



Centers for Medicare & Medicaid Services (CMS)

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

Based on ASC X12N TR3, Version 005010X222A1

Companion Guide Version Number: 5.5,
December 2022

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. This Companion Guide is to be used for conducting Medicare business only.

Preface

This Companion Guide (CG) to the ASC X12N Technical Report Type 3 (TR3) Version 005010 and associated errata adopted under Health Insurance Portability and Accountability Act of 1996 (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) companion guide 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.

Table of Contents

Disclosure Statement.....	ii
Preface.....	iii
1 Introduction	1
1.1 Scope	1
1.2 Overview	1
1.3 References.....	2
1.4 Additional Information	2
2 Getting Started.....	3
2.1 Working Together.....	3
2.2 Trading Partner Registration.....	3
2.3 Trading Partner Certification and Testing Process	6
3 Testing and Certification Requirements.....	7
3.1 Testing Requirements.....	7
3.2 Certification Requirements.....	7
4 Connectivity / Communications	8
4.1 Process Flows	8
4.2 Transmission.....	9
4.2.1 Re-transmission Procedures	9
4.3 Communication Protocol Specifications	9
4.4 Security Protocols and Passwords	10
4.4.1 Guidelines for Creating a “Good” Password	11
4.4.2 X.509 Certificates.....	12
5 Contact Information.....	12
5.1 EDI Customer Service.....	12
5.2 EDI Technical Assistance	12
5.3 Trading Partner Service Number	13
5.4 Applicable Websites / Email	15
6 Control Segments / Envelopes	15
6.1 ISA-IEA	17
Delimiters – Inbound Transactions	17
Delimiters – Outbound Transactions	17
Inbound Data Element Detail and Explanation	17
6.2 GS-GE.....	17
6.3 ST-SE	17
7 Specific Business Rules.....	18
7.1 General Notes.....	18
7.2 General Transaction Notes	20

8	Acknowledgments and Reports	20
8.1	TA1 Interchange Acknowledgement.....	20
8.2	999 Implementation Acknowledgement	21
8.3	Report Inventory	21
9	Trading Partner Agreement	22
10	Transaction-Specific Information	22
10.1	Header	22
10.1.1	Header and Information Source	22
10.1.2	Loop 1000A Submitter Name.....	23
10.1.3	Loop 1000B Receiver Name	24
10.2	Billing Provider.....	24
10.2.1	Loop 2000A Billing Provider Detail.....	24
10.2.2	Loop 2010AA Billing Provider Name	25
10.3	Subscriber Detail.....	25
10.3.1	Loop 2000B Subscriber Hierarchical Level	25
10.3.2	Loop 2010BA Subscriber Name.....	26
10.3.3	Loop 2010BB Payer Name	27
10.4	Patient Detail	28
10.4.1	Loop 2300 Claim Information	28
10.4.2	Loop 2310A Referring Provider Name	31
10.4.3	Loop 2310B Rendering Provider Name	31
10.4.4	Loop 2310D Supervising Provider Name.....	31
10.4.5	Loop 2320 Other Subscriber Information	32
10.4.6	Loop 2330A Other Subscriber Name.....	33
10.4.7	The following table Loop 2330B Other Payer Name	33
10.4.8	Loop 2400 Service Line Number	34
10.4.9	Loop 2410 Drug Identification	39
10.4.10	Loop 2420A Rendering Provider Name.....	41
10.4.11	Loop 2420D Supervising Provider Name.....	41
10.4.12	Loop 2420E Ordering Provider Name	41
10.4.13	Loop 2420F Referring Provider Name.....	42
10.4.14	Loop 2430 Line Adjudication Information.....	42
10.4.15	Loop 2440 Form Identification Code.....	43
10.4.16	Transaction Set Trailer	47
11	Appendices	47
11.1	Implementation Checklist.....	47
11.2	Transmission Examples.....	47
11.3	Frequently Asked Questions.....	49
11.4	Acronym Listing	50
11.5	Change Summary.....	52

List of Tables

Table 1. EDI Transactions and Code Set References	2
Table 2. Additional EDI Resources.....	2
Table 3. ISA Interchange Control Header	15
Table 4. GS Functional Group Header	16
Table 5. Segment / Elements Not Accepted by Medicare	18
Table 6. ST Transaction Set Header.....	22
Table 7. BHT Beginning of Hierarchical Transaction.....	23
Table 8. Loop 1000A NM1 Submitter Name	23
Table 9. Loop 1000B NM1 Receiver Name	24
Table 10. Loop 2000A Billing Provider Detail	24
Table 11. Loop 2010AA NM1 Billing Provider Name	25
Table 12. Loop 2000B HL Subscriber Hierarchical Level	25
Table 13. Loop 2000B SBR Subscriber Information	25
Table 14. Loop 2000B PAT Patient Information	26
Table 15. Loop 2010BA NM1 Subscriber Name	26
Table 16. Loop 2010BA DMG Subscriber Demographic Information	27
Table 17. Loop 2010BB NM1 Payer Name	27
Table 18. Loop 2300 CLM Claim Information	28
Table 19. Loop 2300 DTP Date Elements	29
Table 20. Loop 2300 DTP Admission Date.....	29
Table 21. Loop 2300 PWK Claim Supplement Information	30
Table 22. Loop 2300 CR1 Ambulance Transport Information	30
Table 23. Loop 2300 HI Health Care Diagnosis Code.....	30
Table 24. Loop 2310A NM1 Referring Provider Name	31
Table 25. Loop 2310B NM1 Rendering Provider Name.....	31
Table 26. Loop 2310D NM1 Supervising Provider Name.....	31
Table 27. Loop 2320 SBR Other Subscriber Information	32
Table 28. Loop 2320 CAS Claim Level Adjustments.....	32
Table 29. Loop 2320 AMT COB Payer Paid Amount	32
Table 30. Loop 2330A NM1 Other Subscriber Name	33
Table 31. Loop 2330A REF Other Subscriber Secondary Identification	33
Table 32. Loop 2330B DTP Claim Check or Remittance Date	33
Table 33. Loop 2400 SV1 Professional Service	34
Table 34. Loop 2400 PWK DME Certificate of Medical Necessity Indicator	35
Table 35. Loop 2400 CR1 Ambulance Transport Information	35
Table 36. Loop 2400 CR3 Durable Medical Equipment Certification.....	36
Table 37. Loop 2400 CRC Condition Indicator/ Durable Medical Equipment.....	36
Table 38. Loop 2400 DTP Service Date.....	37
Table 39. Loop 2400 QTY Ambulance Patient Count.....	39
Table 40. Loop 2400 QTY Obstetric Anesthesia Additional Units.....	39
Table 41. Loop 2400 MEA Test Results	39

Table 42. Loop 2410 LIN Drug Identification	40
Table 43. Loop 2410 CTP Drug Quantity	40
Table 44. Loop 2410 CTP Prescription or Compound Drug Association Number	40
Table 45. Loop 2420A NM1 Rendering Provider Name.....	41
Table 46. Loop 2420D NM1 Supervising Provider Name.....	41
Table 47. Loop 2420E NM1 Ordering Provider Name	41
Table 48. Loop 2420F NM1 Referring Provider Name.....	42
Table 49. Loop 2430 SVD Line Adjudication Information.....	42
Table 50. Loop 2430 DTP Line Check or Remittance Date.....	43
Table 51. Loop 2440 LQ Form Identification Code	43
Table 52. Loop 2440 FRM Supporting Documentation	44
Table 53. SE Transaction Set Trailer	47
Table 54. Acronyms Listing and Definitions	50
Table 55. Companion Guide Version History	52

List of Figures

Figure 1. CEDI Process Flows.....	8
Figure 2. CEDI Test Transaction Flows.....	9
Figure 3. 837P Claim File Example	47
Figure 4. 999 Acknowledgement for the 837P Example	48
Figure 5. 277CA Claim within the 837P Example Rejected.....	48
Figure 6. 277CA Claim within an 837P file Accepted Example	49

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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide.

Medicare Fee-For-Service (FFS) is publishing this Companion Guide (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 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](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf) (<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 005010A1.

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 standard 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, and data services. 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 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 locations provide information for where to obtain documentation for Medicare-adopted EDI transactions and code sets.

