Centers for Medicare & Medicaid Services (CMS)

Standard Companion Guide

Health Care Claim Institutional (837I)

Based on ASC X12N TR3, Version 005010X223A2

Companion Guide Version Number: 8.0,
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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.

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1 Introduction

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

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

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 837I 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: Institutional transaction Version 005010X223A2.

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 837I 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 837I.

- *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 837I 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 Version 005010A1 implementation:

Table 2. Additional EDI Resources

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

2　Getting Started

2.1 Working Together

CGS Administrators, LLC (CGS) is dedicated to providing communication channels to ensure communication remains constant and efficient. CGS has several options to assist the community with their electronic data exchange needs. By using any of these methods CGS 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 CGS EDI. The email account is monitored by knowledgeable staff ready to assist you. When communicating via email, please exclude any protected health information (PHI) to ensure security is maintained. In addition to the CGS EDI help desk and email access, see Section 5 for additional contact information.

CGS also has several external communication components in place to reach out to the Trading Partner community. CGS posts all critical updates, system issues and EDI-specific billing material to their website, (https://www.cgsmedicare.com/). All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. CGS also distributes EDI pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the website every three months. In addition to the website, a distribution list (https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp) has been established in order to broadcast urgent messages.

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 CGS 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 CGS 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 CGS.

Medicare requires all trading partners to complete an EDI enrollment form and sign an EDI agreement. The EDI enrollment form (https://www.cgsmedicare.com/parta/edi/index.html) designates the Medicare contractor the entity agrees to engage in EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of the information being exchanged.

Entities processing paper do not need to complete an EDI registration.

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

Medicare requires that CGS furnish information on EDI to new Trading Partners that request Medicare claim privileges. Additionally, Medicare requires CGS 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 CGS prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. CGS 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 provider's EDI number and password serve as an electronic signature and the provider would be liable for any improper usage or illegal action performed with it. A provider's EDI access number and password are not part of the capital property of the provider's operation and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password.

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

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

Additional third-party billing information can be found at (https://www.cgsmedicare.com/parta/edi/enrollment.html).

The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse, or network service vendor. Providers must also not share their personal EDI access number with anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a Provider's EDI number and password to access Medicare systems. Clearinghouse and other third-party representatives must obtain and use their own unique EDI access number and password from CGS. For a complete reference to security requirements, see Section 4.4.

2.3 Trading Partner Certification and Testing Process

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

To begin the testing and certification process, trading partners should complete the J15 Communications and the enrollment form (https://www.cgsmedicare.com/parta/edi/enrollment.html). Once CGS provides the Submitter ID to a trading partner a test file should be submitted to CGS containing at least 25 claims with a T in the ISA15.

Description of delivery and interpretation of results. Once the test file is submitted, verify the file received an accepted 999 and 277CA. Once an error free 277CA populates the EDI helpdesk should be contacted to move the submitter ID into production.

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 CGS, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For MACs, the minimum 95 percent accuracy rate includes the front-end edits applied implementation guide editing module (https://www.cgsmedicare.com/parta/edi/index.html).

  - Test results will be provided to the submitter within three business days; during HIPAA version transitions this time period may be extended, not to exceed ten business days.

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

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

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

3.2 Certification Requirements

Medicare FFS does not certify Trading Partners. However, CGS does certify vendors, clearinghouses, and billing services by conducting testing with them and maintaining an approved vendor list.

- [Part A Approved Vendor List](https://www.cgsmedicare.com/parta/edi/index.html) (https://www.cgsmedicare.com/parta/edi/index.html)

- [Home Health & Hospice Vendor List](https://www.cgsmedicare.com/hhh/edi/index.html) (https://www.cgsmedicare.com/hhh/edi/index.html)

4 Connectivity / Communications

4.1 Process Flows

The following diagram illustrates how ANSI ASC X12 electronic transactions flow into and out of GPNet, CGS/Palmetto GBA's EDI Gateway.

