Disclosure Statement

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

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

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

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

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

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


1.1 Scope

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

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

1.2 Overview

This CG includes information needed to commence and maintain communication exchange with Medicare. In addition, this CG has been written to assist you in designing and implementing the ASC X12N 837P transaction 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, data services, and audit procedures. Information concerning Trading Partner registration and the Trading Partner testing process is also included in this section.

• **Testing and Certification Requirements**: This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.

• **Connectivity/Communications**: This section includes information on Medicare’s transmission procedures as well as communication and security protocols.

• **Contact Information**: This section includes EDI customer service, EDI technical assistance, Trading Partner services and applicable websites.

• **Control Segments/Envelopes**: This section contains information needed to create the Interchange Control Header/Trailer (ISA/IEA), Functional Group Header/Trailer (GS/GE), and Transaction Set Header/Trailer (ST/SE) control segments for transactions to be submitted to or received from Medicare.

• **Specific Business Rules and Limitations**: This section contains Medicare business rules and limitations specific to the ASC X12N 837P.

• **Acknowledgments and Reports**: This section contains information on all transaction acknowledgments sent by Medicare and report inventory.

• **Trading Partner Agreement**: This section contains information related to implementation checklists, transmission examples, Trading Partner Agreements and other resources.

• **Transaction Specific Information**: This section describes the specific CMS requirements over and above the information in the ASC X12N 837P TR3.

### 1.3 References

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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC X12N TR3s</td>
<td><a href="http://store.x12.org/store/">http://store.x12.org/store/</a></td>
</tr>
</tbody>
</table>

### 1.4 Additional Information

For additional information, please visit the CGS EDI Web page at

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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Web Address</th>
</tr>
</thead>
</table>

## 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 accepted 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/](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 has been established in order to broadcast urgent messages. Please register for CGS’s distribution list by [https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp](https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp).

### 2.2 Trading Partner Registration

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

Medicare FFS and 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.

- **Provider/Supplier** – the entity that renders services to beneficiaries and submits health care claims to Medicare.

- **Billing Service** – a third party that prepares and/or submits claims for a provider.

- **Clearinghouse** – a third party that submits and/or exchanges electronic transactions (claims, claim status or eligibility inquiries, remittance advice, etc.) on behalf of a provider.

- **Network Service Vendor** – a third party that provides connectivity between a Trading Partner and CGS.

Medicare requires all trading partners to complete EDI registration and sign an EDI Enrollment form. The EDI enrollment form designates the Medicare contractor and/or CEDI as the entity they agree to engage in for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.

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

For EDI enrollment information, please visit the CGS EDI Web page at [http://www.cgsmedicare.com/partb/edi/enrollment.html](http://www.cgsmedicare.com/partb/edi/enrollment.html).

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 CGS enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for Durable
Medical Equipment [DME] suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

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

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

- To sign up complete the J15 Communications and the enrollment form located on our website: https://www.cgsmedicare.com/partb/edi/enrollment.html.
- What to expect throughout the process: 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 field.
- 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 TR3 editing module at https://www.cgsmedicare.com/partb/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. Vendors may elect to have a Trading Partner test their software for approval and eliminate every user testing.

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 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 that can be accessed at:
4 Connectivity / Communications

4.1 Process Flows

The following diagram illustrates how American National Standards Institute (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 posted under https://www.cgsmedicare.com/partb/edi/index.html

The connectivity specifications are located at the following link: http://www.cgsmedicare.com/pdf/gpnet_comm_manual.pdf

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 the EDI User Guides webpage at https://www.cgsmedicare.com/partb/edi/index.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. Additional information can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library-Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html

- Login IDs are assigned once a request is received with a valid EDI application and an EDI enrollment form on file. EDI transactions submitted by unauthorized trading partners will not be accepted. Password guidelines are provided with receipt of initial passwords from CGS.
- 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. Please see our GPNET communications manual posted under the EDI user guides located on our webpage.

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

5 Contact Information
5.1 EDI Customer Service

For EDI Customer Service information, please visit the contact us area on [https://www.cgsmedicare.com/](https://www.cgsmedicare.com/)

- Mailing Address
  - J15- EDI
  - CGS
  - PO box 20018
  - Nashville, TN 37202

- Telephone Number both toll free 800 number and regular number
  - CGS Part A 866-590-6703 option 2
  - CGS Part B 866-276-9558 option 2
  - CGS HHH 866-299-4500 option 2
  - EDI Fax Numbers
    - 1.615.664.5945 Ohio Part A
    - 1.615.664.5943 Kentucky Part A
    - 1.615.664.5927 Ohio Part B
    - 1.615.664.5917 Kentucky Part B
    - 1.615.664.5947 Home Health & Hospice

- Email Address
  - [https://www.cgsmedicare.com/partb/cs/online_help.html](https://www.cgsmedicare.com/partb/cs/online_help.html)
  - [https://www.cgsmedicare.com/hhh/cs/onlinehelphhh.html](https://www.cgsmedicare.com/hhh/cs/onlinehelphhh.html)
  - [https://www.cgsmedicare.com/parta/cs/online_help.html](https://www.cgsmedicare.com/parta/cs/online_help.html)

- Time and Day of Operations
  - Monday – Friday 8am EST to 5pm EST.

