	Remittance Trace Number		16	
146	2200D	STC10	Health Care Claim Status			
146	2200D	STC10-1	Health Care Claim Status Category Code		30	Any valid Health Care Claim Status Code Category, except "R".
147	2200D	STC10-4	Code List Qualifier Code		3	Not present.
148	2200D	STC11-4	Code List Qualifier Code		3	Not present.
148	2200D	STC12	Free-form Message Text		264	Not present.
149	2200D	REF	Payer Claim Control Number			
149	2200D	REF02	Payer Claim Control Number		50	For VMS, 14 digits. For MCS, 13 digits. For FISS, 14-23 characters.
	2200D	REF	Institutional Bill Type Identification			Part A only.
150	2200D	REF02	Bill Type Identifier		50	
	2200D	REF	Patient Control Number			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
151	2200D	REF02	Patient Control Number		20	Transmitted value from the associated 276. If not transmitted from the 276 and claim found, will be the patient account number from the internal system.
	2200D	REF	Pharmacy Prescription Number			
152	2200D	REF02	Pharmacy Prescription Number		50	Transmitted value from the associated 276. If not transmitted from the 276, will be the pharmacy prescription number from the internal system.
	2200D	REF	Voucher Identifier			Not used by Medicare.
	2200D	REF	Claim Identification Number for Clearinghouses			
154	2200D	REF02	Clearinghouse Trace Number		50	Transmitted value from the associated 276.
	2200D	DTP	Claim Service Date			
156	2200D	DTP03	Claim Service Period		35	Transmitted value from the associated 276.
	2220D	SVC	Service Line Information			Part A: The appropriate Part A Claim Level Only Processing = E4 Cat & 247 - Claim Status Code indicates only claim level processing to occur.
157	2220D	SVC01-1	Product or Service ID Qualifier		2	Claim found: transmitted value from the associated 276.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
159	2220D	SVC01-2	Procedure Code		48	Claim Found: Procedure code used to adjudicate the claim (from the internal system); Claim Not Found: value transmitted from the associated 276.
159	2220D	SVC01-3	Procedure Modifier		2	Claim found: If applicable, first procedure modifier used to adjudicate the claim (from the internal system). Claim Not Found: value transmitted from the associated 276.
159	2220D	SVC01-4	Procedure Modifier		2	Claim found: If applicable, second procedure modifier used to adjudicate the claim (from the internal system) Claim not found: Transmitted value from the associated 276.
159	2220D	SVC01-5	Procedure Modifier		2	Claim found: If applicable, third procedure modifier used to adjudicate the claim (from the internal system). Claim Not Found: transmitted value from associated 276.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
160	2220D	SVC01-6	Procedure Modifier		2	Claim found: If applicable, third procedure modifier used to adjudicate the claim (from the internal system) Claim not found: Transmitted value from the associated 276.
160	2220D	SVC02	Line Item Charge Amount		10	Refer to TR3 Section B.1.1.3.1.2
160	2220D	SVC03	Line Item Payment Amount		10	Refer to TR3 Section B.1.1.3.1.2
160	2220D	SVC04	Revenue Code		48	Claim found: If 2220D SVC01-2 is present then SVC04 may be present. Claim not found: Transmitted value from the associated 276.
160	2220D	SVC07	Units of Service Count		15	Claim found: Units from the internal system. Claim not found: Transmitted value from the associated 276.
	2220D	STC	Service Line Status Information			Line found: Up to five iterations of the STC are allowed for all occurrences in these transactions. Part A only returns Claim Level status information.
161	2220D	STC01	Health Care Claim Status			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
161	2220D	STC01-1	Health Care Claim Status Category Code	A4	30	Line Not Found: “A4”.
161	2220D	STC01-2	Health Care Claim Status Code	35, 247	30	Line found: Part A = “247”. Otherwise, valid Claim Status Code. Line Not Found: “35” when Part B or CEDI, “247” when Part A.
167	2220D	STC01-4	Code List Qualifier Code		3	Not used by Medicare.
168	2220D	STC02	Status Information Effective Date		8	Line found: Date the claim moved to the current location status from the internal system, in CCYYMMDD format. Line Not Found: Current (system) date in CCYYMMDD format.
168	2220D	STC10	Health Care Claim Status			
169	2220D	STC10-4	Code List Qualifier Code		3	Not used by Medicare.
169	2220D	STC11	Health Care Claim Status			
170	2220D	STC11-4	Code List Qualifier Code		3	Not used by Medicare.
	2220D	REF	Service Line Item Identification			
171	2220D	REF02	Line Item Control Number		50	Contains at least one non-space character and transmitted value from associated 276.
	2220D	DTP	Service Line Date			
172	2220D	DTP02	Date Time Period Format Qualifier		3	Transmitted value from associated 276.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
172	2220D	DTP03	Date Time Period		35	Transmitted value from associated 276.