Figure 1. GPNet V5010 Test 837 Claims Transaction Flow
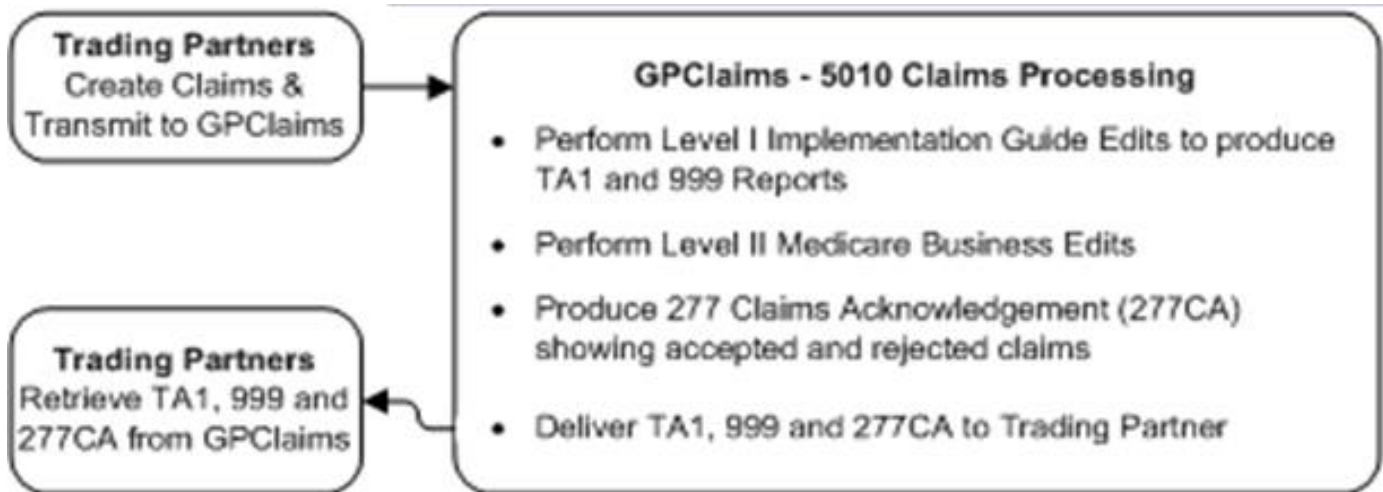
Figure 2. GPNet V5010 837 Claims Transaction Flow
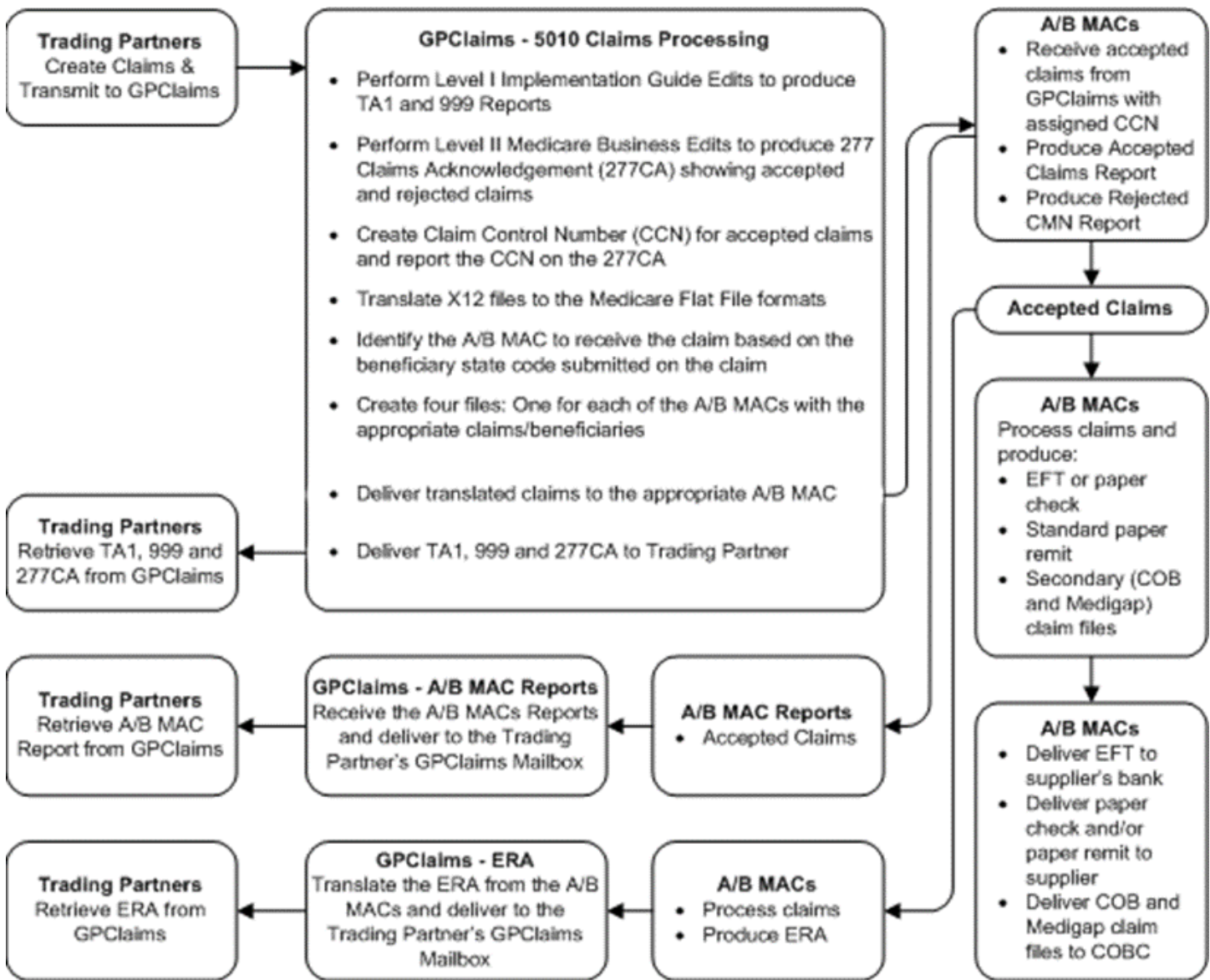
4.2 Transmission