- 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

For additional schedule information, see: https://www.cgsmedicare.com/partb/cs/2019_holiday_schedule.pdf

5.2 EDI Technical Assistance

See Section 5.1 for Technical Assistance Information

5.3 Trading Partner Service Number

See Section 5.1 for the Trading Partner Service number

5.4 Applicable Websites / Email

Please visit the CGS EDI Webpage at http://www.cgsmedicare.com/.

6 Control Segments / Envelopes

Enveloping information must be as follows:

*Table 3 – Control Segments / Envelope Requirements*

<table>
<thead>
<tr>
<th>Page #</th>
<th>Element</th>
<th>Name</th>
<th>Codes/Content</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISA</td>
<td>ISA</td>
<td>Interchange Control Header</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.4</td>
<td>ISA01</td>
<td>Authorization Information</td>
<td>00</td>
<td>Medicare expects the value to be 00.</td>
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<tr>
<td>C.4</td>
<td>ISA02</td>
<td>Authorization Information</td>
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<td>ISA02 shall contain 10 blank spaces.</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA03</td>
<td>Security Information</td>
<td>00</td>
<td>Medicare expects the value to be 00.</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA04</td>
<td>Security Information</td>
<td></td>
<td>Medicare does not use Security Information and will ignore content sent in ISA04.</td>
</tr>
<tr>
<td>Page #</td>
<td>Element</td>
<td>Name</td>
<td>Codes/Content</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-------------------------------</td>
<td>---------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>C.4</td>
<td>ISA05</td>
<td>Interchange ID Qualifier</td>
<td>27, ZZ</td>
<td>Must be “27” or “ZZ”.</td>
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<tr>
<td>C.4</td>
<td>ISA06</td>
<td>Interchange Sender ID</td>
<td></td>
<td>CGS-assigned Submitter ID. This is also required in the GS02.</td>
</tr>
<tr>
<td>C.5</td>
<td>ISA07</td>
<td>Interchange ID Qualifier</td>
<td>27, ZZ</td>
<td>Must be “27” or “ZZ”.</td>
</tr>
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<td>C.5</td>
<td>ISA08</td>
<td>Interchange Receiver ID</td>
<td></td>
<td>MAC contract number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ohio Part B 15202 Home Health &amp; Hospice 15004</td>
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<td>Ohio Part A 15201</td>
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<td>C.5</td>
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<td>Repetition Separator</td>
<td></td>
<td>Defined by Submitter.</td>
</tr>
<tr>
<td>C.6</td>
<td>ISA14</td>
<td>Acknowledgement Requested</td>
<td>1</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GS</td>
<td></td>
<td>Functional Group Header</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.7</td>
<td>GS02</td>
<td>Application Sender Code</td>
<td></td>
<td>Submitter number assigned by CGS.</td>
</tr>
<tr>
<td>C.7</td>
<td>GS03</td>
<td>Application Receiver’s Code</td>
<td></td>
<td>MAC contract number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ohio Part B 15202 Home Health &amp; Hospice 15004</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ohio Part A 15201</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kentucky B 15102</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kentucky Part A 15101</td>
</tr>
<tr>
<td>C.7</td>
<td>GS04</td>
<td>Functional Group Creation Date</td>
<td></td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>C.7</td>
<td>GS08</td>
<td>Version Identifier Code</td>
<td>005010X222A1</td>
<td>Medicare expects value “005010X222A1“.</td>
</tr>
</tbody>
</table>