Table 1. EDI Transactions and Code Set References

Resource	Location
ASC X12N TR3s	The official ASC X12 website
Washington Publishing Company Health Care Code Sets	The official Washington Publishing Company website

1.4 Additional Information

The websites in the following table provide additional resources for HIPAA:

Table 2. Additional EDI Resources

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

Resource	Web Address
CAQH CORE Operating Rules	https://www.caqh.org/core/operating-rules
CEDI website	https://www.ngscedi.com

2 Getting Started

2.1 Working Together

National Government Services, Inc. Common Electronic Data Interchange (CEDI) is dedicated to providing communication channels to ensure communication remains constant and efficient. CEDI has several options to assist the community with their electronic data exchange needs. By using any of these methods, CEDI 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 accessible as a method of communicating with CEDI. 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 CEDI help desk and email access, see Section 5 for additional contact information.

CEDI also has several external communication components in place to reach out to the Trading Partner community. CEDI posts all critical updates, system issues, and EDI-specific billing material to the [CEDI website](https://www.ngscedi.com) (https://www.ngscedi.com). All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. CEDI also distributes EDI-pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the website as it becomes available. In addition to the website, a distribution list has been established in order to broadcast urgent messages. [Please register for CEDIs distribution list by subscribing](https://www.ngscedi.com/listserv/subscribe.htm) (https://www.ngscedi.com/listserv/subscribe.htm).

Specific information about the above-mentioned items can be found in the following sections.

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 CEDI 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 CEDI 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.
- *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 CEDI.

To enroll for exchanging transactions with CEDI, complete the on-line enrollment forms located on the [CEDI website](https://www.ngscedi.com) (<https://www.ngscedi.com>).

- CEDI Enrollment Agreement Form: Used to enroll in electronic claim transmission.
- CEDI Trading Partner Action Request Form: Used to apply for a Trading Partner/submitter ID to log in and send claim files. This form is also used to indicate the type of transactions requested for the Trading Partner/submitter ID.
- CEDI Supplier Authorization Form: Used to authorize a third-party biller or clearinghouse to send the electronic claims for the supplier.
- CEDI ERA Enrollment Form: Allows a provider to receive ERA from the Common Electronic Data Interchange (CEDI). Enrolls both the NPI and PTAN for Electronic Remittance Advice (ERA). This form is required for new ERA enrollments and changes to an existing ERA setup if the form is not on file with CEDI.

CEDI enrollment documents are completed and submitted on-line. CEDI enrollment forms do not need to be faxed.

Submitted enrollment forms will be issued Packet ID (PID) numbers which will be assigned once the enrollment packet is submitted electronically. The PID will also be emailed to the email address provided on the enrollment packet. The PID number can be used to track the submitted enrollment packet.

When a CEDI enrollment packet is submitted, an acknowledgment email will be generated and sent back to the email address entered on the packet. Once the request has been approved and processed, a setup confirmation will be sent via email. The Trading Partner/submitter must contact the CEDI Help Desk by telephone to obtain their initial password.

Instructions on how to complete the enrollment packet are included on the CEDI website.

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.O. 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 CEDI furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires CEDI 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 CEDI prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. CEDI 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 the appropriate MAC provider enrollment department (for Medicare Part A and Part B provider) or the National Supplier Clearinghouse (for Durable Medical Equipment suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A Trading Partner's EDI number and password serve as an electronic signature and the Trading Partner would be liable for any improper usage or illegal action performed with it. A Trading Partner's EDI access number and password are not part of the capital property of the Trading Partner's operation and may not be given to a new owner of the Trading Partner'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 CEDI which third party agents they will be using on their EDI Enrollment form.

Third parties are required to register with CEDI 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 the [CEDI website](https://www.ngscedi.com/) (https://www.ngscedi.com/). The third-party agreement form can be found on the [CEDI website enrollment page](https://enroll.ngscedi.com/enrollment) (https://enroll.ngscedi.com/enrollment).

Trading Partners 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. Trading Partners 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 Trading Partner'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 CEDI. For a complete reference to security requirements, see Section 4.4.

2.3 Trading Partner Certification and Testing Process

Software vendors and in-house programmers not previously approved to submit X12 version 5010A1 claims must schedule testing with CEDI prior to transmission of their first claim file. There is no charge for this system testing. Suppliers and third parties who elect to use a software vendor that has been approved for X12 by CEDI are not required to test.

To begin testing with CEDI:

1. Test files for 5010A1 claims should be submitted under the CEDI assigned Test Vendor Login ID (begins with a V08). If you are not sure you have a Vendor Test ID, send an email to the [CEDI Help Desk](mailto:ngs.cedihelpdesk@anthem.com) (ngs.cedihelpdesk@anthem.com) requesting the ID be sent to you. If it is discovered that you do not have a Vendor Test Login ID number, you will be asked to complete the Trading Partner Test ID Request form in order to obtain one.
2. You will be assigned a contact at CEDI who will work with you as you test the 5010A1 claim transaction.
3. You will be asked to inform your testing contact when a test file is being submitted.
4. Test files cases should contain no more than 25 claims and contain real data.
5. All test claims are subject to receiving the TRN, TA1, 999 and/or 277CA indicating whether they have passed or rejected.
6. If test claims pass, the vendor will receive an email asking how they want their vendor information to appear on the Approved Entity list on the CEDI website.
7. If test claims do not pass, the vendor will be asked to fix the errors and send another test file in until they have successfully passed testing.
8. Test results will be provided to the vendor within three business days. During HIPAA version transitions, this time-period may be extended, not to exceed ten business days.

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.

- 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 CEDI, 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. Trading Partners do not need to test if they are using an approved software vendor. Trading Partners may see if their vendor has passed testing or to locate an approved vendor on the [CEDI Approved Entities List](https://www.ngscedi.com/approvedentities) (<https://www.ngscedi.com/approvedentities>).

Trading Partners who submit transactions directly to more than one A/B MAC, and/or CEDI must contact each A/B MAC and/or CEDI 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 and/or CEDI 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 provider 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, CEDI does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining the [CEDI Approved Vendor](https://enroll.ngscedi.com/approvedentities) (<https://enroll.ngscedi.com/approvedentities>).

4 Connectivity / Communications

4.1 Process Flows

The following diagrams show how production and test transactions flow into and out of CEDI.