Please see the GPNet Communications Manual and Connectivity Specifications posted under Manuals and User Guides (https://www.cgsmedicare.com/parta/edi/manuals.html)

4.2.1 Re-transmission Procedures

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

4.3 Communication Protocol Specifications

Please see the GPNet Communications Manual posted under [Manuals and User Guides](https://www.cgsmedicare.com/parta/edi/manuals.html) (https://www.cgsmedicare.com/parta/edi/manuals.html)

Note: Internet connectivity is only available using our CAQH CORE connectivity method for the following transactions:

- 276: ASC X12 Health Care Claim Status Request

- 277: ASC X12 Health Care Information Status Notification

- 835: ASC X12 Health Care Claim Payment/ Advice

- 999: ASC X12 Implementation Acknowledgment For Health Care Insurance

Under the internet portal demonstration, for select transaction and with prior CMS approval

4.4 Security Protocols and Passwords

All Trading Partners must adhere to CMS information security policies; including, but not limited to, the transmission of electronic claims, claim status, receipt of the remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information. Violation of this policy will result in revocation of all methods of system access. CGS is responsible for notifying all affected Trading Partners as well as reporting the system revocation to CMS.

Password guidelines are provided with receipt of initial passwords from CGS. Please contact the EDI helpdesk for assistance with passwords and resets

CMS' information security policy strictly prohibits the sharing or loaning of Medicare assigned IDs and passwords. Users should take appropriate measures to prevent unauthorized disclosure or modification of assigned IDs and passwords. The Trading Partner should protect password privacy by limiting knowledge of the password to key personnel. The password should be changed when there are any personnel changes.