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

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

Table 4 – Outbound Transaction Delimiters

<table>
<thead>
<tr>
<th>Delimiter Value</th>
<th>Character Used</th>
<th>Dec Value</th>
<th>Hex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element separator</td>
<td>*</td>
<td>42</td>
<td>2A</td>
</tr>
<tr>
<td>Component Element Separator</td>
<td>^</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Component Element Separator</td>
<td>&gt;</td>
<td>62</td>
<td>5E</td>
</tr>
<tr>
<td>Segment Terminator</td>
<td>~</td>
<td>126</td>
<td>3E</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>2000A</td>
<td>CUR</td>
<td>Foreign Currency Information</td>
<td></td>
<td>Medicare does not support the submission of foreign currency.</td>
</tr>
<tr>
<td>96</td>
<td>2010AA</td>
<td>REF</td>
<td>Billing Provider UPIN/License Information</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>106</td>
<td>2010AC</td>
<td>Loop Rule</td>
<td>Pay To Plan Loop</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>129</td>
<td>2010BA</td>
<td>REF</td>
<td>Subscriber Secondary Identification (REF01 = “SY”)</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>138</td>
<td>2010BB</td>
<td>REF</td>
<td>Payer Secondary Identification</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>140</td>
<td>2010BB</td>
<td>REF</td>
<td>Billing Provider Secondary Identification</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>142</td>
<td>2000C</td>
<td>HL</td>
<td>Patient Hierarchical Level</td>
<td></td>
<td>Must not be present. For Medicare, the subscriber is always the same as the patient.</td>
</tr>
<tr>
<td>144</td>
<td>2000C</td>
<td>PAT</td>
<td>Patient Information</td>
<td></td>
<td>Must not be present. For Medicare, the subscriber is always the same as the patient.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>----------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>147</td>
<td>2010CA</td>
<td>Loop Rule</td>
<td>Patient Name Loop</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>186</td>
<td>2300</td>
<td>CN1</td>
<td>Contract Information</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>191</td>
<td>2300</td>
<td>REF</td>
<td>Mandatory Medicare (Section 4081) Crossover Indicator</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>196</td>
<td>2300</td>
<td>REF</td>
<td>Payer Claim Control Number</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>332</td>
<td>2330C</td>
<td>Loop Rule</td>
<td>Other Payer Referring Provider</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>336</td>
<td>2330D</td>
<td>Loop Rule</td>
<td>Other Payer Rendering Provider</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>340</td>
<td>2330E</td>
<td>Loop Rule</td>
<td>Other Payer Service Facility Location</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>343</td>
<td>2330F</td>
<td>Loop Rule</td>
<td>Other Payer Supervising Provider</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>347</td>
<td>2330G</td>
<td>Loop Rule</td>
<td>Other Payer Billing Provider</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>395</td>
<td>2400</td>
<td>CN1</td>
<td>Contract Information</td>
<td></td>
<td>Must not be present.</td>
</tr>
<tr>
<td>416</td>
<td>2400</td>
<td>HCP</td>
<td>Line Pricing/Repricing Information</td>
<td></td>
<td>Must not be present.</td>
</tr>
</tbody>
</table>

### 7.2 General Transaction Notes

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

- The maximum number of characters to be submitted in any dollar amount field is seven characters. Claims containing a dollar amount in excess of 99,999.99 will be rejected.
• Claims that contain percentage amounts with values in excess of 99.99 will be rejected.
• For the exception of the CAS segment, all amounts must be submitted as positive amounts. Negative amounts submitted in any non-CAS amount element will cause the claim to be rejected.
• Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.
• Only loops, segments, and data elements valid for the TR3 will be translated. Submitting invalid data will cause files to be rejected.
• Medicare requires the NPI be submitted as the identifier for all claims. Claims submitted with legacy identifiers will be rejected. (Non-VA contractors)
• National Provider Identifiers will be validated against the NPI algorithm. Claims which fail validation will be rejected.
• The MAC will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) will cause the transaction to be rejected.
• Submissions with more than one GS-GE (Functional Group) per ISA-IEA (Interchange) will be rejected.

8 Acknowledgments and Reports

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

Medicare has adopted three new acknowledgement transactions with the Version 005010 implementation: the 277CA, the 999, and the TA1 segment – which provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure. 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 at: https://www.cgsmedicare.com/partb/edi/index.html.
The CGS Trading Partner Agreement process is identical to the CGS EDI enrollment and registration process.

10 Transaction-Specific Information

This section describes the specific CMS requirements over and above the standard information in the 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:

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ST</td>
<td>ST02</td>
<td>Transaction Set Control Number</td>
<td></td>
<td>9</td>
<td>The MAC will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.</td>
</tr>
<tr>
<td>70</td>
<td>BHT</td>
<td>BHT02</td>
<td>Transaction Set Purpose Code</td>
<td>00</td>
<td>2</td>
<td>Must equal “00” (ORIGINAL).</td>
</tr>
<tr>
<td>71</td>
<td>BHT06</td>
<td>CH</td>
<td>Claim/Encounter Identifier</td>
<td></td>
<td>2</td>
<td>Must equal “CH” (CHARGEABLE).</td>
</tr>
</tbody>
</table>

10.1.2 Loop 1000A Submitter Name

The following table defines the specific details associated with Loop 1000A Submitter Name:
### Table 7 – Loop 1000A Submitter Name

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>1000A</td>
<td>NM105</td>
<td>Submitter Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
<tr>
<td>75</td>
<td>1000A</td>
<td>NM109</td>
<td>Submitter ID</td>
<td>80</td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

#### 10.1.3 Loop 1000B Receiver Name

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

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

#### 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 9 – Loop 2000A Billing Provider Detail*

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000A</td>
<td>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.</td>
</tr>
<tr>
<td>2010AA</td>
<td>REF: must not be present (non-VA contractors). NM109: billing provider must be “associated” to the submitter (from a Trading Partner management perspective) in 1000A NM109.</td>
</tr>
<tr>
<td></td>
<td>CGS will provide appropriate direction to VA providers.</td>
</tr>
</tbody>
</table>

10.2.2 Loop 2010AA Billing Provider Name

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

*Table 10 – Loop 2010AA Billing Provider Name*

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>89</td>
<td>2010AA</td>
<td>NM105</td>
<td>Billing Provider Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

10.3 Subscriber Detail

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

10.3.1 Loop 2000B Subscriber Hierarchical Level

The following table defines the specific details associated with Loop 2000B Subscriber Hierarchical Level.
### Table 11 – Loop 2000B Subscriber Hierarchical Level