Figure 1. CEDI Process Flows

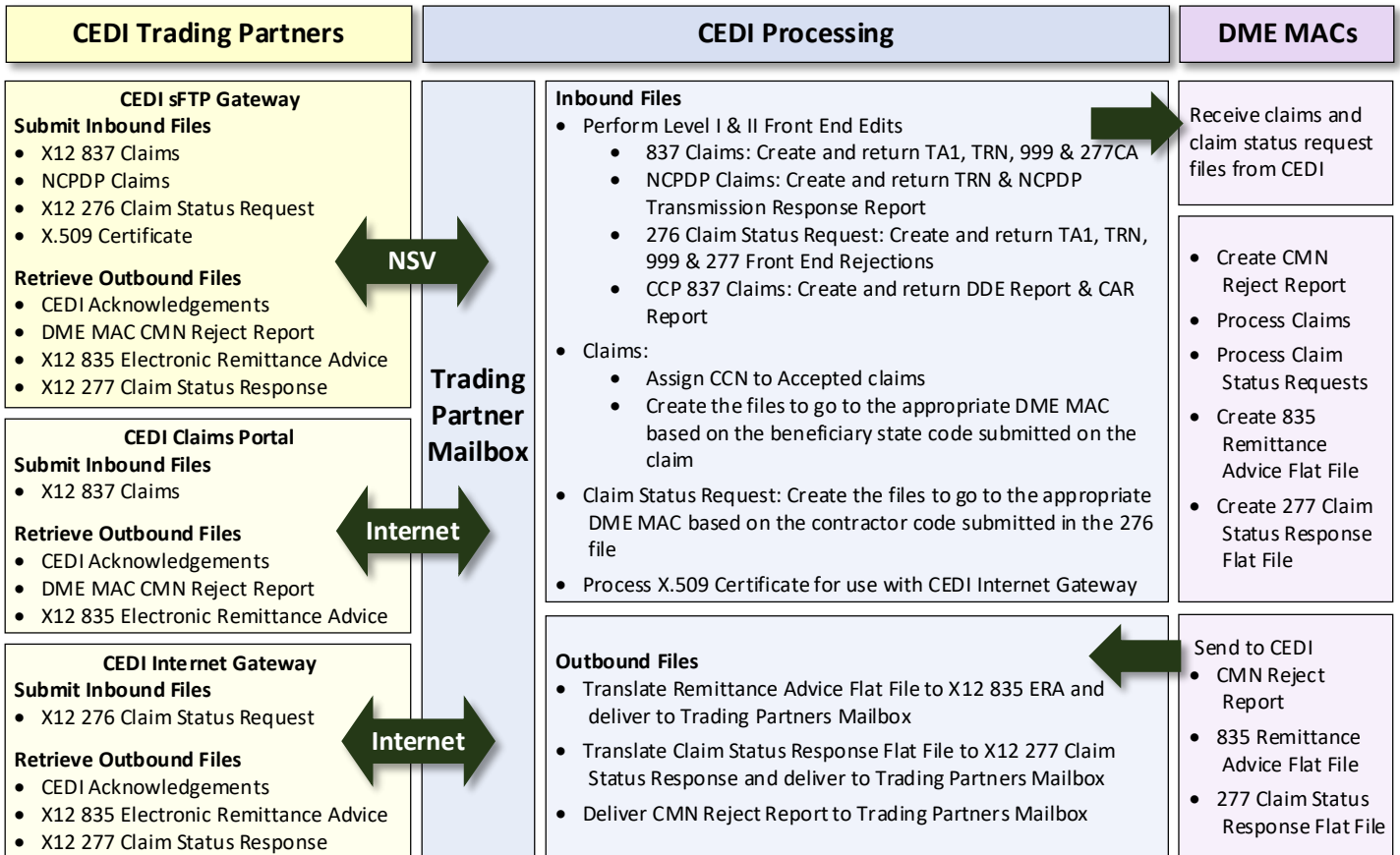
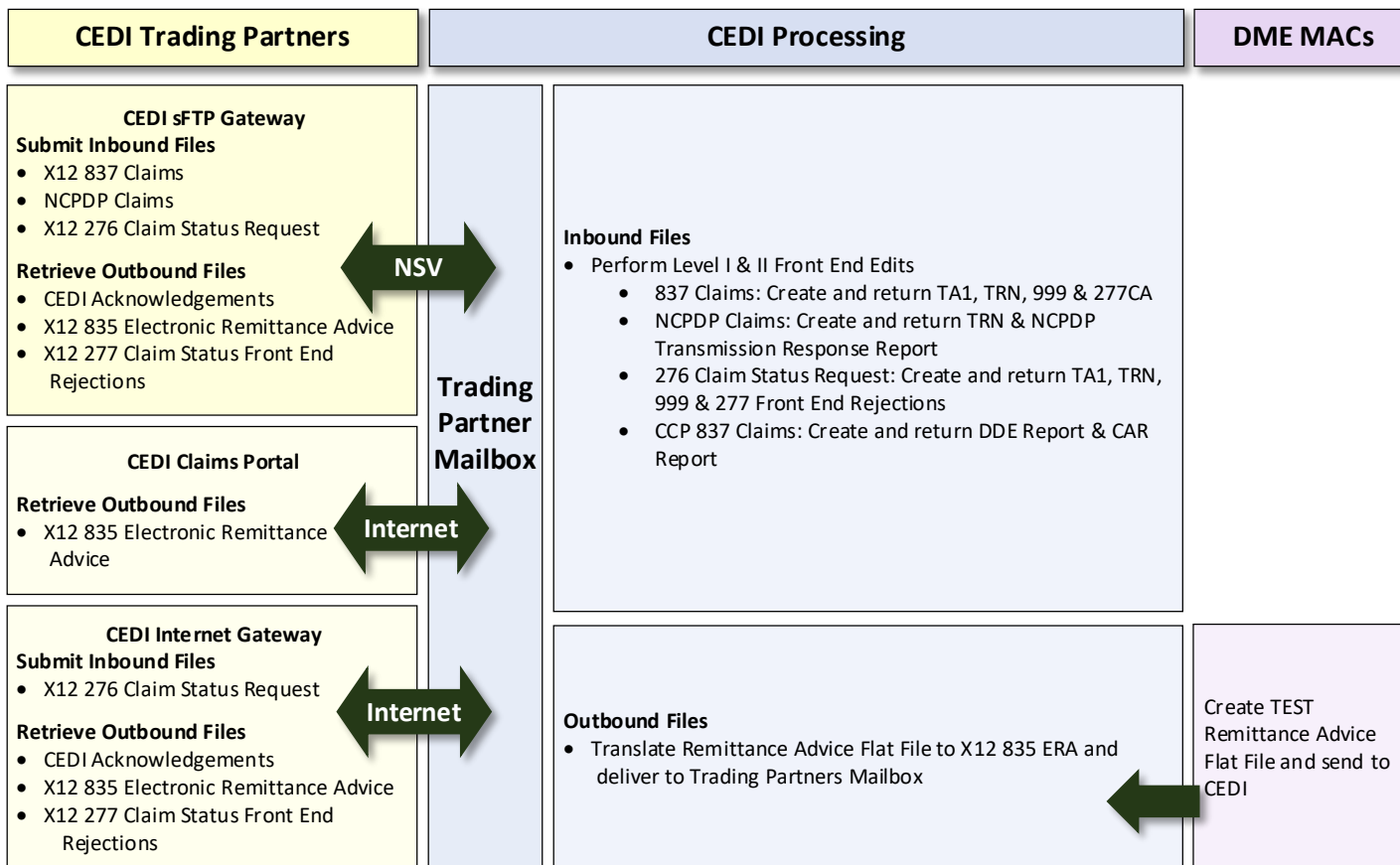


Figure 2. CEDI Test Transaction Flows



4.2 Transmission

CEDI offers two Gateways for connectivity – the CEDI Secure File Transfer Protocol (sFTP) Gateway and CEDI Internet Gateway. Refer to Section 4.3 in this Companion Guide for more information.

4.2.1 Re-transmission Procedures

CEDI does not require any identification of a previous transmission of a claim. All claims sent should be marked as original transmissions.

4.3 Communication Protocol Specifications

The CEDI sFTP Gateway can be used for all transactions – X12 837 claims, NCPDP claims, X12 276/277 Claim Status Request/Claim Status Response, X12 835 Electronic Remittance Advice, and the associated response transactions and reports. CEDI Trading Partners must use a Network Service Vendor (NSV) to connect to the CEDI sFTP Gateway using their CEDI assigned ID and password. NSVs provide a secure, continuous connection for CEDI Trading Partners. To view the list of NSVs who provide connectivity to CEDI and obtain additional

information on the services and pricing they offer, please use the contact information on the [Telecommunications page of the CEDI website](http://www.ngscedi.com/Telecommunications) (www.ngscedi.com/Telecommunications).

The CEDI Internet Gateway supports CAQH CORE compliant exchanges of the 276/277 Claim Status Request/Response and 835 ERA transactions using HTTP+MIME or SOAP+WSDL Message Envelope Standards and X.509 Certificates for authentication. **Note:** The CEDI Internet Gateway does not support the following transactions: X12 837 Claims, NCPDP Claims, or real time 276/277 Claim Status Request/Response and the CEDI Internet Gateway will reject these transactions.

CAQH CORE Phase I, II, & III Operating Rules and communication protocol specifications are located on the [CAQH CORE website](https://www.caqh.org/core/operating-rules) (https://www.caqh.org/core/operating-rules).

CEDI Trading Partners have one mailbox for all their inbound and outbound CEDI transactions and are not restricted to using only the sFTP or only the Internet Gateway for their 276/277 or 835 transactions. Both Gateways are merely methods of accessing the Trading Partner's CEDI mailbox to send and retrieve transactions. For example, it is possible to retrieve TA1, 999, & 277 Claim Status Responses via the Internet Gateway for 276 Claim Status Requests that were originally submitted via the sFTP Gateway and vice versa depending on the commands used upon connection.

Trading Partners who elect to use the CEDI Internet Gateway for the 276/277 and/or 835 transactions are required to obtain an X.509 Certificate to be used for the authentication process. To upload the X.509 Certificate, the Trading Partner will connect and login to the sFTP Gateway using their CEDI assigned login ID and password. CEDI will return a Transaction Acknowledgement Report (TRN) indicating if the X.509 Certificate was accepted or rejected by CEDI. If the Certificate is rejected, the Trading Partner must correct the errors and resubmit the Certificate before they can begin using the CEDI Internet Gateway. When the X.509 Certificate is accepted, the Trading Partner is approved to use the CEDI Internet Gateway.