The submitter ID and Password are required to transmit files to CGS.

5   Contact Information

5.1 EDI Customer Service

J15- Part A/Home Health & Hospice (HHH) Correspondence

CGS

PO box 20018

Nashville, TN 37202

EDI Helpdesk Numbers

CGS Part A – 1-866-590-6703 Option 2

CGS Part B – 1-866-276-9558 Option 2

CGS HHH – 1-866-299-4500 Option 2

EDI Fax Numbers

Ohio Part A – 1-615-664-5945

Kentucky Part A – 1-615-664-5943

Ohio Part B – 1-615-664-5927

Kentucky Part B – 1-615-664-5917

Home Health & Hospice – 1-615-664-5947

Hours of Operation and Holiday Schedule

Monday – Friday 8:00 a.m. to 5:00 p.m. Eastern Time.

CGS Holiday Schedule

- New Year's Day
- Martin Luther King, Jr.'s Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

5.2 EDI Technical Assistance

See section 5.1 for Technical Assistance Information

5.3 Trading Partner Service Number

See section 5.1 for Technical Assistance Information

5.4 Applicable Websites / Email

CGS Medicare Part B Online Help (https://www.cgsmedicare.com/partb/cs/online_help.html)

CGS Home Health & Hospice Online Help (https://www.cgsmedicare.com/hhh/cs/onlinehelphhh.html)

CGS Medicare Part A Online Help (https://www.cgsmedicare.com/parta/cs/online_help.html)

CGS Medicare Website (http://www.cgsmedicare.com)

6   Control Segments / Envelopes

Enveloping information must be as follows:

Note: A hyphen in the table below means N/A.

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	-	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	-	Medicare does not use Security Information and will ignore content sent in ISA04.
C.4	ISA05	Interchange ID Qualifier	28, ZZ	Must be "28" or "ZZ"
C.4	ISA06	Interchange Sender ID	-	Each MAC will assign its own ID. This is also required in the GS02.
C.5	ISA07	Interchange ID Qualifier	28, ZZ	Must be "28" or "ZZ"
C.5	ISA08	Interchange Receiver ID	-	Medicare Administrative Contractor (MAC) contract number for the inbound transactions. Ohio Part A 15201 Kentucky Part A 15101 Home Health & Hospice 15004

Page #	Element	Name	Codes/Content	Notes/Comments
C.5	ISA11	Repetition Separator	-	CGS repetition separator character.
C.6	ISA14	Acknowledgement Requested	1	Medicare requires submitter to send code value 1 – Interchange Acknowledgment Requested (TA1). Medicare will only return a TA1 segment when there is an error in the ISA/IEA Interchange Envelope.
C.7	GS02	Application Sender Code	-	Submitter number assigned by CGS
C.7	GS03	Application Receiver's Code	-	CGS contract number.
C.7	GS04	Functional Group Creation Date	-	Must not be a future date
C.7	GS08	Version Identifier Code	005010X223A2	Medicare expects value "005010X223A2"

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

Trading Partners should contact CGS for a list of delimiters to expect from Medicare. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

Table 4. CGS Delimiters

Delimiter	Character Used	Dec Value	Hex Value
Data Element Separator	*	42	2A
Repetition Separator	^	94	5E

Delimiter	Character Used	Dec Value	Hex Value
Component Element Separator	>	62	3E
Segment Terminator	~	126	7E

Inbound Data Element Detail and Explanation

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

6.2 GS-GE

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

6.3 ST-SE

Medicare FFS follows the HIPAA-adopted TR3 requirements.

7 Specific Business Rules

This section describes the specific 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: A hyphen in the table below means N/A.

Table 5. Segment / Elements Not Accepted by Medicare

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
81	2000A	CUR	Foreign Currency Information	-	Medicare does not support the submission of foreign currency.
99	2010AC	Loop Rule	Pay to Plan Loop	-	Must not be present.