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

### 10.3.2 Loop 2010BA Subscriber Name

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

### Table 12 – Loop 2010BA Subscriber Name

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010BA</td>
<td>NM1</td>
<td>Subscriber Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>122</td>
<td>2010BA</td>
<td>NM102</td>
<td>Subscriber Entity Type Qualifier</td>
<td>1</td>
<td>1</td>
<td>The value accepted is 1.</td>
</tr>
<tr>
<td>122</td>
<td>2010BA</td>
<td>NM105</td>
<td>Subscriber Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
<tr>
<td>122</td>
<td>2010BA</td>
<td>NM108</td>
<td>Subscriber Identification Code Qualifier</td>
<td>MI</td>
<td>2</td>
<td>The value accepted is “MI”.</td>
</tr>
<tr>
<td>123</td>
<td>2010BA</td>
<td>NM109</td>
<td>Subscriber Primary Identifier</td>
<td></td>
<td>80</td>
<td>If a Medicare Health Insurance Claim Number (HICN): Must be 10 – 11 positions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>in the format of NNNNNNUNNNNA or NNNNNNNNNA or NNNNNNNNNAN where “A”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>represents an alpha character and “N” represents a numeric digit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If Railroad IDs: 2010BA NM109 must be 7 – 12 positions in the format of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ANNNNNN, AANNNNNN, ANNNNNNNNN, AANNNNNNNN, AAANNNNNN, or AAANNNNNNNN where</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“A” represents an alpha character and “N” represents a numeric digit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If MBI: must be 11 positions in the format of C A A A N A N A A N A N N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>where “C” represents a constrained numeric 1 thru 9, “A” represents</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>represents numeric 0 thru 9, and “AN” represents either “A” or “N”.</td>
</tr>
</tbody>
</table>
10.3.3 Loop 2010BB Payer Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>134</td>
<td>2010BB</td>
<td>NM108</td>
<td>Payer Identification Code Qualifier</td>
<td>PI</td>
<td>2</td>
<td>The value accepted is “PI”</td>
</tr>
</tbody>
</table>

10.4 Patient Detail

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

10.4.1 Loop 2300 Claim Information

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>158</td>
<td>2300</td>
<td>CLM01</td>
<td>Patient Control Number</td>
<td></td>
<td>38</td>
<td>Only 20 characters will be stored and returned by Medicare.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>-----------</td>
<td>-------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>159</td>
<td>2300</td>
<td>CLM02</td>
<td>Total Claim Charge Amount</td>
<td></td>
<td>18</td>
<td>Must be &gt;= 0 and &lt;= 99,999.99. When Medicare is primary payer, CLM02 must equal the sum of all SV102 service line charge amounts. When Medicare is Secondary. Total Submitted Charges (CLM02) must equal the sum of all 2320 &amp; 2430 CAS amounts and the 2320 AMT02 (AMT01=D).</td>
</tr>
<tr>
<td>159</td>
<td>2300</td>
<td>CLM05-3</td>
<td>Claim Frequency Code</td>
<td>1</td>
<td>1</td>
<td>Must be equal to “1” (ORIGINAL).</td>
</tr>
<tr>
<td>163</td>
<td>2300</td>
<td>CLM20</td>
<td>Delay Reason Code</td>
<td></td>
<td>2</td>
<td>Data submitted in CLM20 will not be used for processing.</td>
</tr>
<tr>
<td>2300</td>
<td>DTP</td>
<td>Date Elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>164</td>
<td>2300</td>
<td>DTP03</td>
<td>Onset of Current Illness or Injury Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>165</td>
<td>2300</td>
<td>DTP03</td>
<td>Initial Treatment Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>167</td>
<td>2300</td>
<td>DTP03</td>
<td>Acute Manifestation Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>168</td>
<td>2300</td>
<td>DTP03</td>
<td>Accident Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>169</td>
<td>2300</td>
<td>DTP03</td>
<td>Last Menstrual Period Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>170</td>
<td>2300</td>
<td>DTP03</td>
<td>Last X-Ray Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>171</td>
<td>2300</td>
<td>DTP03</td>
<td>Prescription Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>173</td>
<td>2300</td>
<td>DTP03</td>
<td>Disability From Date</td>
<td></td>
<td>35</td>
<td>Future dates are allowed in this situation.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>-----------</td>
<td>-------------------------------------</td>
<td>-------------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>174</td>
<td>2300</td>
<td>DTP03</td>
<td>Last Worked Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>176</td>
<td>2300</td>
<td>DTP</td>
<td>Admission Date</td>
<td></td>
<td></td>
<td>If 2400.SV105 = &quot;21&quot;, &quot;51&quot; or &quot;61&quot; then 2300.DTP with DTP01 = &quot;435&quot; must be present.</td>
</tr>
<tr>
<td>176</td>
<td>2300</td>
<td>DTP03</td>
<td>Related Hospitalization Admission Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>177</td>
<td>2300</td>
<td>DTP03</td>
<td>Related Hospitalization Discharge Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>2300</td>
<td>PWK</td>
<td>Claim Supplement Information</td>
<td></td>
<td></td>
<td>Only the first iteration of the PWK, at either the claim level and/or line level, will be considered in the claim adjudication.</td>
<td></td>
</tr>
<tr>
<td>184</td>
<td>2300</td>
<td>PWK02</td>
<td>Attachment Transmission Code</td>
<td>BM, FX, EL, FT</td>
<td>2</td>
<td>Must be “BM”, “FX”, “EL”, or “FT”.</td>
</tr>
<tr>
<td>2300</td>
<td>CR1</td>
<td>Ambulance Transport Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>212</td>
<td>2300</td>
<td>CR102</td>
<td>Patient Weight</td>
<td></td>
<td>10</td>
<td>A maximum of 4 whole numbers and up to 2 decimal positions are allowable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient weight in excess of 9,999.99 pounds will be rejected.</td>
</tr>
<tr>
<td>213</td>
<td>2300</td>
<td>CR106</td>
<td>Transport Distance</td>
<td></td>
<td>15</td>
<td>Must not exceed 4 digits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transport distance in excess of 9,999 miles will be rejected.</td>
</tr>
</tbody>
</table>
### 10.4.2 Loop 2310A Referring Provider Name