Trading Partners must submit a new X.509 Certificate to CEDI using the same process as above prior to the expiration of their current Certificate or if their current Certificate has been compromised.

For [HTTP+MIME connections to the CEDI Internet Gateway](https://cedisw.ngscedi.com/CoreBatchGateway/TransactionSocketServlet), use the URL:
(https://cedisw.ngscedi.com/CoreBatchGateway/TransactionSocketServlet)

For [SOAP+WSDL connections to the CEDI Internet Gateway](https://cedisw.ngscedi.com/CoreBatchGateway/soap/coreservice), use the URL:
(https://cedisw.ngscedi.com/CoreBatchGateway/soap/coreservice)

The [Telecommunications page of the CEDI website](http://www.ngscedi.com/Telecommunications) (www.ngscedi.com/Telecommunications) provides additional information regarding the two CEDI Gateways, a listing of the CEDI approved Network Service Vendors for connection to the CEDI sFTP Gateway, and a listing of the CEDI approved Certificate Authorities for issuance of the X.509 Certificates to access the CEDI Internet Gateway.

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. CEDI is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS.

EDI transactions submitted by unauthorized Trading Partners will not be accepted by CEDI. Trading Partners must enroll with CEDI to obtain a Trading Partner identification number and must contact the CEDI Help Desk by telephone to obtain their initial password (refer to Section 2.2). The Trading Partner will be prompted to change the initial password at the time of the first connection to CEDI. Trading Partners must protect password privacy by limiting knowledge of the password to key personnel and changing the password when there are changes to personnel.

Passwords will expire every 60 days, and thus required to be changed at least every 60 days but may be changed more frequently at the discretion of the Trading Partner. CEDI offers a self-service password reset portal to aide in the process of resetting passwords.

4.4.1 Guidelines for Creating a “Good” Password

Most security breaches are a direct result of users selecting “bad” passwords. The selection of a “good” password is critical to ensuring the security and integrity of your health care information. A good password is one that is difficult for others to guess and yet is easily remembered by the user.

Passwords will expire every sixty days.

The following basic guidelines should help when creating a password:

DO

- Must be exactly eight (8) characters in length
- Must contain both alphabetic and numeric characters in the password
- Must contain at least 1 uppercase and 1 lowercase letter
- Must contain a special character; for example: ! \$ %
- Passwords are case sensitive
- Must contain a minimum of four (4) characters different than the previous password
- Must be different than the last nine (9) passwords

DON'T

- Do not use English defined words
- Do not use your user ID or any permutation of it as the password
- Do not use your company name, department name, or any permutation of it as a password
- Do not use your name or initials in any form
- Do not use family members or pets as part of the password

- Do not use swear words or obscene words; they're among the first words tried when guessing passwords
- Do not write down your password
- Do not reuse your password
- Do not store your password in scripts, files, or applications unless compensating controls are in place
- Do not use any form of date such as month, day, year, etc.

4.4.2 X.509 Certificates

X.509 Certificates are used for exchanging transactions through the CEDI Internet Gateway (refer to Section 4.3 for additional information). The CEDI website includes a list of the CEDI approved Certificate Authorities for exchange of CAQH CORE compliant X12 276/277 Claim Status Request/Claim Status Response (including associated TA1 and 999 acknowledgments) and X12 835 Electronic Remittance Advice transactions.

Only three active X.509 certificates will be accommodated within CEDI for any one Trading Partner. A new X.509 certificate must be submitted to CEDI prior to an older certificate's expiration in order to avoid interruption in ability to use the Internet Gateway. X.509 Certificates must not be valid for more than three years.

5 Contact Information

5.1 EDI Customer Service

For CEDI customer service, contact the CEDI Help Desk:

- Phone: 866-311-9184
- Email: [CEDI Help Desk](mailto:ngs.cedihelpdesk@anthem.com) (ngs.cedihelpdesk@anthem.com)
- Fax: (not available)
- The CEDI Help Desk is open Monday through Friday from 9:00 a.m. ET through 7:00 p.m. ET.
- The CEDI Help Desk is closed Thursdays from 3:00 p.m. ET through 4:00 p.m. ET for training.
- Information on closures and holidays is available on the [CEDI website – Important Events](http://www.ngscedi.com/Important%20Events) (www.ngscedi.com/Important Events)

5.2 EDI Technical Assistance

For CEDI technical support, contact the CEDI Help Desk:

- Phone: 866-311-9184
- Email: [CEDI Help Desk](mailto:ngs.cedihelpdesk@anthem.com) (ngs.cedihelpdesk@anthem.com)

- Fax: (not available)
- The CEDI Help Desk is open Monday through Friday from 9:00 a.m. ET through 7:00 p.m. ET.
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- Information on closures and holidays is available on the [CEDI website – Important Events](http://www.ngscedi.com/Important%20Events) (www.ngscedi.com/Important Events)

5.3 Trading Partner Service Number

All CEDI Trading Partner services are accommodated by contacting the CEDI Help Desk:

- Phone: 866-311-9184
- Email: [CEDI Help Desk](mailto:ngs.cedihelpdesk@anthem.com) (ngs.cedihelpdesk@anthem.com)

Questions regarding the exchange of the X12N 837P claim transaction, and technical support for this transaction are addressed by the CEDI Help Desk.

Questions regarding the actual claim status content (i.e. pending, paid, etc.) are addressed by the Durable Medical Equipment (DME) MAC that processed the claim:

- **Jurisdiction A – Noridian Healthcare Solutions**
 - Noridian Healthcare Solutions supports the following states: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
 - Customer Service and IVR: 866-419-9458
 - [Noridian Healthcare Solutions](https://med.noridianmedicare.com/web/jadme) (https://med.noridianmedicare.com/web/jadme)
- **Jurisdiction B – CGS Administrators LLC**
 - CGS Administrators LLC supports the following states: IL, IN, KY, MI, MN, OH, WI
 - Provider Contact Center: 866-590-6727
 - Automated IVR System: 877-299-7900
 - [CGS Administrators LLC](https://www.cgsmedicare.com/jb) (https://www.cgsmedicare.com/jb)
- **Jurisdiction C – CGS Administrators LLC**
 - CGS Administrators LLC supports the following states: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VA, VI, and WV
 - Customer Service: 866-270-4909
 - Automated IVR System: 866-238-9650
 - [CGS Administrators LLC](https://www.cgsmedicare.com/jc) (https://www.cgsmedicare.com/jc)

- **Jurisdiction D – Noridian Healthcare Solutions**

- Noridian supports the following states: AK, AS, AZ, CA, GU, HI, ID, IA, KS, MO, MP, MT, ND, NE, NV, OR, SD, UT, WA, WY
- Supplier Contact Center: 877-320-0390
- Automated IVR System: 877-320-0390
- [Noridian Healthcare Solutions](https://med.noridianmedicare.com/web/jddme/) (https://med.noridianmedicare.com/web/jddme/)

Questions regarding assigning the National Provider Identifier (NPI) are addressed by the National Plan & Provider Enumeration System (NPPES):

- Phone: 800-465-3203
- Email: [NPPES Customer Service](mailto:customerservice@npienumerator.com) (customerservice@npienumerator.com)
- [NPPES](https://nppes.cms.hhs.gov/NPPES/Welcome.do) (https://nppes.cms.hhs.gov/NPPES/Welcome.do)

Questions regarding the assignment of the Durable Medical Equipment Provider Transaction Access Number (PTAN) are addressed by the National Provider Enrollment Eastern Region (NPEAST) or Provider Enrollment Western Region (NPWEST):

- **NPEAST (Novitas Solutions)**

States: Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Wisconsin, District of Columbia, Puerto Rico, US Virgin Islands

- Phone: 866-520-5193
- [NPEAST Novitas Solutions](https://www.novitas-solutions.com) (https://www.novitas-solutions.com)

- **NPWEST (Palmetto GBA)**

States: Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands

- Phone: 866-238-9652
- [NPWEST Palmetto GBA](https://www.palmettogba.com) (https://www.palmettogba.com)

Questions regarding the proper use of the Healthcare Common Procedure Coding System (HCPCS) are addressed by the Pricing, Data Analysis and Coding (PDAC):

- Phone: 877-735-1326

- Email: Visit [Palmetto GBA PDAC](https://www.dmepdac.com/palmetto/PDAC.nsf/Ad/Contact%20Us) (https://www.dmepdac.com/palmetto/PDAC.nsf/Ad/Contact Us) and select the “Contact Us” option
- [Palmetto GBA PDAC](https://www.dmepdac.com/) (https://www.dmepdac.com/)

Questions regarding the Medicare provider and supplier enrollment process capturing the provider/supplier information from the CMS-855 family of forms and creating the NPI crosswalk entries are addressed by the Provider Enrollment, Chain and Ownership (PECOS):

- Phone: 866-484-8049
- [PECOS](https://pecos.cms.hhs.gov/pecos/login.do) (https://pecos.cms.hhs.gov/pecos/login.do)

5.4 Applicable Websites / Email

See sections 5.1, 5.2, 5.3 for applicable website/email information.