Page #	Loop ID	Reference	Name	Codes/Content	Notes/Comments
120	2010BA	REF	Subscriber Secondary Identification (REF01 = "SY")	-	Must not be present.
127	2010BB	REF	Payer Secondary Identification	-	Must not be present.
131	2000C	Loop Rule	Patient Hierarchical Level	-	Must not be present. For Medicare, the subscriber is always the same as the patient.
158	2300	CN1	Contract Information	-	Must not be present.
396	2330C	Loop Rule	Other Payer Attending Provider	-	Must not be present.
400	2330D	Loop Rule	Other Payer Operating Physician	-	Must not be present.
404	2330E	Loop Rule	Other Payer Other Operating Physician	-	Must not be present.
408	2330F	Loop Rule	Other Payer Service Facility Location	-	Must not be present.
412	2330G	Loop Rule	Other Payer Rendering Provider Name	-	Must not be present.
416	2330H	Loop Rule	Other Payer Referring Provider	-	Must not be present.
420	2330I	Loop Rule	Other Payer Billing Provider	-	Must not be present.

8 Acknowledgments and Reports

CGS will provide acknowledgments and reports for submitted X12 version 005010 transactions.

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 Report Inventory

CGS does not provide any proprietary acknowledgments.

9   Trading Partner Agreement

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

Medicare FFS requires all Trading Partners to sign a Trading Partner Agreement with CGS. This agreement can be found on the [CGS website](https://www.cgsmedicare.com/parta/edi/index.html) (https://www.cgsmedicare.com/parta/edi/index.html).

Additionally, CGS requires the following: The CGS Trading Partner Agreement process is identical to our EDI enrollment and registration process.

10 Transaction-Specific Information

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

10.1 Header

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

10.1.1 Header and Information Source

The following tables define the specific details associated with Header and Information Source:

Note: A hyphen in the table below means N/A.

Table 6. Header and Information Source

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
67	-	ST02	Transaction Set Control Number	-	9	The MAC will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
68	-	BHT02	Transaction Set Purpose Code	00	2	Must equal "00" (ORIGINAL).
69	-	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: A hyphen in the table below means N/A.

Table 7. Loop 1000A NM1 Submitter Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
72	1000A	NM105	Submitter Middle Name or Initial	-	25	The first position must be alphabetic (A-Z).
72	1000A	NM109	Submitter ID	-	80	The MAC will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission. Submitter ID must match the value submitted in ISA06 and GS02.

10.1.3 Loop 1000B Receiver Name

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

Note: A hyphen in the table below means N/A.

Table 8. Loop 1000B NM1 Receiver Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
77	1000B	NM103	Receiver Name	-	60	-
77	1000B	NM109	Receiver Primary Identifier	-	80	The MAC will reject an interchange (transmission) that is not submitted with a valid Part A MAC code. Each individual MAC determines this identifier. Submitter ID must match the value submitted in ISA08 and GS03.

10.2 Billing Provider

10.2.1 Loop 2010AA Billing Provider

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

Note: A hyphen in the table below means N/A.

Table 9. Loop 2010AA Billing Provider

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
89	2010AA	N403	Billing Provider Postal Code	-	15	When the postal code does not include a +4 value, use 9998.

10.3 Subscriber Detail

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

10.3.1 Loop 2000B Subscriber Hierarchical Level

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

Table 10. Loop 2000B Subscriber Hierarchical Level

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
108	2000B	HL04	Hierarchical Child Code	0	1	The value accepted is "0".
109	2000B	SBR01	Payer Responsibility Sequence Number Code	P, S, T	1	The values accepted are "P" or "S" or "T".
110	2000B	SBR02	Individual Relationship Code	18	2	For Medicare, the subscriber is always the same as the patient.
110	2000B	SBR09	Claim Filing Indicator Code	MA	2	For Medicare, the subscriber is always the same as the patient.

10.3.2 Loop 2010BA Subscriber Name

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

Note: A hyphen in the table below means N/A.