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

**Table 15 – Loop 2310A Referring Provider Name**

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2310A</td>
<td>NM1</td>
<td>Referring Provider Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>258</td>
<td>2310A</td>
<td>NM105</td>
<td>Referring Provider Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

### 10.4.3 Loop 2310B Rendering Provider Name

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

**Table 16 – Loop 2310B Rendering Provider Name**

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2310B</td>
<td>NM1</td>
<td>Rendering Provider Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>263</td>
<td>2310B</td>
<td>NM105</td>
<td>Rendering Provider Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

### 10.4.4 Loop 2310D Supervising Provider Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
</table>

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.
Table 17 – Loop 2310D Supervising Provider Name

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>281</td>
<td>2310D</td>
<td>NM105</td>
<td>Supervising Provider Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

10.4.5 Loop 2320 Other Subscriber Information

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

Table 18 – Loop 2320 Other Subscriber Information

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>296</td>
<td>2320</td>
<td>SBR01</td>
<td>Payer Responsibility Sequence Number Code</td>
<td></td>
<td>1</td>
<td>2320 SBR01 = “P” must be present when 2000B SBR01 = ”S”.</td>
</tr>
<tr>
<td>298</td>
<td>2320</td>
<td>SBR09</td>
<td>Claim Filing Indicator Code</td>
<td></td>
<td>2</td>
<td>The value cannot be “MA” or “MB”.</td>
</tr>
<tr>
<td></td>
<td>2320</td>
<td>CAS</td>
<td>Claim Level Adjustments</td>
<td></td>
<td></td>
<td>CAS segment must not be present when 2000B SBR01 = “P”.</td>
</tr>
<tr>
<td>305</td>
<td>2320</td>
<td>AMT01</td>
<td>COB Payer Paid Amount</td>
<td>D</td>
<td></td>
<td>Medicare requires one occurrence of 2320 loop with an AMT segment AMT01 = ”D” must be present when 2000B SBR01 = ”S”.</td>
</tr>
</tbody>
</table>
10.4.6 Loop 2330A Other Subscriber Name

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

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

10.4.7 The following table Loop 2330B Other Payer Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2330B</td>
<td>DTP</td>
<td>Claim Check or Remittance Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>325</td>
<td>2330B</td>
<td>DTP03</td>
<td>Date Time Period</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
</tbody>
</table>
## 10.4.8 Loop 2400 Service Line Number