6 Control Segments / Envelopes

Enveloping information must be as follows:

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 3. ISA Interchange Control Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.4	ISA01	Authorization Information Qualifier	00	Medicare expects the value to be 00.
C.4	ISA02	Authorization Information	[10 spaces]	ISA02 shall contain 10 blank spaces.
C.4	ISA03	Security Information Qualifier	00	Medicare expects the value to be 00 and ISA04 shall contain 2 blank spaces.
C.4	ISA04	Security Information	[10 spaces]	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	[CEDI Submitter ID]	CEDI assigned Submitter ID. This is also required in the GS02.
C.5	ISA07	Interchange ID Qualifier	27, ZZ	Must be “27” or “ZZ”

Page #	Element	Name	Codes/Content	Notes/Comments
C.5	ISA08	Interchange Receiver ID	16013, 17013, 18003, 19003	DME MAC Contractor ID: <ul style="list-style-type: none"> • DME MAC JA: 16013 • DME MAC JB: 17013 • DME MAC JC: 18003 • DME MAC JD: 19003 Note: CEDI will route claims to the appropriate DME MAC based on the beneficiary's state code reported in 2010BA N402
C.5	ISA11	Repetition Separator	[Submitter Defined]	Defined by the 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.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 4. GS Functional Group Header

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS02	Application Sender Code	[CEDI Submitter ID]	Submitter number assigned by CEDI
C.7	GS03	Application Receiver's Code	16013, 17013, 18003, 19003	DME MAC Contractor ID: <ul style="list-style-type: none"> • DME MAC JA: 16013 • DME MAC JB: 17013 • DME MAC JC: 18003 • DME MAC JD: 19003 Note: CEDI will route claims to the appropriate DME MAC based on the beneficiary's state code reported in 2010BA N402.
C.7	GS04	Functional Group Creation Date	[date]	Must not be a future date

Page #	Element	Name	Codes/Content	Notes/Comments
C.7	GS08	Version Identifier Code	005010X222A1	Medicare expects value "005010X222A1"

Interchange Control (ISA/IEA), Functional Group (GS/GE), and Transaction Set (ST/SE) envelopes 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

The TA1 will use the delimiters on the submitted file as the delimiters in the TA1.

If there are no rejections being returned at the functional group level, the 999 will return standard delimiters regardless of those used in the submitted file. If there are rejections being returned at the Functional Group level, the 999 will return the delimiters used in the original submitted file.

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 CMS 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.

Note: Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 5. Segment / Elements Not Accepted by Medicare

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

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
144	2000C	PAT	Patient Information	[Not Used]	Must not be present. For Medicare, the subscriber is always the same as the patient.
147	2010CA	Loop Rule	Patient Name Loop	[Not Used]	Must not be present.
186	2300	CN1	Contract Information	[Not Used]	Must not be present.
191	2300	REF	Mandatory Medicare (Section 4081) Crossover Indicator	[Not Used]	Must not be present.
196	2300	REF	Payer Claim Control Number	[Not Used]	Must not be present.
332	2330C	Loop Rule	Other Payer Referring Provider	[Not Used]	Must not be present.
336	2330D	Loop Rule	Other Payer Rendering Provider	[Not Used]	Must not be present.
340	2330E	Loop Rule	Other Payer Service Facility Location	[Not Used]	Must not be present.
343	2330F	Loop Rule	Other Payer Supervising Provider	[Not Used]	Must not be present.
347	2330G	Loop Rule	Other Payer Billing Provider	[Not Used]	Must not be present.
395	2400	CN1	Contract Information	[Not Used]	Must not be present.
416	2400	HCP	Line Pricing/Repricing Information	[Not Used]	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.
- With 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.
- 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 adopted three acknowledgement transactions with the Version 005010 implementation: the 277CA, the TA1, and the 999. These acknowledgments will replace proprietary reports previously provided by the MACs.

Medicare FFS has adopted 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 Acknowledgement

The TA1 is used by Medicare FFS to communicate the rejection of an 837P file 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:

- An 837P claim file is received, and the version of the transmission cannot be determined.
- An 837P claim file is received, and the version of the transmission is unsupported by Medicare FFS.

The TA1 returned by CEDI will be within an X12 ISA-IEA envelope.

National Government Services, CEDI will not return a TA1 if the submitted file is not recognized as an X12 format.

8.2 999 Implementation Acknowledgement

Medicare FFS has adopted 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.

Technical specifications for the ASC X12 999 are published for the ASC X12N 837 Professional Health Care Claim transaction at the official ASC X12 website.

CEDI has the ability to receive inbound ASC X12 999 acknowledgement transactions from Trading Partners via the CEDI Internet Gateway only. However, CEDI will not monitor for receipt of a 999 submitted by a Trading Partner. If a Trading Partner has an issue with an outbound file they have retrieved from CEDI, they are advised to contact the [CEDI Help Desk](mailto:ngs.cedihelpdesk@anthem.com) (ngs.cedihelpdesk@anthem.com).

8.3 Report Inventory

Transaction Acknowledgment (TRN) Report

- The TRN is a CEDI text file indicating initial validation of the submitted file, including whether or not the file was identified as an ASC X12 file and whether the Trading Partner is authorized.
- The TRN will contain the Time Stamp, File Name, Trading Partner ID, and Original File size of the received claim file.
- The TRN will be generated for transactions sent via the CEDI Internet Gateway; however, the TRN will not be available for retrieval via the CEDI Internet Gateway. Instead, any TRNs generated for transactions sent via the Internet Gateway will only be available for retrieval via the sFTP Gateway.

DME MAC Front-End Report (RPT) files

- The RPT is a report indicating if there are errors in the Certificate of Medical Necessity (CMN) submitting on a claim received by the DME MAC from CEDI.
- The RPT is typically returned within one to two DME MAC business days after the claim was submitted to CEDI.
- The RPT will only be generated if CMN rejections are found.
- Claims that receive a CMN rejection are still sent into the DME MACs processing system; however, the CMN will not be entered with the claim.

NOTE: If a CMN or DIF is submitted on a claim with date of service on or after January 1, 2023, the claim will be rejected by CEDI.

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 CEDI. The CEDI Trading Partner Action Request Form can be found on the [Enrollment page of the CEDI website](https://enroll.ngscedi.com/cedienrollment) (<https://enroll.ngscedi.com/cedienrollment>).

The CEDI Trading Partner Agreement process is part of the overall CEDI registration process. Refer to Section 2.2 for details on the agreements required by CEDI.

10 Transaction-Specific Information

This section defines specific CMS requirements over and above the standard information in the ASC X12N 837P TR3.

10.1 Header

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

10.1.1 Header and Information Source

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

Note: Any values in the Codes column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 6. ST Transaction Set Header

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
70	N/A	ST02	Transaction Set Control Number	[Control Number]	9	CEDI will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.

Table 7. BHT Beginning of Hierarchical Transaction

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
71	N/A	BHT02	Transaction Set Purpose Code	00	2	Must equal "00" (ORIGINAL).
72	N/A	BHT06	Claim/Encounter Identifier	CH	2	Must equal "CH" (CHARGEABLE).

10.1.2 Loop 1000A Submitter Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 8. Loop 1000A NM1 Submitter Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
75	1000A	NM105	Submitter Middle Name or Initial	[Name or Initial]	25	The first position must be alphabetic (A-Z).
75	1000A	NM109	Submitter ID	[Submitter ID]	80	CEDI 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 the specific details associated with Loop 1000B Receiver Name:

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 9. Loop 1000B NM1 Receiver Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
80	1000B	NM109	Receiver Primary Identifier	[Primary Identifier]	80	CEDI will reject an interchange (transmission) that is not submitted with a valid DME MAC contractor code. Each individual MAC determines this identifier. Submitter ID must match the value submitted in ISA08 and GS03. Note: CEDI will route claims to the appropriate DME MAC based on the beneficiary's state code reported in 2010BA N402

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 the specific details associated with Loop 2000A Billing Provider.