Table 11. Loop 2010BA Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
113	2010BA	NM102	Subscriber Entity Type Qualifier	1	1	The value accepted is "1".
113	2010BA	NM105	Subscriber Middle Name or Initial	-	25	The first position must be alphabetic (A-Z).
114	2010BA	NM108	Subscriber Identification Code Qualifier	MI	2	The value accepted is "MI".

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
114	2010BA	NM109	Subscriber Primary Identifier	-	80	The MBI: must be 11 positions in the format of C A AN N A AN N A A N N where "C" represents a constrained numeric 1 thru 9, "A" represents alphabetic character A – Z but excluding S, L, O, I, B, Z, "N" represents numeric 0 thru 9, and "AN" represents either "A" or "N".
118	2010BA	DMG02	Subscriber Birth Date	-	35	Must not be a future date.

10.3.3 Loop 2010BB Payer Name

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

Table 12. Loop 2010BB Payer Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
113	2010BB	NM108	Payer Identification Code Qualifier	PI	2	The value accepted is "PI".

10.4 Patient Detail

The following sub-sections contain specific details associated with Patient Detail.

10.4.1 Loop 2300 Claim Information

The following tables define the specific details associated with Loop 2300 Claim Information.

Note: A hyphen in the table below means N/A.

Table 13. Loop 2300 Claim Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
144	2300	CLM01	Patient Control Number	-	38	Only 20 characters will be stored and returned by Medicare.
145	2300	CLM02	Total Claim Charge Amount	-	10	When Medicare is primary payer, CLM02 must equal the sum of all SV203 service line charge amounts. When Medicare is Secondary or Tertiary payer, Total Submitted Charges (CLM02) must equal the sum of all 2320 & 2430 CAS amounts and the 2320 AMT02 (AMT01= "D").
147	2300	CLM20	Delay Reason Code	-	2	Data submitted in CLM20 will not be used for processing.
148	2300	DTP03	Admission Date	-	-	Must not be a future date.
149	2300	DTP03	Discharge Hour	-	-	Must be in format HHMM.MM
-	2300	PWK	Claim Supplement Information	-	-	Only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
156	2300	PWK02	Attachment Transmission Code	BM, FX, FT, EL	2	Must be "BM", "FX", "FT", or "EL".

10.4.2 Loop 2310A Attending Provider Name

The following tables define the specific details associated with Loop 2310A Attending Provider Name.

Note: A hyphen in the table below means N/A.

Table 14. Loop 2310A Attending Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
320	2310A	NM105	Attending Provider Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.3 Loop 2310B Operating Physician Name

The following table defines the specific details associated with Loop 2310B Operating Physician Name.

Note: A hyphen in the table below means N/A.

Table 15. Loop 2310B Operating Physician Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
327	2310B	NM105	Operating Physician Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.4 Loop 2310C Other Operating Physician Name

The following table defines the specific details associated with Loop 2310C Other Operating Physician Name.

Note: A hyphen in the table below means N/A.

Table 16. Loop 2310C Other Operating Physician Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
332	2310C	NM105	Other Operating Physician Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.5 Loop 2310D Rendering Provider Name

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

Note: A hyphen in the table below means N/A.

Table 17. Loop 2310D Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
337	2310D	NM105	Rendering Provider Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.6 Loop 2310E Service Facility Location

The following table defines the specific details associated with Loop 2310E Service Facility Location.

Note: A hyphen in the table below means N/A.

Table 18. Loop 2310E Service Facility Location

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
346	2310E	N403	Service Facility Location Postal Code	-	15	When the postal code does not include a +4 value, use 9998.

10.4.7 Loop 2310F Referring Provider Name

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

Note: A hyphen in the table below means N/A.

Table 19. Loop 2310F Referring Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
350	2310F	NM105	Referring Provider Middle Name	-	25	The first position must be alphabetic (A-Z).
352	2310F	REF	Referring Provider Name Secondary Identification	-	-	Must not be present (non-VA contractors). Submission of this segment will cause your claim to reject.