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2400</td>
<td>SV1</td>
<td>Professional Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>352</td>
<td>2400</td>
<td>SV101-1</td>
<td>Product or Service ID Qualifier</td>
<td>HC</td>
<td>2</td>
<td>Must be “HC”.</td>
</tr>
<tr>
<td>353</td>
<td>2400</td>
<td>SV101-3, SV101-4, SV101-5, SV101-6</td>
<td>Procedure Modifier</td>
<td>2</td>
<td></td>
<td>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, or SV101-6 must have a value of “RT” and one of these segments must have a value of “LT”.</td>
</tr>
<tr>
<td>354</td>
<td>2400</td>
<td>SV102</td>
<td>Line Item Charge Amount</td>
<td>18</td>
<td></td>
<td>SV102 must be greater than 0. SV102’s decimal positions are limited to 0, 1, or 2.</td>
</tr>
<tr>
<td>355</td>
<td>2400</td>
<td>SV103</td>
<td>Unit or Basis for Measurement Code</td>
<td>MJ, UN</td>
<td>2</td>
<td>SV103 must be “UN” for DME claims. SV103 must be &quot;MJ&quot; when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be &quot;UN&quot;.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------------</td>
<td>-------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>355</td>
<td>2400</td>
<td>SV104</td>
<td>Service Unit Count</td>
<td>MJ</td>
<td>15</td>
<td>Anesthesia claims must be submitted with minutes (qualifier MJ). Does not apply for DME claims.</td>
</tr>
<tr>
<td>355</td>
<td>2400</td>
<td>SV104</td>
<td>Service Unit Count</td>
<td>MJ</td>
<td></td>
<td>The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Cannot exceed 9,999. Does not apply for DME claims.</td>
</tr>
<tr>
<td>355</td>
<td>2400</td>
<td>SV104</td>
<td>Service Unit Count</td>
<td>UN</td>
<td></td>
<td>Must be &gt; 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.</td>
</tr>
<tr>
<td>360</td>
<td>2400</td>
<td>SV503</td>
<td>Quantity</td>
<td></td>
<td></td>
<td>DME Only: Must be &gt; 0 with a maximum of 3 whole numbers (must not exceed 999).</td>
</tr>
<tr>
<td>360</td>
<td>2400</td>
<td>SV504</td>
<td>Monetary Amount</td>
<td></td>
<td></td>
<td>DME Only: Must be &gt; 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.</td>
</tr>
<tr>
<td>360</td>
<td>2400</td>
<td>SV505</td>
<td>Monetary Amount</td>
<td></td>
<td></td>
<td>DME Only: Must be &gt; 0 with maximum of 7 digits – inclusive of up to 3 decimal positions.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2400</td>
<td>PWK</td>
<td>Durable Medical Equipment Certificate of Medical Necessity Indicator</td>
<td>(PWK01 = &quot;CT&quot;)</td>
<td></td>
<td></td>
<td>Must not be present on Part B claims. DME only.</td>
</tr>
<tr>
<td>2400</td>
<td>CR1</td>
<td>Ambulance Transport Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>369</td>
<td>CR102</td>
<td>Patient Weight</td>
<td></td>
<td></td>
<td></td>
<td>Must not exceed 4 whole numbers and 2 decimals. Patient weight in excess of 9,999.99 pounds will be rejected.</td>
</tr>
<tr>
<td>370</td>
<td>CR106</td>
<td>Transport Distance</td>
<td></td>
<td>15</td>
<td></td>
<td>Must not exceed 4 digits. Transport distance in excess of 9,999 miles will be rejected.</td>
</tr>
<tr>
<td>2400</td>
<td>CR3</td>
<td>Durable Medical Equipment Certification</td>
<td></td>
<td></td>
<td></td>
<td>Must not be present on Part B claims. CR3 segment must be present when DME CMN information is included with the claim.</td>
</tr>
<tr>
<td>371</td>
<td>CR303</td>
<td>Unit or Basis for Measurement Code</td>
<td></td>
<td>2</td>
<td></td>
<td>DME Only: Must not exceed 2 digits. DME Only: Must be &gt; 0 unless 2400 L02 = “08.02”.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>-----------</td>
<td>-------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2400</td>
<td>CRC</td>
<td>Condition Indicator/ Durable Medical Equipment</td>
<td></td>
<td></td>
<td></td>
<td>Must not be present on a Part B Claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DME only: CR3 segment must be present when DME CMN information is included</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>with the claim.</td>
</tr>
<tr>
<td>378</td>
<td>2400</td>
<td>CRC01</td>
<td>Code Category</td>
<td>09</td>
<td></td>
<td>DME Only: When CRC Condition Indicator (CRC01 = “09”) is submitted, either</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CRC03 or CRC04 must be “38”.</td>
</tr>
<tr>
<td>2400</td>
<td>DTP</td>
<td>Service Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>---------------------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 381    | 2400    | DTP03     | Date – Service Date       |       | 35     | Must not be a future date.  
DME only: Must not be a single date of service when modifier RR is reported with more than 1 unit of service.  
DME only: When a Service Date range extends into the future, the procedure code must equate to an Inexpensive Supply, PEN Amino Acid, PEN Enteral, PEN Immunosuppressant Drug, PEN Kit/Supply, PEN Lipid, PEN Pump, PEN Special Parenteral, or PEN Dextrose/Home Mix.  
DME only: Must be a single DOS when procedure code is NOT “E0935” or “E0936” and the procedure code is not considered a Glucose Monitoring or Inexpensive Supply, and the procedure code is categorized as Frequently Serviced DME, Inexpensive or Routinely Purchased DME, Capped Rental DME, Stationary Liquid and Portable Oxygen Equipment, Oxygen Concentrators, Gaseous Oxygen Equipment, Liquid Oxygen Equipment, or Portable Oxygen Equipment. |
<p>| 382    | 2400    | DTP03     | Date – Prescription Date  |       | 35     | Must not be a future date. |</p>
<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td>DTP</td>
<td>Date – Certification Revision / Recertification Date</td>
<td></td>
<td></td>
<td>DME only: Must not be present on a Part B claim.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DME only: Must not be a future date.</td>
</tr>
<tr>
<td>2400</td>
<td>DTP</td>
<td>Date – Begin Therapy Date</td>
<td></td>
<td></td>
<td>DME only: Must not be present on a Part B claim.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DME only: Must not be a future date.</td>
</tr>
<tr>
<td>2400</td>
<td>DTP</td>
<td>Date – Last Certification Date</td>
<td></td>
<td></td>
<td>DME only: Must not be present on a Part B claim.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DME only: Must not be a future date.</td>
</tr>
<tr>
<td>2400</td>
<td>DTP</td>
<td>Date - Last Seen Date</td>
<td></td>
<td></td>
<td>Part B only: Must not be a future date</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Part B only: Segment must not be present for DME claims.</td>
</tr>
<tr>
<td>387</td>
<td>2400</td>
<td>DTP03</td>
<td>Test Performed Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>389</td>
<td>2400</td>
<td>DTP03</td>
<td>Last X-Ray Date</td>
<td></td>
<td>35</td>
<td>Part B only: Must not be a future date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Part B only: Segment must not be present for DME claims.</td>
</tr>
<tr>
<td>390</td>
<td>2400</td>
<td>DTP03</td>
<td>Initial Treatment Date</td>
<td></td>
<td>35</td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>2400</td>
<td>QTY</td>
<td>Ambulance Patient Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>391</td>
<td>2400</td>
<td>QTY02</td>
<td>Ambulance Patient Count</td>
<td></td>
<td>15</td>
<td>Must be between 1 and 99.</td>
</tr>
</tbody>
</table>
### Loop 2400 Details