Table 10. 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. NM109: billing provider must be "associated" to the submitter (from a Trading Partner management perspective) in 1000A NM109.

10.2.2 Loop 2010AA Billing Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 11. Loop 2010AA NM1 Billing Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
89	2010AA	NM105	Billing Provider Middle Name	[Name or Initial]	25	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 12. Loop 2000B HL Subscriber Hierarchical Level

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
115	2000B	HL04	Hierarchical Child Code	0	1	The value accepted is "0"

Table 13. Loop 2000B SBR Subscriber Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 14. Loop 2000B PAT Patient Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
120	2000B	PAT08	Patient Weight	[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.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 15. Loop 2010BA NM1 Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
122	2010BA	NM102	Subscriber Entity Type Qualifier	1	1	The value accepted is 1.
122	2010BA	NM105	Subscriber Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).
122	2010BA	NM108	Subscriber Identification Code Qualifier	MI	2	The value accepted is "MI"

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
123	2010BA	NM109	Subscriber Primary Identifier	[Primary Identifier]	80	For the Medicare Beneficiary Identifier (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”.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 16. Loop 2010BA DMG Subscriber Demographic Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
127	2010BA	DMG02	Subscriber Birth Date	[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 17. Loop 2010BB NM1 Payer Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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.

Note: Any values in the Codes column in brackets describes the type of value sent.

10.4.1 Loop 2300 Claim Information

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 18. Loop 2300 CLM Claim Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
158	2300	CLM01	Patient Control Number	[Number]	38	Only 20 characters will be stored and returned by Medicare.
159	2300	CLM02	Total Claim Charge Amount	[Amount]	18	Must be ≥ 0 and $\leq 99,999.9$. 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	[Code]	2	Data submitted in CLM20 will not be used for processing.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 19. Loop 2300 DTP Date Elements

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
164	2300	DTP03	Onset of Current Illness or Injury Date	[Date]	35	Must not be a future date.
165	2300	DTP03	Initial Treatment Date	[Date]	35	Must not be a future date.
167	2300	DTP03	Acute Manifestation Date	[Date]	35	Must not be a future date.
168	2300	DTP03	Accident Date	[Date]	35	Must not be a future date.
169	2300	DTP03	Last Menstrual Period Date	[Date]	35	Must not be a future date.
170	2300	DTP03	Last X-Ray Date	[Date]	35	Must not be a future date.
171	2300	DTP03	Prescription Date	[Date]	35	Must not be a future date.
173	2300	DTP03	Disability From Date	[Date]	35	Future dates are allowed in this situation.
174	2300	DTP03	Last Worked Date	[Date]	35	Must not be a future date.

In the table below, for Loop 2300 Admission Date Segment, if 2400.SV105 = “21”, “51” or “61” then 2300.DTP with DTP01 = “435” must be present.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 20. Loop 2300 DTP Admission Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
176	2300	DTP03	Related Hospitalization Admission Date	[Date]	35	Must not be a future date.
177	2300	DTP03	Related Hospitalization Discharge Date	[Date]	35	Must not be a future date.

In the table below, for Loop 2300 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.

Table 21. Loop 2300 PWK Claim Supplement Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
184	2300	PWK02	Attachment Transmission Code	BM, FX, EL, FT	2	Must be "BM", "FX", "EL", or "FT"

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 22. Loop 2300 CR1 Ambulance Transport Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
212	2300	CR102	Patient Weight	[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	[Miles]	15	Must not exceed 4 digits. Transport distance in excess of 9,999 miles will be rejected.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 23. Loop 2300 HI Health Care Diagnosis Code

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
227	2300	HI01-2	Health Care Diagnosis Code	[Diagnosis Code]	30	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 the specific details associated with Loop 2310A Referring Provider Name.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 24. Loop 2310A NM1 Referring Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
258	2310A	NM105	Referring Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.3 Loop 2310B Rendering Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 25. Loop 2310B NM1 Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
263	2310B	NM105	Rendering Provider Middle Name	[Name or Initial]	25	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.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 26. Loop 2310D NM1 Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
281	2310D	NM105	Supervising Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.5 Loop 2320 Other Subscriber Information

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 27. Loop 2320 SBR Other Subscriber Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
296	2320	SBR01	Payer Responsibility Sequence Number Code	[Code]	1	2320 SBR01 = "P" must be present when 2000B SBR01 = "S"
298	2320	SBR09	Claim Filing Indicator Code	[Code]	2	The value cannot be "MA" or "MB"

In the table below, for Loop 2320 Claim Level Adjustments, CAS segment must not be present when 2000B SBR01 = "P".

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 28. Loop 2320 CAS Claim Level Adjustments

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
301	2320	CAS01	Claim Level Adjustments	[Code]	2	CAS segment must not be present when 2000B SBR01 = "P"

Table 29. Loop 2320 AMT COB Payer Paid Amount

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
305	2320	AMT01	Coordination of Benefits (COB) Payer Paid Amount	D	3	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 the specific details associated with Loop 2330A Other Subscriber Name.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 30. Loop 2330A NM1 Other Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
313	2330A	NM105	Other Insured Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 31. Loop 2330A REF Other Subscriber Secondary Identification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
319	2330A	REF02	Other Insured Additional Identifier	[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 The following table Loop 2330B Other Payer Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 32. Loop 2330B DTP Claim Check or Remittance Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
325	2330B	DTP03	Date Time Period	[Date]	35	Must not be a future date.

10.4.8 Loop 2400 Service Line Number

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 33. Loop 2400 SV1 Professional Service

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
352	2400	SV101-1	Product or Service ID Qualifier	HC	2	Must be "HC".
353	2400	SV101-3, SV101-4, SV101-5, SV101-6	Procedure Modifier	[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	[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.
355	2400	SV104	Service Unit Count	[Quantity]	15	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/Content	Length	Notes/Comments
360	2400	SV503	Quantity	[Quantity]	15	DME Only: Must be greater than 0 with a maximum of 3 whole numbers (must not exceed 999).
360	2400	SV504	Monetary Amount	[Amount]	18	DME Only: Must be greater than 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.
360	2400	SV505	Monetary Amount	[Amount]	18	DME Only: Must be greater than 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.

Table 34. Loop 2400 PWK DME Certificate of Medical Necessity Indicator

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
366	2400	PWK01	Durable Medical Equipment (DME) Certificate of Medical Necessity Indicator	CT	2	DME only. Must not be present on Part B claims.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 35. Loop 2400 CR1 Ambulance Transport Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
369	2400	CR102	Patient Weight	[Weight]	10	Does not apply to DME. Must not exceed 4 whole numbers and 2 decimals. Patient weight in excess of 9,999.99 pounds will be rejected.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
370	2400	CR106	Transport Distance	[Miles]	15	Does not apply to DME. Must not exceed 4 digits. Transport distance in excess of 9,999 miles will be rejected.

In the table below, for Loop 2400 DME Certification, CR3 segment must be present when DME CMN information is included with the claim. Must not be present on Part B claims.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 36. Loop 2400 CR3 Durable Medical Equipment Certification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
371	2400	CR303	Unit or Basis for Measurement Code	[Unit]	2	DME Only: Must not exceed 2 digits. DME Only: Must be greater than 0 unless 2400 L02 = "08.02".

In the table below, for Loop 2400 Condition Indicator/ DME, DME only: CR3 segment must be present when DME CMN information is included with the claim. Must not be present on a Part B Claim.

Table 37. Loop 2400 CRC Condition Indicator/ Durable Medical Equipment

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
378	2400	CRC01	Code Category	09	2	DME Only: When CRC Condition Indicator (CRC01 = "09") is submitted, either CRC03 or CRC04 must be "38".