10.4.8 Loop 2320 Other Subscriber Information

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

Note: A hyphen in the table below means N/A.

Table 20. Loop 2320 Other Subscriber Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
355	2320	SBR01	Payer Responsibility Sequence Number Code	-	1	The SBR must contain a different value in each iteration of the SBR01. Each value may only be used one time per claim.
356	2320	SBR09	Claim Filing Indicator Code	-	2	The value cannot be "MA" or "MB".
-	2320	CAS	Claim Level Adjustment	-	-	CAS segment must not be present when 2000B SBR01 = "P".
364	2320	AMT01	COB Payer Paid Amount	D	-	Medicare requires that one occurrence of 2320 loop with an AMT segment where AMT01 = "D" must be present when 2000B SBR01 = "S".

10.4.9 Loop 2330A Other Subscriber Name

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

Note: A hyphen in the table below means N/A.

Table 21. Loop 2330A Other Subscriber Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
378	2330A	NM105	Other Insured Middle Name	-	25	The first position must be alphabetic (A-Z).

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
383	2330A	REF02	Other Insured Additional Identifier	-	9	Must be 9 digits with no punctuation. First 3 digits cannot be higher than "272". Digits 1-3, 4-5, and 6-9 cannot be zeros.

10.4.10 Loop 2330B Other Payer Name

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

Note: A hyphen in the table below means N/A.

Table 22. Loop 2330B Other Payer Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
389	2330B	DTP03	Adjudication or Payment Date	-	35	Must not be future date.

10.4.11 Loop 2400 Service Line Number

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

Note: A hyphen in the table below means N/A.

Table 23. Loop 2400 Service Line Number

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
423	2400	LX01	Assigned Number	-	-	LX01 must be greater than zero and less than or equal to "449". An individual claim with service lines greater than "449" will be rejected (However, the transmission of claims will be accepted, per HIPAA).
425	2400	SV202-1	Product or Service ID Qualifier	HC, HP	2	Must be "HC" or "HP".

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
426	2400	SV202-2	Procedure Code	-	-	If A0427, A0428 (with a QL modifier in SV202-3, SV202-4, SV202-5, or SV202-6), A0425, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0488, or A0436 (non-scheduled transportation claim) are the only codes present, 2310A NM1 must not be preset. Otherwise, 2310A NM1 must be present.
427	2400	SV203	Line Item Charge Amount	-	10	SV203 must be greater than zero. SV203's decimal positions are limited to 0, 1, or 2.
428	2400	SV205	Quantity	-	15	SV205 must be greater than zero and less than or equal to "999,999.9". Must be 0 or 1 decimal position.
434	2400	DTP03	Service Date	-	35	Must not be a future date, except for type of bill 0322 after 1/1/2021

10.4.12 Loop 2410 Drug Identification

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

Note: A hyphen in the table below means N/A.

Table 24. Loop 2410 Drug Identification

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
452	2410	CTP04	National Drug Unit Count	-	15	CTP04 must be greater than "0" and less than or equal to "9,999,999.999". CTP04 is limited to up to 3 decimal positions.

10.4.13 Loop 2420A Operating Physician Name

The following table defines the specific details associated with Loop 2420A Operating Physician Name.

Note: A hyphen in the table below means N/A.

Table 25. Loop 2420A Operating Physician Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
457	2420A	NM105	Operating Physician Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.14 Loop 2420B Other Operating Physician Name

The following table defines the specific details associated with Loop 2420B Other Operating Physician Name.

Note: A hyphen in the table below means N/A.

Table 26. Loop 2420B Other Operating Physician Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
462	2420B	NM105	Other Operating Physician Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.15 Loop 2420C Rendering Provider Name

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

Note: A hyphen in the table below means N/A.

Table 27. Loop 2420C Rendering Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
467	2420C	NM105	Rendering Provider Name	-	25	The first position must be alphabetic (A-Z).

10.4.16 Loop 2420D Referring Provider Name

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

Note: A hyphen in the table below means N/A.