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td>QTY</td>
<td>Obstetric Anesthesia Additional Units</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>392</td>
<td>QTY02</td>
<td>Obstetric Additional Units</td>
<td></td>
<td></td>
<td>15</td>
<td>Must be between 1 and 99.</td>
</tr>
<tr>
<td>2400</td>
<td>MEA</td>
<td>Test Results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Loop 2410 Details

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

#### Table 22 – Loop 2410 Drug Identification

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2410</td>
<td>LIN</td>
<td>Drug Identification</td>
<td></td>
<td></td>
<td></td>
<td>For DME claims, must be present when 2400 SV101-1 contains a default Healthcare Common Procedure Coding System (HCPCS) code.</td>
</tr>
<tr>
<td>425</td>
<td>LIN02</td>
<td>Product or Service ID Qualifier</td>
<td>N4</td>
<td>2</td>
<td>Must be N4.</td>
<td></td>
</tr>
<tr>
<td>425</td>
<td>LIN03</td>
<td>National Drug Code</td>
<td></td>
<td>11</td>
<td>Must be exactly 11 alphanumeric positions.</td>
<td></td>
</tr>
<tr>
<td>2410</td>
<td>CTP</td>
<td>Drug Quantity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 10.4.10 Loop 2420A Rendering Provider Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>431</td>
<td>2420A</td>
<td>NM105</td>
<td>Rendering Provider Middle Name</td>
<td></td>
<td></td>
<td>The first position must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>426</td>
<td>2410</td>
<td>CTP04</td>
<td>National Drug Unit Count</td>
<td></td>
<td>15</td>
<td>Must be greater than 0 and less than or equal to 9,999,999.999.</td>
</tr>
<tr>
<td>427</td>
<td>2410</td>
<td>CTP05-1</td>
<td>Unit or Basis for Measurement Code</td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>2410</td>
<td>REF</td>
<td>Prescription or Compound Drug Association Number</td>
<td></td>
<td></td>
<td>Must be submitted with REF01 = “XZ” if service line includes modifier J1.</td>
</tr>
<tr>
<td>428</td>
<td>2410</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>XZ</td>
<td></td>
<td>If service line (SV1) includes Modifier J1, REF01 = “XZ” must be present.</td>
</tr>
</tbody>
</table>

### 10.4.11 Loop 2420D Supervising Provider Name

The following table defines the specific details associated with Loop 2420D Supervising Provider Name.
### Table 24 – Loop 2420D Supervising Provider Name

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2420D</td>
<td>NM1</td>
<td>Supervising Provider Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>450</td>
<td>2420D</td>
<td>NM105</td>
<td>Supervising Provider Middle Name</td>
<td></td>
<td></td>
<td>First position of Supervising Provider Middle Name must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

### 10.4.12 Loop 2420E Ordering Provider Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2420E</td>
<td>NM1</td>
<td>Ordering Provider Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>455</td>
<td>2420E</td>
<td>NM105</td>
<td>Ordering Provider Middle Name</td>
<td></td>
<td></td>
<td>First position of Ordering Provider Middle Name must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>

### 10.4.13 Loop 2420F Referring Provider Name

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

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2420F</td>
<td>NM1</td>
<td>Referring Provider Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>466</td>
<td>2420F</td>
<td>NM105</td>
<td>Referring Provider Middle Name</td>
<td></td>
<td></td>
<td>First position of Referring Provider Middle Name must be alphabetic (A-Z).</td>
</tr>
</tbody>
</table>
10.4.14 Loop 2430 Line Adjudication Information