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 38. Loop 2400 DTP Service Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
381	2400	DTP03	Date – Service Date	[Date]	35	<p>Must not be a future date.</p> <p>DME only:</p> <ul style="list-style-type: none"> • Must not be a single date of service when modifier RR is reported with more than 1 unit of service. • 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. • 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 Served 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/Content	Length	Notes/Comments
382	2400	DTP03	Date – Prescription Date	[Date]	35	Must not be a future date.
383	2400	DTP03	Date – Certification Revision / Recertification Date	[Date]	35	DME only: Must not be a future date. Must not be present on a Part B claim.
384	2400	DTP03	Date – Begin Therapy Date	[Date]	35	DME only: Must not be a future date. Must not be present on a Part B claim.
385	2400	DTP03	Date – Last Certification Date	[Date]	35	DME only: Must not be a future date. Must not be present on a Part B claim.
386	2400	DTP03	Date – Last Seen Date	[Date]	35	Segment must not be present for DME claims. Part B only: Must not be a future date
387	2400	DTP03	Test Performed Date	[Date]	35	Must not be a future date.
389	2400	DTP03	Last X-Ray Date	[Date]	35	Segment must not be present for DME claims. Part B only: Must not be a future date.
390	2400	DTP03	Initial Treatment Date	[Date]	35	Must not be a future date.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 39. Loop 2400 QTY Ambulance Patient Count

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
391	2400	QTY02	Ambulance Patient Count	[Quantity]	15	Does not apply to DME. Must be between 1 and 99.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 40. Loop 2400 QTY Obstetric Anesthesia Additional Units

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
392	2400	QTY02	Obstetric Additional Units	[Quantity]	15	Does not apply to DME. Must be between 1 and 99.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 41. Loop 2400 MEA Test Results

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
394	2400	MEA03	MEA – Test Results	[Numeric]	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 the specific details associated with Loop 2410 Drug Identification. For DME claims, must be present when 2400 SV101-1 contains a default Healthcare Common Procedure Coding System (HCPCS) code.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 42. Loop 2410 LIN Drug Identification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
425	2410	LIN02	Product or Service ID Qualifier	N4	2	Must be N4.
425	2410	LIN03	National Drug Code	[National Drug Code]	11	Must be exactly 11 alphanumeric positions.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 43. Loop 2410 CTP Drug Quantity

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
426	2410	CTP04	National Drug Unit Count	[Quantity]	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	[Code]	2	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.

In the table below, for Loop 2410 Prescription or Compound Drug Association Number, must be submitted with REF01 = "XZ" if service line includes modifier J1.

Table 44. Loop 2410 CTP Prescription or Compound Drug Association Number

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
428	2410	REF01	Reference Identification Qualifier	XZ	3	If service line (SV1) includes Modifier J1, REF01 = "XZ" must be present.

10.4.10 Loop 2420A Rendering Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 45. Loop 2420A NM1 Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
431	2420A	NM105	Rendering Provider Middle Name	[Name or Initial]	25	The first position must be alphabetic (A-Z).

10.4.11 Loop 2420D Supervising Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 46. Loop 2420D NM1 Supervising Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
450	2420D	NM105	Supervising Provider Middle Name	[Name or Initial]	25	First position of Supervising Provider Middle Name must be alphabetic (A-Z).

10.4.12 Loop 2420E Ordering Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 47. Loop 2420E NM1 Ordering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
455	2420E	NM105	Ordering Provider Middle Name	[Name or Initial]	25	First position of Ordering Provider Middle Name must be alphabetic (A-Z).

10.4.13 Loop 2420F Referring Provider Name

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 48. Loop 2420F NM1 Referring Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
466	2420F	NM105	Referring Provider Middle Name	[Name or Initial]	25	First position of Referring Provider Middle Name must be alphabetic (A-Z).

10.4.14 Loop 2430 Line Adjudication Information

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

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 49. Loop 2430 SVD Line Adjudication Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
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	[Quantity]	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	[Number]	6	Must be an integer (no decimals).

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 50. Loop 2430 DTP Line Check or Remittance Date

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
490	2430	DTP03	Adjudication or Payment Date	[Date]	35	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.

If a CMN or DIF is submitted on a claim with date of service on or after January 1, 2023, the claim will be rejected by CEDI.

Table 51. Loop 2440 LQ Form Identification Code

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
493	2440	LQ01	Code List Qualifier Code	UT	3	DME claims only. Must be "UT" Not valid for Part B Claims.
493	2440	LQ02	Industry Code	CMN or DIF Form Number	30	DME claims only. Must be a valid DME MAC CMN/DIF number. Only valid for date of service prior to 01/01/2023. Not valid for Part B Claims.

In the table below, for loop 2440 Supporting Documentation, FRM is only for Durable Medical Equipment (DME) Claims. This loop must not be present for Part B Claims.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 52. Loop 2440 FRM Supporting Documentation

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
495	2440	FRM01	Question Number/Letter	[Alphanumeric]	20	DME claims only. 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	[Alphanumeric]	20	DME claims only. 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	[Alphanumeric]	20	DME claims only. FRM01 Question number must be valid for the LQ02 CMN/DIF number.
495	2440	FRM01	Question Number/Letter	[Alphanumeric]	20	DME claims only. 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	[Alphanumeric]	20	DME claims only. 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.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
495	2440	FRM01	Question Number/Letter	[Alphanumeric]	20	DME claims only. 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.
495	2440	FRM02	Question Number/Letter	[Code]	1	DME claims only. 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	[Alphanumeric]	50	DME claims only. When LQ02 = "04.04" and FRM01 = "07B", "09B", "10B" or "10C", FRM03 must be present.
495	2440	FRM03	Question Response	[Alphanumeric]	50	DME claims Only. When LQ02 = "06.03" and FRM01 = "02" or "03", FRM03 must be present.
495	2440	FRM03	Question Response	[Alphanumeric]	50	DME claims Only. When LQ02 = "09.03" and FRM01 = "01", "01A", "01B", "01C", "02", "02A", "02B", "02C", "03" or "04", FRM03 must be present.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
495	2440	FRM03	Question Response	[Alphanumeric]	50	DME claims Only. 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.
495	2440	FRM03	Question Response	[Alphanumeric]	50	DME claims Only. 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	[Date]	8	DME claims Only. Must not be a future date.
495	2440	FRM04	Question Response	[Date]	8	DME claims Only. When LQ02 = "484.03" and FRM with FRM01 = "1C" or "6C" is present, then FRM04 must be present.
495	2440	FRM05	Question Response	[Percent (Decimal Format)]	6	DME claims Only. When LQ02 = "10.03" and FRM01 = "08B", "08E" or "08H", FRM05 must be present.
495	2440	FRM05	Question Response	[Percent (Decimal Format)]	6	DME claims Only. When LQ02 = "484.03" and FRM01 = "1B" or "6B", FRM05 must be present.
495	2440	FRM05	Question Response	[Percent (Decimal Format)]	6	DME claims Only. 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.

Note: Any values in the Codes/Content column in brackets describes the type of value sent. The Notes/Comments column will have the data entered in the field.

Table 53. SE Transaction Set Trailer

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

11 Appendices

11.1 Implementation Checklist

Vendors and In-House Programmers

- Obtain the ASC X12 TR3 Implementation Guides and the Washington Publishing Company Health Care Code Sets listed under Section 1.3 EDI Transactions and Code Set References (Table 1).
- Obtain additional resource materials as needed listed under Section 1.4 Additional EDI Resources (Table 2).
- Successfully test X12 version 5010 claims by following Section 2.3 Trading Partner Certification and Testing Process.

11.2 Transmission Examples

Following is an example of an 837P claim file.

Figure 3. 837P Claim File Example

```

ISA*00*      *00*      *ZZ*B08XXXXXX  *ZZ*17013
*190123*1100*^*00501*067660001*1*P>~GS*HC*B08XXXXXX*PCACEV2.18*20190123*1100*4001*X*005010X222A1~ST*837*000000001*
005010X222A1~BHT*0019*00*000004*20190123*105958*CH~NM1*41*2*EDIT TEST SUBMITTER*****46*B08XXXXXX~PER*IC*CONTACT
NAME*TE*5024441111~NM1*40*2*DME MAC JURISDICTION B*****46*17013~HL*1**20*1~NM1*85*2*BILLING
PROVIDER*****XX*1234567893~N3*106 SOME RD*SUIE
A~N4*HENDERSONVILLE*TN*370753495~REF*EI*123456789~PER*IC*NAME*TE*6158228888~HL*2*1*22*0~SBR*P*18*****MB~NM1*IL*
1*LASTNAME*FIRSTNAME****MI*#####~N3*1234 SOME STREET~N4*LOUISVILLE*KY*10168~DMG*D8*19270829*M~NM1*PR*2*DME
MAC JURISDICTION B*****PI*17013~N4*LOUISVILLE*KY*40223~CLM*JB CLAIM
1*40***12>B>1*Y*A*Y*Y~HI*BK>71598~LX*1~SV1*HC>E0627>RR*40*UN*1***1~DTP*472*D8*20181202~REF*6R*001H0000000014030920
10~NM1*DK*1*PROVIDER*ORDERING*****XX*1234567893~N3*2425
STREET~N4*CITY*KY*40508~SE*29*000000001~GE*1*4001~IEA*1*067660001~
    
```

The 837P claim file in the example above will produce a TRN report indicating that one interchange was received, recognized as an X12 transaction and format supported by CEDI, and accepted through the CEDI front end trading partner management system.