10.2.5. Loop 2200E Dependent Level Structures (277)

The following table defines specific details associated with 277 Dependent Level Structures.

Table 15 – Loop 2200E Dependent Level Detail (277)

Loop ID	Notes/Comments
2200E	Dependent-level structures are not used by Medicare. The patient is always the Subscriber.

11. Appendices

11.1. Implementation Checklist

First Coast provides a step-by-step guide to trading partners on how to submit electronic transactions. For additional information 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~ IEA*0*100469823~

Note: ISA14 must contain a “1” in order to receive a TA1 rejection. If the ISA14 is populated with a “0” a TA1 will not be returned.

11.2.2.999 – File Accepted

ISA*00* *00* *ZZ*592015694 *ZZ*P9999 *980903*1215*^*00501*100469823*0*P*>~

GS*FA*09102*P9999*20190225*160139*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HR*20198773*005010X212~
AK2*276* 000000001 *005010X212~
IK5*A~ AK9*A*1*1*1~
SE*6*0001~
GE*1*1~
IEA*1*000000001~

11.2.3.999 – File Rejected

ISA*00* *00* * ZZ*592015694 *ZZ*P9999 *190226*0855*^*00501*000000001*1*P*:~

GS*FA*09102*P9999*20190226*085508*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HR*100000016*005010X212~
AK2*276*6R92000Dx*005010X212~
IK3*NM1*4*2100*8~
IK4*1*98*7*RP~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

11.2.4. 276 - Inbound Claim Status Request

ISA*00* *00* * 27*P9999 *ZZ*592015694 *190220*0301*^*00501*012074022*1*P*:~

GS*HR*09102*P9999*20190220*0301*12074022*X*005010X212~
ST*276*RCM9T5001*005010X212~
BHT*0010*13*012074022*20190220*0301~
HL*1**20*1~
NM1*PR*2*MEDICARE FLORIDA*****PI*09102~
HL*2*1*21*1~
NM1*41.2*DOCOTORS OFFICE*****46*P9999~
HL*3*2*19*1~
NM1*1P*2* DOCOTORS OFFICE *****XX*9999999999~
HL*4*3*22*0~ DMG*D8*19480312*F~
NM1*IL*1*PATIENT'EXAMPLE****MI*100000000A~
TRN*1*11868249TB49824~
AMT*T3*8800~
DTP*472*DS*20190111~
SE*15*RCM9TB001~
GE*1*12074022~
IEA*1*012074022~

11.2.5.277 – Claim Status Outbound Response

ISA*00* *00* * ZZ*592015694 *ZZ*P9999 *190226*0855*^*00501*000000001*0*P*:~

GS*HN*09102*P9999*20190220*22482565*1*X*005010X212~
ST*277*000000001*005010X212~
BHT*0010*08*20190510001*20190220*22482565*DG~
HL*1**20*1~
NM1*PR*2*FIRST COAST SERVICE OPTIONS PI*09102~
PER*IC*MEDICARE EDI*TE*8888670940~
HL*2*1*21*1~
NM1*41*2*DOCTORS OFFICE 46*P9999~
HL*3*2*19*1~
NM1*1P*2* DOCTORS OFFICE **"*XX*9999999999~
HL*4*3*22*0~
NM1*IL*1*PATIENT*EXAMPLE****MI*100000000A~
TRN*1*11868249TB49824~
STC*A3^21*20190124**8800**20190124**20190124*338384097*A3^1~
REF*1K*1019018683730~
DTP*472*D8*20190111~
SVC*HC^29888ALT*4600*0****1~
STC*F2^107*20190124~
SE*32*000000001~
GE*1*1~ IEA*1*000000004~

11.3. Frequently Asked Questions

Frequently asked questions can be accessed at https://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 16 – Acronyms List

Acronym	Definition
276/277	276/277 Health Care Claim Status Request and Response
277CA	277 Claim Acknowledgment
999	Implementation Acknowledgment
ASC	Accredited Standards Committee
CAQH CORE	Council for Affordable Quality Healthcare - Committee on Operating Rules for Information Exchange
CEDI	Common Electronic Data Interchange
CCEM	Combined Common Edit Module
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
FFS	Medicare Fee-For-Service
FISS	Fiscal Intermediary Standard System
GS/GE	GS – Functional Group Header / GE – Functional Group Trailer
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
NSV	Network Service Vendor

Acronym	Definition
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
SFTP	Secure File Transfer Protocol
ST/SE	ST – Transaction Set Header / SE – Transaction Set Trailer
TA1	Interchange Acknowledgment
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 17 – Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
1.0	November 5, 2010	All	Initial Draft
2.0	January 3, 2011	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, 8.2 and 11.4	5th Publication Version