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

**Table 27 – Loop 2430 Line Adjudication Information**

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

10.4.15 Loop 2440 Form Identification Code

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

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

**Table 28 – Loop 2440 Form Identification Code**

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2440</td>
<td>LQ</td>
<td></td>
<td>Form Identification Code</td>
<td></td>
<td></td>
<td>DME claims only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------------------------</td>
<td>-------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>493</td>
<td>2440</td>
<td>LQ01</td>
<td>Code List Qualifier Code</td>
<td>UT</td>
<td>3</td>
<td>DME Must be “UT”. DME claims only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FRM</td>
<td>Supporting Documentation</td>
<td></td>
<td></td>
<td>FRM segment is used for DME claims only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>DME claims only. Not valid for Part B Claims. When LQ02='484.03' and FRM01='6A' or '6B', an occurrence of FRM01 with the value of '6C' is required.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>DME claims only. Not valid for Part B Claims. When LQ02='484.03' and FRM01='6C', an occurrence of FRM01 with the value of '6A' or '6B' is required.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>FRM01 Question number must be valid for the LQ02 CMN/DIF number.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>When LQ02 = ‘484.03”, occurrences of FRM01 = &quot;1A&quot; or &quot;1B&quot;, and FRM01 = &quot;1C&quot;, and FRM01 = &quot;05&quot; must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>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.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td>---------------------------</td>
<td>-------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM01</td>
<td>Question Number/Letter</td>
<td></td>
<td>20</td>
<td>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.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM02</td>
<td>Question Number/Letter</td>
<td></td>
<td>1</td>
<td>DME claims only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = '484.03” and FRM with FRM01 = &quot;04&quot;, &quot;07&quot;, &quot;08&quot; or &quot;09&quot; is present, then FRM02 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM03</td>
<td>Question Response</td>
<td></td>
<td>50</td>
<td>DME claims only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;04.04&quot; and FRM01 = &quot;07B&quot;, &quot;09B&quot;, &quot;10B&quot; or &quot;10C&quot;, FRM03 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM03</td>
<td>Question Response</td>
<td></td>
<td>50</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;06.03&quot; and FRM01 = &quot;02&quot; or &quot;03&quot;, FRM03 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM03</td>
<td>Question Response</td>
<td></td>
<td>50</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;09.03&quot; and FRM01 = &quot;01&quot;, &quot;01A&quot;, &quot;01B&quot;, &quot;01C&quot;, &quot;02&quot;, &quot;02A&quot;, &quot;02B&quot;, &quot;02C&quot;, &quot;03&quot; or &quot;04&quot;, FRM03 must be present.</td>
</tr>
<tr>
<td>Page #</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Length</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------------------</td>
<td>-------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM03</td>
<td>Question Response</td>
<td></td>
<td>50</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;10.03&quot; and FRM01 = &quot;03&quot;, &quot;03A&quot;, &quot;03B&quot;, &quot;04&quot;, &quot;04A&quot;, &quot;04B&quot;, &quot;05&quot;, &quot;06&quot;, &quot;08A&quot;, &quot;08C&quot;, &quot;08D&quot;, &quot;08F&quot;, &quot;08G&quot; or &quot;09&quot;, FRM03 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM03</td>
<td>Question Response</td>
<td></td>
<td>50</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = '484.03&quot; and FRM with FRM01 = &quot;1A&quot;, &quot;1B&quot;, &quot;02&quot;, &quot;03&quot; or &quot;05&quot; is present, then FRM03 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM04</td>
<td>Question Response</td>
<td></td>
<td>8</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Must not be a future date.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM04</td>
<td>Question Response</td>
<td></td>
<td>8</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;484.03&quot; and FRM with FRM01 = &quot;1C&quot; or &quot;6C&quot; is present, then FRM04 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM05</td>
<td>Question Response</td>
<td></td>
<td>6</td>
<td>DME claims Only. Not valid for Part B Claims.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When LQ02 = &quot;10.03&quot; and FRM01 = &quot;08B&quot;, &quot;08E&quot; or &quot;08H&quot;, FRM05 must be present.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM05</td>
<td>Question Response</td>
<td></td>
<td>6</td>
<td>When LQ02 = &quot;484.03&quot; and FRM01 = &quot;1B&quot; or &quot;6B&quot;, FRM05 must be present.</td>
</tr>
</tbody>
</table>
10.4.16 Transaction Set Trailer

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

Table 29 – Transaction Set Trailer

<table>
<thead>
<tr>
<th>Page #</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Length</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>496</td>
<td>SE02</td>
<td>SE</td>
<td>Transaction Set Control Number</td>
<td>9</td>
<td></td>
<td>Must have the same value as ST02. Must be greater than zero.</td>
</tr>
<tr>
<td>495</td>
<td>2440</td>
<td>FRM05</td>
<td>Question Response</td>
<td>6</td>
<td></td>
<td>DME claims Only. Not valid for Part B Claims. Must be between 0 and 100 and can contain up to one decimal place.</td>
</tr>
</tbody>
</table>

11 Appendices

11.1 Implementation Checklist

When you decide to go live with CGS EDI you will need the following:

- EDI Enrollment Form if you have not submitted this form previously to CGS.
- 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

An example of the 837P control segments and envelopes is below.

ISA*00* 00*27*SSSSSSSSSS 27*15202 190131*1131*^*00501*000000017*0*P*>~
GS*HC*SSSSSSSSSS*15202*20190131*1131*17001*X*005010X222A1~
Please refer to the GPNet communications manual posted under Manuals and User guides at https://www.cgsmedicare.com/partb/edi/index.html

11.3 Frequently Asked Questions

Frequently asked questions can be accessed at https://cgsmedicare.com/. Click on the line of business. FAQ’s can be located on the menu.

11.4 Acronym Listing

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>276/277</td>
<td>276/277 Claim Status Request and Response transaction</td>
</tr>
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### 11.5 Change Summary

The following table details the version history of this CG.

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<th>Version</th>
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<th>Change Summary</th>
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