Transaction Acknowledgement

Time Stamp = 20190123094910
 File Name = CEDI_837claim1.txt
 Trading Partner ID = B08XXXXXX@B08XXXXXX
 Original File Size = 994

No input validation problemssubsequent reports to follow***

1 envelope processed out of 1 identified

Following is an example of a 999 acknowledgment for the 837P example above indicating the file was accepted through the X12 standard and syntax rules and passed along to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

Figure 4. 999 Acknowledgement for the 837P Example

```
ISA*00*      *00*      *ZZ*17013      *ZZ*B08XXXXXX
*190123*0949*^*00501*023972505*0*P*::~~GS*FA*PCACEV2.18*B08XXXXXX*20190123*0949*23902741*X*005010X231A1~ST*999*0001*0
05010X231A1~AK1*HC*4001*005010X222A1~AK2*837*000000001*005010X222A1~IK5*A~AK9*A*1*1*1~SE*6*0001~GE*1*23902741~IEA*1
*023972505~
```

Following is an example 277CA indicating the claim within the 837P example above was rejected due to the date of service for the procedure code billed.

Figure 5. 277CA Claim within the 837P Example Rejected

```
ISA*00*      *00*      *ZZ*17013      *ZZ*B08XXXXXX
*190123*0949*^*00501*023972506*0*P*::~~GS*HN*PCACEV2.18*B08XXXXXX*20190123*0949*23902742*X*005010X214~ST*277*0001*005
010X214~BHT*0085*08*2019012309491047679*20190123*0949*TH~HL*1**20*1~NM1*PR*2*DME MAC JURISDICTION
B*****46*17013~TRN*1*2019012309491047681~DTP*050*D8*20190123~DTP*009*D8*20190123~HL*2*1*21*1~NM1*41*2*EDIT TEST
SUBMITTER*****46*B08XXXXXX~TRN*2*000004~STC*A1:19:PR*20190123*WQ*40~QTY*AA*1~AMT*YY*40~HL*3*2*19*1~NM1*85*2*BILLI
NG
PROVIDER*****XX*1234567893~TRN*1*0~STC*A1:19:85**WQ*40~QTY*QC*1~AMT*YY*40~HL*4*3*PT~NM1*QC*1*LASTNAME*FIRSTNAME
***MI*#####~TRN*2*JB CLAIM
1~STC*A7:254*20190123*U*40~DTP*472*D8*20181202~SE*25*0001~GE*1*23902742~IEA*1*023972506~
```

Following is an example of a 277CA (unrelated to the 837P example above) indicating a claim within an 837P file was accepted and sent on to the appropriate DME MAC based on the beneficiary state code on the claim for processing.

Figure 6. 277CA Claim within an 837P file Accepted Example

```

ISA*00*      *00*      *ZZ*17013      *ZZ*B08XXXXXX
*190123*1038*^*00501*023972508*0*P*~GS*HN*PCACEV2.18*B08XXXXXX*20190123*1038*23902744*X*005010X214~ST*277*0001*005
010X214~BHT*0085*08*2019012310383547685*20190123*1038*TH~HL*1**20*1~NM1*PR*2*DME MAC JURISDICTION
B*****46*17013~TRN*1*2019012310383547687~DTP*050*D8*20190123~DTP*009*D8*20190123~HL*2*1*21*1~NM1*41*2*EDIT TEST
SUBMITTER*****46*B08XXXXXX~TRN*2*000004~STC*A1:19:PR*20190123*WQ*40~QTY*90*1~AMT*YU*40~HL*3*2*19*1~NM1*85*2*BILLI
NG
PROVIDER*****XX*1234567893~TRN*1*0~STC*A1:19:85**WQ*40~QTY*QA*1~AMT*YU*40~HL*4*3*PT~NM1*QC*1*LASTNAME*FIRSTNAM
E***MI*#####~TRN*2*JB CLAIM
1~STC*A1:19:QC*20190123*WQ*40~REF*1K*17013190238#####~DTP*472*D8*20150402~SE*26*0001~GE*1*23902744~IEA*1*0239725
08~
    
```

11.3 Frequently Asked Questions

Frequently asked questions can be accessed at [Medicare FFS EDI Operations](https://www.cms.gov/ElectronicBillingEDITrans/) (https://www.cms.gov/ElectronicBillingEDITrans/) and the [CEDI website](https://www.ngscedi.com/) (https://www.ngscedi.com/) by selecting the resource link for “FAQs.”

11.4 Acronym Listing

Table 54. Acronyms Listing and Definitions

Acronym	Definition
276	276 Claim Status Request transaction
277	277 Claim Status Response transaction
277CA	277 Claim Acknowledgement
835	835 Electronic Remittance Advice transaction
837P	837 Professional Claims transaction
999	Implementation Acknowledgment
ASC	Accredited Standards Committee
CAQH CORE	Council for Affordable Quality Healthcare – Committee on Operating Rules for Information Exchange
CCN	Claim Control Number
CEDI	Common Electronic Data Interchange
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CMN	Certificate of Medical Necessity
COB	Coordination of Benefits
DME	Durable Medical Equipment
DIF	DME Information Form
EDI	Electronic Data Interchange
ERA	Electronic Remittance Advice
FFS	Medicare Fee-For-Service
FISMA	Federal Information Security Management Act
GS/GE	GS – Functional Group Header / GE – Functional Group Trailer
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HTTP	Hyper Text Transfer Protocol
HTTPS	Hyper Text Transfer Protocol Secure
IOM	Internet-only Manual

Acronym	Definition
ISA/IEA	ISA – Interchange Control Header / IEA – Interchange Control Trailer
IVR	Integrated Voice Response
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MIME	Multipurpose Internet Mail Extensions
NCPDP	National Council for Prescription Drug Programs
NPEAST	National Provider Enrollment Eastern Region
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
NPWEST	National Provider Enrollment Western Region
NSV	Network Service Vendor
PDAC	Pricing, Data Analysis and Coding
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
PID	Packet Identifier
PTAN	Provider Transaction Access Number
sFTP	Secure File Transfer Protocol
SOAP	Simple Object Access Protocol
ST/SE	ST – Transaction Set Header / SE – Transaction Set Trailer
TA1	Interchange Acknowledgment
TR3	Technical Report Type 3
TRN	Transaction Acknowledgment report (CEDI proprietary report)
WSDL	Web Services Description Language
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 55. 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	1 st Publication Version
3.0	April 2011	6.0	2 nd Publication Version
4.0	September 2015	All	3 rd Publication Version
5.0	March 2019	All	4 th Publication Version
5.1	May 2020	1.3, 8.2, 11.4	Removed all active URLs referencing “www.wpc-edi.com” and “www.nex12.org”, and replaced them with “the official Washington Publishing Company website” and “the official ASC X12 website”
5.2	February 2021	4.4	Updated URL for ARS Guides
5.3	September 2021	4.1, 5.3, 10.3.2, 11.4	Section 4.1 – Updated process flows Section 5.3 – Reordered states under Jurisdiction B to be in alphabetical order, added MP state code under JD Section 10.3.2 – Removed references to HICN, spelled out MBI acronym Section 11.4 – Removed HICN; added MBI Verified hyperlinks and updated as needed throughout the document
5.4	January 2022	All	508 compliance and table formatting.

Version	Date	Section(s) Changed	Change Summary
5.5	December 2022	Section 4.1 Section 5.3 Section 8.3 Section 10.4.14 Section 11.4	Section 4.1, Figure 1 – updated process flow Section 5.3 – replaced NSC with NPEAST and NPWEST Section 8.3 – added note for claims submitted with a CMN/DIF and date of service on or after 01/01/2023 Section 10.4.15 – added note for claims submitted with a CMN/DIF and date of service on or after 01/01/2023; updated Notes/Comment for LQ01; added row for LQ02 Section 11.4 – updated list of Acronyms