Table 28. Loop 2420D Referring Provider Name

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
472	2420D	NM105	Operating Physician Middle Name	-	25	The first position must be alphabetic (A-Z).

10.4.17 Loop 2430 Line Adjudication Information

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

Note: A hyphen in the table below means N/A.

Table 29. Loop 2430 Line Adjudication Information

Page #	Loop ID	Reference	Name	Codes/Content	Length	Notes/Comments
477	2430	SVD03	Product/Service ID Qualifier	HC, HP	2	Must be "HC" or "HP".
479	2430	SVD05	Quantity	-	15	Must be greater than zero. Must be less than or equal to "999,999.9". Must be 0 or 1 decimal position.
479	2430	SVD06	Bundled Line Number	-	6	Must be an integer (no decimals).
486	2430	DTP03	Line Check/Remit Date	-	35	Must not be a future date.

10.4.18 Transaction Set Trailer

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

Note: A hyphen in the table below means N/A.

Table 30. Transaction Set Trailer

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

11 Appendices

11.1 Implementation Checklist

In order to go live with CGS EDI, the following requirements must be met:

- EDI Enrollment Form must be submitted or on file.
- EDI Application
- Approved Vendor Software or approved Clearinghouse or Billing Service
- Approved Network Service Vendor

Upon approval of the request to exchange files with CGS, a letter will be sent to the requestor.

11.2 Transmission Examples

Figure 3. Example of the 837I Control Segments and Envelopes

```
ISA*00* *00* *28*SSSSSSSSSS *28*15201 *190131*1131*^*00501*000000017*0*P*>~

GS*HC*SSSSSSSSSS*15202*20190131*1131*17001*X*005010X223A2~

ST*837*000017001*005010X223A2~

SE*25*000017001~

GE*1*17001~

IEA*1*000000017~
```

Please refer to the GPNet communications manual posted under Manuals and user guides (https://www.cgsmedicare.com/parta/edi/index.html).

11.3 Frequently Asked Questions

Frequently asked questions can be accessed at:

Medicare FFS EDI Operations (https://www.cms.gov/ElectronicBillingEDITrans/)

CGS Frequently asked questions (https://www.cgsmedicare.com/). Click on the line of business, then the FAQ's can be located on the menu.

11.4 Acronym Listing

Table 31. 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
CEDI	Common Electronic Data Interchange
CG	Companion Guide
CMS	Centers for Medicare & Medicaid Services
CMN	Certificate of Medical Necessity
DME	Durable Medical Equipment
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
ISA/IEA	ISA – Interchange Control Header / IEA – Interchange Control Trailer
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier

Acronym	Definition
MIME	Multipurpose Internet Mail Extensions
NCPDP	National Council for Prescription Drug Programs
NPI	National Provider Identifier
NSV	Network Service Vendor
PDAC	Pricing, Data Analysis and Coding
PECOS	Provider Enrollment Chain and Ownership System
PHI	Protected Health Information
PID	Packet Identifier
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 32. Companion Guide Version History

Version	Date	Section(s) Changed	Change Summary
1.0	November 5, 2010	All	Initial Draft
2.0	January 3, 2011	All	1st Publication Version
3.0	April 2011	6.0	2nd Publication Version
4.0	September 2015	All	3rd Publication Version
4.0	June 2016	All	Updated CMS URLs
5.0	March 2017	2.2,4.1.3,4.3&4.4	Updated hyperlinks and connectivity information
5.1	November 2017	All	Updated CGS and CMS URL
6.0	March 2019	All	4th Publication Version
6.1	June 2020	1.3	11.4
6.2	April 2021	10.3.10 2400 DTP03	Service Date Language updated.
7.0	July 2022	All	508 Compliance
8.0	June 2023	3.1, 10.2.1 and 10.4.6	10.2.1 and 10.4.2 – Added instruction for +4 postal code when not provided by USPS. 3.1 Corrected spelling of Implementation